



Cumbria Safeguarding Adults Board Annual Report 2023-24

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Glossary of Terms

CNTW	Cumbria, Northumberland Tyne & Wear NHS Trust
CSAB	Cumbria Safeguarding Adults Board The overarching purpose of an SAB is to help safeguard adults with care and support needs.
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.
DASH	Domestic Abuse, Stalking & Honour Based Violence Is used by a practitioner to assess the risk of domestic violence to an individual, including children.
DBS	Disclosure and Barring Service A DBS check is a process undertaken by the Disclosure and Barring Service which checks an individual's criminal record.
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
ICB	Integrated Care Board NHS organisations responsible for planning health services for their local population.
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.
IRIS	Incident Reporting System IRIS is a system used by health and social care workers to record relevant information pertaining to individual's, for whom they are providing care or support.
L&D	Learning & Development This is a sub-group of Cumbria Safeguarding Adult's Board.
LGR	Local Government Review Local Government Review of the provision of local, district and county council arrangements.
LSCFT	Lancashire & South Cumbria NHS Foundation Trust
LSCICB	Lancashire & South Cumbria Integrated Care Board (NHS)

LSPR	Local Safeguarding Practice Review Is a multi-agency review that is undertaken when a child dies or is seriously injured as a result of abuse or neglect and there are concerns agencies could have worked together better to help safeguard the child.
MAPPA	Multi-agency public protection arrangements A system to ensure the effective management of violent and sexual offenders.
MCA	Mental Capacity Act 2005
MDS	Modern Day Slavery Modern Day Slavery is when an individual is exploited by others for personal or commercial gain.
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.
NFCC	National Fire Chiefs Council The professional voice of UK Fire & Rescue, who provide support to improve services.
NHS	National Health Service
NSIP	Northumberland Stalking Intervention Programme Part of an initiative aimed at addressing stalking and harassment across England and Wales.
NSD	National Security Division NSD consists of specialist security officers dedicated to supervising terrorism-risk offenders.
NWAS	North West Ambulance Service
PiPoT	Person in a Position of Trust A process that is used to support the approach and process to follow when responding to concerns or allegations about a person in a position of trust.
P&QA	Performance & Quality Assurance Group This is a sub-group of Cumbria Safeguarding Adults Board.
RAR	Rehabilitation Activity Requirement This is a legal requirement given by a Judge to a person who has committed a crime to secure their rehabilitation.
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.

SAR Safeguarding Adult Review

A Safeguarding Adults Review takes place when 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.

S42 Section 42 Enquiry

A duty of the local authority to investigate if an adult may be at risk of abuse or neglect.

VARMM Vulnerable Adult at Risk Management Model

A multi-agency process used to help manage high-risk safeguarding adults' cases.

1. A message from the Independent Chair

It really does not feel that a full year has passed since I introduced the last Annual Report, and yet there has been an incredible amount of work and progress made across the whole partnership of services which make up the fabric of Cumbria Safeguarding Adults Board.

The partnership has secured new working arrangements following the creation of two new councils in April 2023, Westmorland and Furness Council and Cumberland Council.

There already was a very complicated patchwork of geographical boundaries between the services in Cumbria and a real risk, that introducing two new organisations would further complicate communications and transitions between services. All of the Board partners, as well as the Councils' Services, have however worked diligently together to ensure any risks were mitigated and there was a smooth transfer of services and the community's vulnerable adults remained safeguarded throughout.

In fact, the new service arrangements have brought a greater degree of vibrancy to operations and given an opportunity for redesign and a refresh of the work required in the safeguarding agenda.

In the midst of these changes, the Board has had to deal and respond to many issues which services are reporting, as a change in the pressures they have to face. Self-neglect still prevails as the biggest challenge in our communities, not just here in Cumbria but across the country. The recent 2nd national analysis of Safeguarding Adult Reviews, as also identified by the 1st national analysis, that self-neglect is the primary reason for the need for investigation.

I particularly wanted to highlight in this introduction, the work of carers at home, which is often missed. Families, friends, and neighbours provide a resource, the magnitude of which is on a par with all of our services. Without their work, our society simply could not function. Across the partnership there is obvious recognition of this work, and practical support in place for these unpaid carers and there is a great enthusiasm to do more in this arena next year.

The response from partners to the pressures outlined here, has remained outstanding throughout this year. Whilst undertaking and delivering on our priorities, the board has had an exceptional year in delivering learning across our agenda. The number of events, and the attendance are evidence enough of their popularity, but the feedback from professionals sharing the impact on service delivery is the very real proof of their worth.

For the year that comes, we know that resources and capacity will continue to be challenged, and that the increase in cases, and the acuity of those cases our services need to address, will increase further. This is a very dangerous combination and will raise the degree of risk for the partnership and our community's safety. We have balanced this in this year, but we know we will need to do even more in the next.

Again, thank you for your interest and support for the collective of individuals; in services, at home and in our communities, who deliver safeguarding for all of us.

Kind regards and keep safe.

Robert 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 2023/24 to safeguard adults at risk of abuse or neglect.

This year seen new beginnings with the establishment of 2 new unitary authorities, Cumberland Council and Westmorland & Furness Council. CSAB continued as a partnership with a Pan Cumbria approach to ensure we worked together to safeguard adults at risk of abuse or neglect.

In this report we will describe the activity and achievements of the Board and sub-groups during Year 2 of our 5-year [Strategic Plan](#). In addition we will report the themes, learning and actions taken for Safeguarding Adult Reviews (SARs) published during the reporting period.

We have measured our achievements against the goals and initiatives outlined in our [2-year Business Plan 2022-24](#). The development of this 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.

3. Who are we and what do we do?

Cumbria Safeguarding Adults Board (CSAB) is a statutory body who, as directed by The Care Act 2014 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 through our sub-group structures; -

- Cumbria Constabulary*
- North East & North Cumbria Integrated Care Board*
- Lancashire & South Cumbria Integrated Care Board*
- Cumberland Council*
- Westmorland & Furness 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 Cumberland and Westmorland & Furness
- People First Independent Advocacy
- Lay Membership
- National Probation Service North West
- Department of Work & Pensions
- North West Ambulance Service

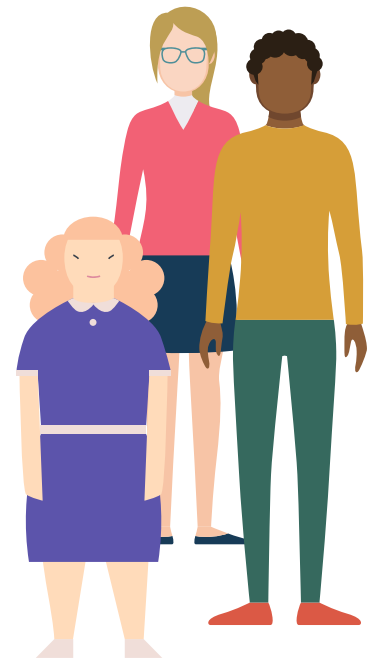
The Board leads adult safeguarding across Cumbria and works with organisations and our partners to ensure that they have effective safeguarding arrangements in place, ensuring adults who may be at risk of abuse or neglect are able to;

- 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.

Empowerment

People being supported and encouraged to make their own decisions and give informed consent



Prevention

It is better to take action before harm occurs

Proportionality

The least intrusive response appropriate to the risk presented



Protection

Support and representation for those in greatest need

Partnership

Local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse



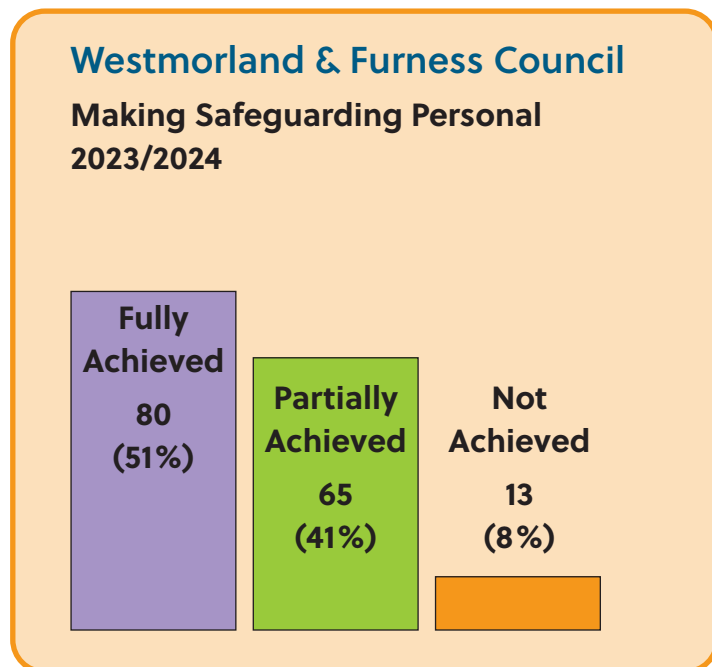
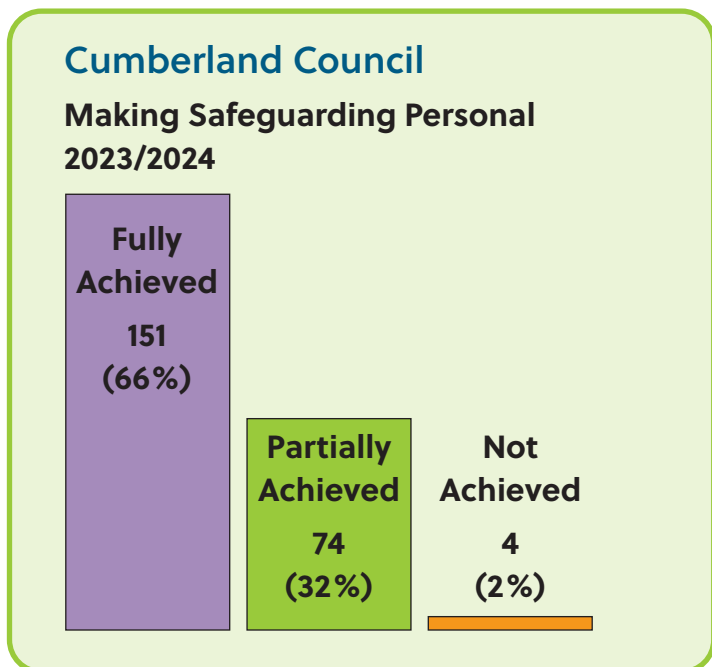
Accountability and transparency

In safeguarding practice

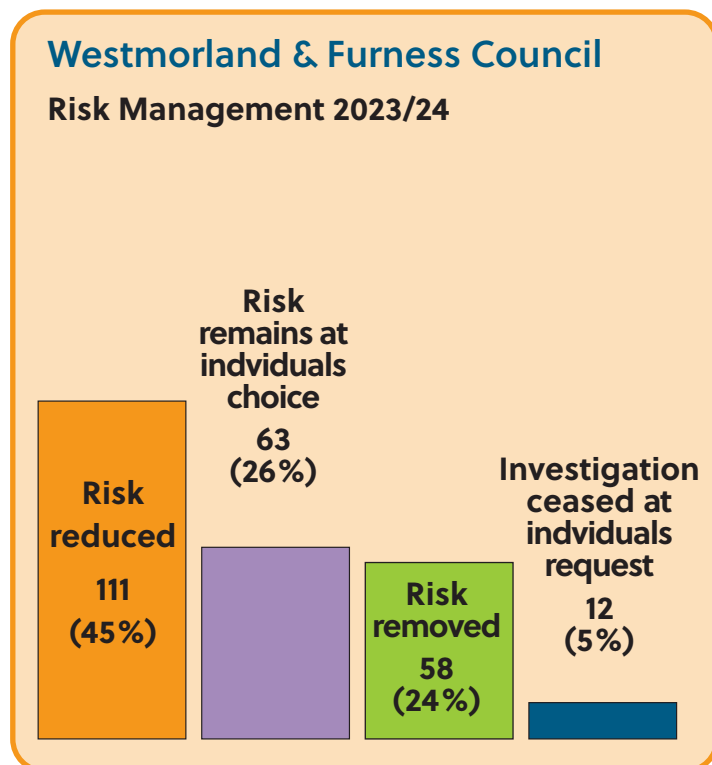
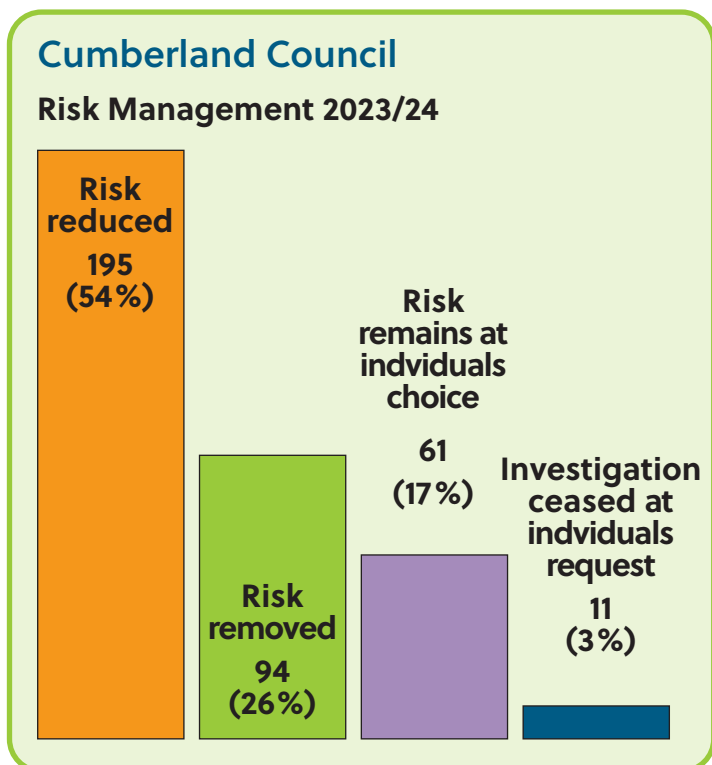


Making Safeguarding Personal – outcomes

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.



6.1 John's story

Through our Learning & Development sub-group members share examples of good practice to promote and encourage learning from each other across the safeguarding partnership.

John is a 73-year-old gentleman who lived alone with his dog in an isolated old worker's cottage in Cumbria. John paid a peppercorn rent to a private landlord he had no contact with. Although the property was rented John considered it as belonging to him for the rest of his life. John expressed a very deeply held wish to remain in his property until the day he died as he had been born there and lived most of his life there. John is no longer in contact with family, however, has a friend in the nearby village who provided him with some help and support.

John has unstable diabetes with some evidence of mild cognitive issues. However, John had managed to live independently for many years, driving to his GP surgery every day for support with his insulin from the practice nurses. John recently lost his driving licence due to poor eyesight and so the District Nursing Team visited John at home to administer his insulin as he could no longer get to the GP surgery.

The District Nursing Team visiting John discovered that his home was in extremely poor condition. There was no heating or hot water, it was Winter and the property was very cold with temperatures consistently below freezing. They found that the electrics were unsafe and John did not appear to have a working fridge or oven. During visits District Nurses found John did not appear to have sufficient food and the food he did have was often spoiled or out of date.

John was regularly found to be hypothermic and with low blood sugars when the District Nurses visited and there were concerns that John did not understand the risk of serious harm or death, if he did not manage his diabetes and keep himself warm and well fed. As a result John's GP and District Nurses raised a safeguarding concern with Adult Social Care due to the high risk of harm or death in relation to self-neglect.

On occasions John could become verbally aggressive when it was suggested that his home was no longer suitable for him to live in. John often expressed threats of self-harm if he was no longer able to live in his cottage. The professionals involved were concerned and felt that John was capable of carrying out such threats.

Although John did not agree that he was at risk of harm he did accept support from the District Nursing Team and Adult Social Care with food packages and coal for heating. However John was not accepting of additional support and did not agree that his home was unsafe for him to live in. John was aware that the safeguarding process had been started but did not wish to engage with this, although John was happy to continue with visits from professionals over the winter period to check his wellbeing. In his absence John agreed that an Advocate could represent him and his views during safeguarding meetings.

These safeguarding meetings brought together all of the professionals involved with John's care including Environmental Health who attended his home due to concerns for John's safety. Professionals held different opinions in respect of John's capacity to understand the risks and it appeared his capacity did fluctuate. It was agreed that whilst John had capacity to make unwise decisions in parts of his life such as his accommodation, he was felt to lack capacity in relation to managing his health and nutritional needs. As a result this required professionals involved to assess risks as they occurred and ensure communication with the multi-disciplinary team. This presented challenges to professionals, as at times John's situation was high risk and concerning to all involved.

As time progressed it was Environmental Health who advised John that they had no choice but to take enforcement action against the landlord of the property as it was no longer fit for habitation. As a result John was advised he would need to move out or face court action himself. Further to this advice John accepted that he could no longer live safely in his home and agreed to move with his dog into sheltered accommodation in the nearby village which was close to his friend.

There were benefits to John living in the village and he was able to resume visiting the GP surgery daily for diabetes management support and John was able to source food independently from the local shop and café.

Following his move John told professionals involved in his care that although he was sad to no longer live in the cottage where he had been born and had hoped to live out his life, moving to sheltered accommodation had ultimately been the right decision.

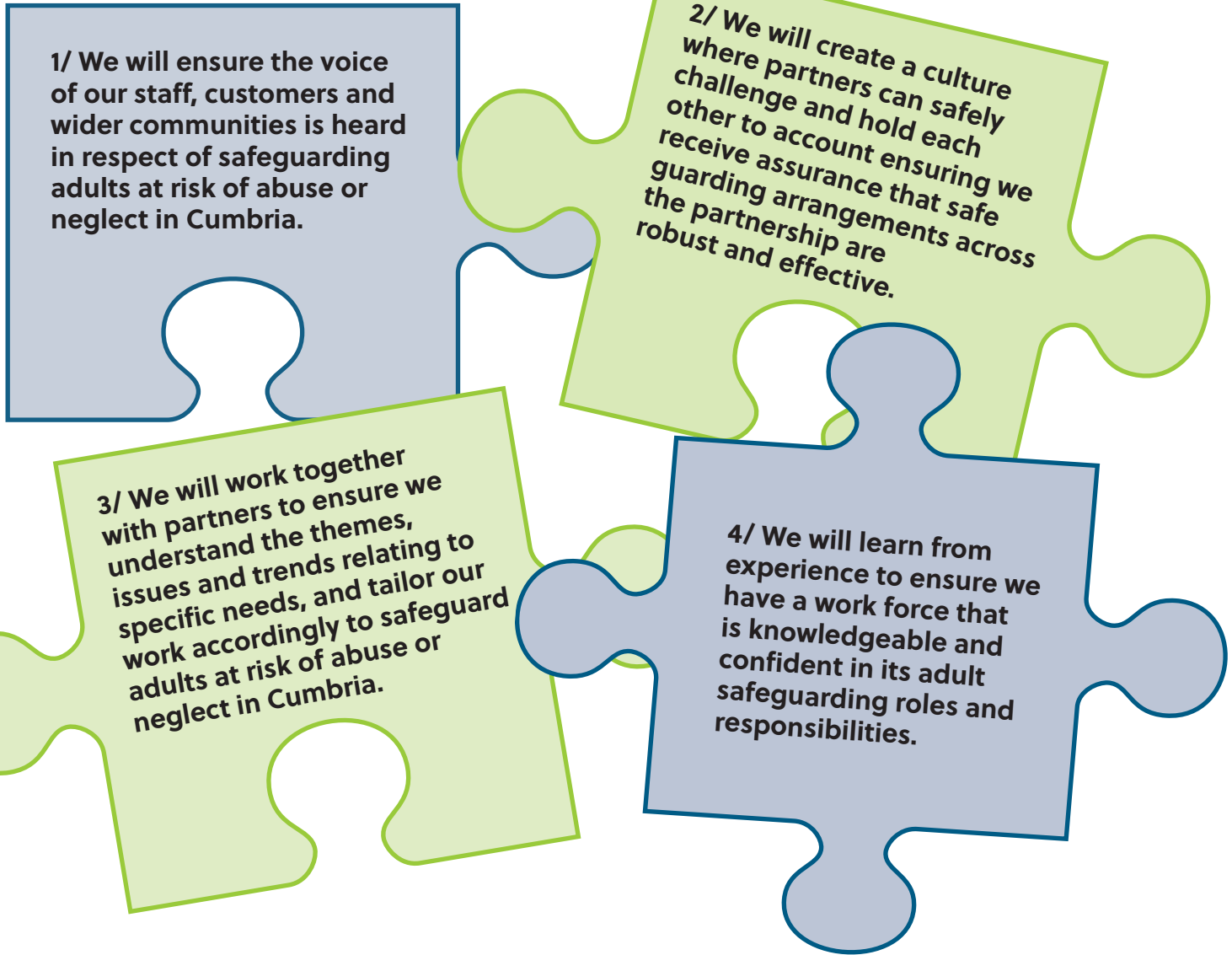
John continues to be supported in the community, having his care needs met locally and living happily in his new home which is warm and safe whilst still maintaining some independence and autonomy.

John's story demonstrates persistence and co-ordination of support from Adult Social Care and the District Nursing Team who supported him with food and coal deliveries over the winter months (including Christmas Dinner!). In doing so they significantly reduced the risk to John and developed a positive relationship with him that eventually supported John in his decision to move when he was required to do so.

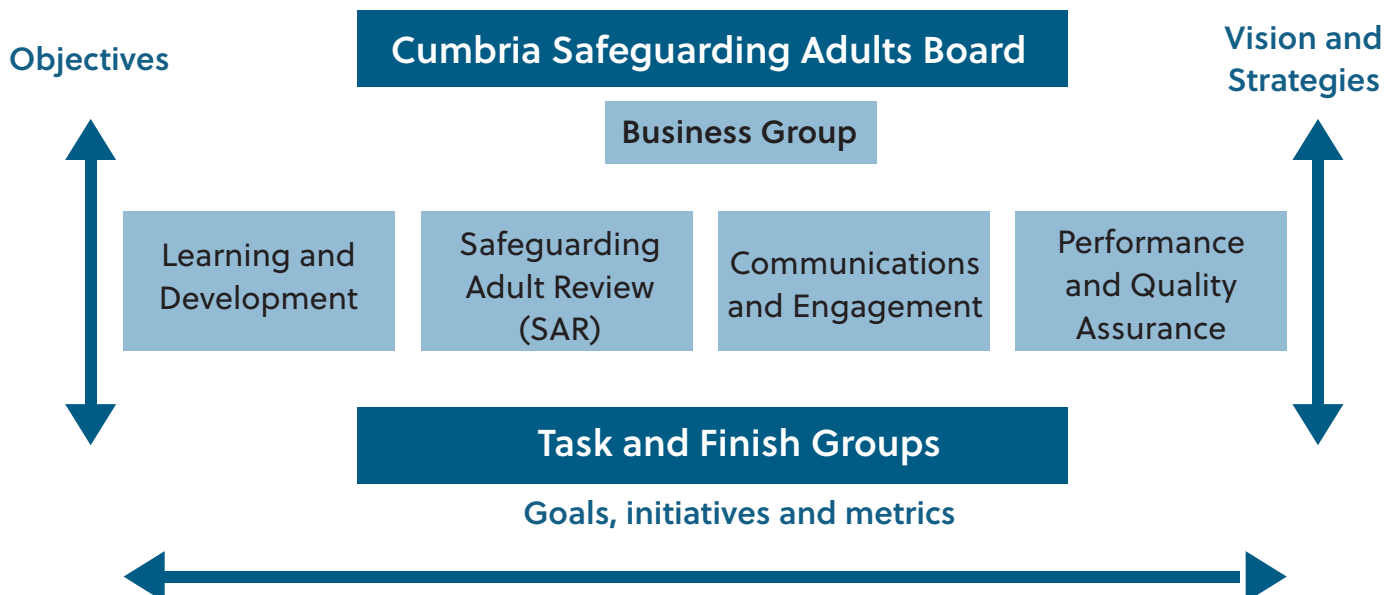
John's home was of 'magnetic importance' to him and this was considered at all times by professionals. John's right to make 'unwise decisions' as a capacitated adult in relation to his living accommodation was understood and respected. The risks to John from his lack of capacity in relation to his health and nutritional needs, were mitigated by professionals as far as possible whilst still maintaining his human rights and wishes in the other aspects of his life. John's story is an example of how a multi-disciplinary team worked effectively together to reduce the risks, ensure John's voice and wishes were considered and make safeguarding personal.

John's story has been presented to Cumbria Safeguarding Adults Board and will be shared with practitioners across the system through lunch & learn sessions during 2024/25 to highlight how professionals working together, developing effective relationships, safeguarded John from the risks associated with self-neglect.

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. 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?

Learning & Development sub-group

Delivered **14** 'lunch and learn' sessions **728** participants

MCA week of action June 2023

During 2022/23 we delivered an audit across the partnership to seek assurance regarding respect of Mental Capacity Act policy, training and leadership. The findings from this informed planning for a week of action during which we delivered learning sessions and briefings based on the five principles of the MCA.

85% responded sessions improved understanding of the term executive functioning



NHS England 'Commitment to Carers' lunch and learn session

92% increased knowledge & confidence when working with carers

"fantastic list of resources, great information for practice"

CSAB supported National Carers Week, briefings available on our [website](#).

SAR lunch and learn sessions: Jessica and Sarah

100% responded sessions met expectations

What did you find most useful from the session?

"reminder to put person at the centre"

"reinforcing that a multi-agency approach is best practice"

Recordings of our [lunch and learn sessions](#) are available on our website.

The delivery of learning is through a pool of facilitators drawn from across the partnership. During 2023/24 we continued to increase the pool and support facilitators through a programme of regular drop-in sessions to provide on-going learning, development and peer support for the group.

6 sessions during 2023/24

Communication & Engagement sub-group

Posters & leaflets

During 2023/24 we disseminated our '[See it, Report it, Stop it](#)' posters and leaflets across 700+ establishments where members of the public access including; Post Offices, Banks, Sports Centres, Churches and Pharmacies to raise public awareness of abuse and neglect.



Staff survey

We delivered a CSAB Staff Survey aimed at practitioners across the partnership to evaluate our communication methods.

204 staff completed the survey

Responses informed an improvement plan and action for the Communication and Engagement sub-group in collaboration with Learning and Development.



News for subscribers

Relevant safeguarding messages were shared/disseminated throughout the year using a variety of platforms. Monthly newsletters are published supported by a range of 5-minute briefings & Quick Guides covering a range of safeguarding subjects to provide information for practitioners and the public.



Published during the period

Subscribers to our newsletters are national and positive feedback has been received regarding the content.

10 newsletters




16 5-minute briefings

2 Quick Guides to...

A Quick Guide to... [Advocacy](#)

A Quick Guide to....[substance misuse](#) & self-neglect

Subscribers to news: April 2023 = 4573
 March 2024 = 5124  551 new subscribers



Followers April 2023 = 708
 March 2024 = 753



Increased by 45 followers

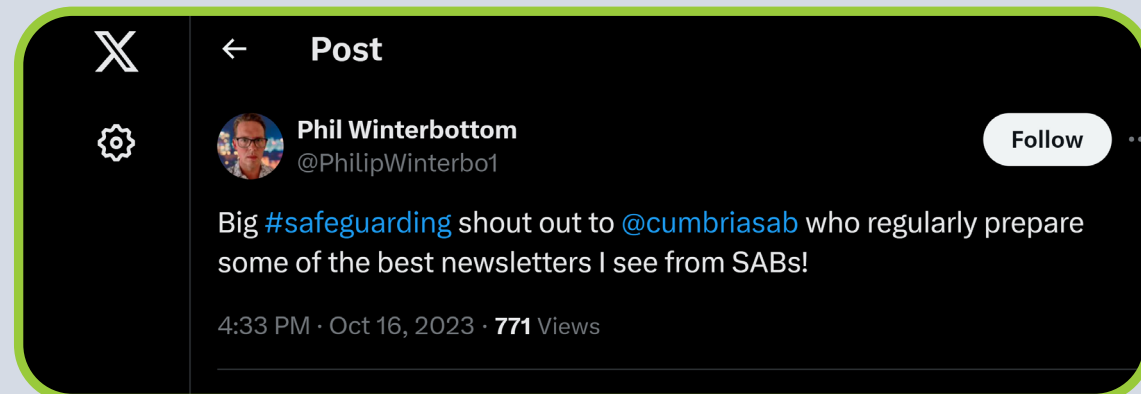
There was a total of **13,580** visits to the website during **2023/24** a significant increase of almost 5k visitors when compared to the visits during the previous 12-month period.



Highest number of visits in June 2023



Lowest number of visits in December 2023



In June 2023, we delivered a local campaign and supported National Carers Week, to raise awareness of support available to carers. This is positive evidence of the impact and reach the campaign had.



Cumbria Safeguarding Adults Board

National Safeguarding Adults Week 2023: Safeguarding yourself & others



Delivered 3 lunch & learn sessions

What is Safeguarding Adults?

Introduction to safeguarding, types of abuse and how to report. **38** attended including; Dentists, Parish Councils, Community Associations, Dentists & Building Societies **95%** felt more informed about safeguarding adults



Introduction to Trauma Informed Practice

32 attended **100%** agreed the session improved their understanding of the ways trauma may impact on how people they are working with present

Why does Language Matter?

11 attended **100%** agreed the session improved awareness and understanding of the importance of language

“Power of language”

“Good introduction would like to learn more”
“Good example of application in practice”



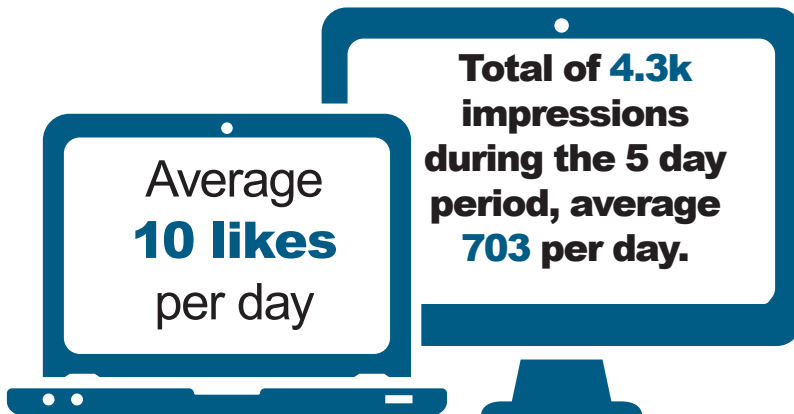
'X' Top post earned 775 impressions on Day 2.

Welcome to Day 2 of #NationalSafeguardingAdults Week @AnnCraftTrust Do you know what #safeguarding adults is, what is #abuse and importantly how to report concerns in #Cumbria Check out our website where you will find more information and resources

269 visits to CSAB website

480 page views

Down from 2022



Followers **751** up from **644** in 2022

Subscribers to CSAB news up **700+** from 2022

5,075 subscribers received daily briefings = total **25,375** briefings published during the week

@cumbriasab cumbriasab.org.uk

8.4 Performance & Quality Assurance Group

We received assurance from our partners through annual assurance presentations. To support the process partners are provided with a template which includes prompts and suggested evidence sources. This formed a rolling programme of assurance during the year, including themes relevant to learning from Safeguarding Adult Reviews.

- Established a Task and Finish Group to review the data presented to CSAB to include data pertaining to safeguarding concerns and activity from the wider partnership.
- A repository of 'assurance' was developed to capture and acknowledge the various forms of assurance received by CSAB.
- Safeguarding data was presented by Cumberland Council and Westmorland & Furness Council. Refer to 'Our Year in Data' section 10, for more details.
- 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.

12 partners completed self-assessment and assurance in relation to leadership & culture across their organisation.

12 presented evidence to 4 check and challenge events during 2023/24.



Supervision and staff support



Learning and Development

Recording, processes and procedures



Culture



Whistleblowing



Feedback from the process was positive with both 'compliments & challenges' captured from events illustrating how partners learned from each other during the process.

"Promoted useful learning from each other and also better understand the challenges we all face"

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. The process informed assurance reports to CSAB by the Chair of the SAR sub-group.

During **2023/24**, the group seen a significant increase in referrals to consider for a SAR. A total of **13** were considered (increase from **3** during **2022/23**). Members of the sub-group and agencies involved with the subject of referrals provide additional information to inform robust decision making applying the decision-making tool.

Of the 13 referrals the sub-group received during 2023/24, it was agreed;

5 did not meet the statutory criteria for a SAR (either a mandatory or discretionary review process).

1 referral met the statutory criteria for a mandatory SAR and it was agreed this should be commissioned to run in parallel with a Domestic Homicide Review. A process for identifying an independent reviewer was completed and the SAR will complete during 2024/2025 with learning reported in next year's Annual Report.

1 referral met criteria for a mandatory SAR, this was commissioned during 2023/24 with the final SAR report expected to be presented to CSAB in 2024/25.

The SAR sub-group considered and agreed **6** referrals met criteria for a mandatory SAR, where there were concerns about the individuals ability to protect themselves from self-neglect. The Independent Reviewer will adopt a systems methodology to examine the barriers in the system for frontline practice when working with adults who experience self neglect.

The Chair and Business Manager utilise the National SAR Reviewers Network to commission Independent Reviewers. This process supports identification of reviewers with relevant experience and knowledge for SARs.

8.6 Policy & Guidance Task & Finish Group

This Task & Finish Group was established to review safeguarding adults' policy and procedures continued to meet to ensure guidance was reviewed and developed. Membership of the group was reviewed as the group reconvened to undertake routine review of policy and guidance for the Board.

[Policy & guidance can be found here.](#)



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.

Miss B

During 2023/24 CSAB accepted a SAR, Miss B. However in agreement with family and to ensure the anonymity of the individual concerned it was agreed not to publish the report. The learning has been shared with those agencies involved in the care to ensure lessons inform frontline practice.

Miss B's sad death was unexpected and there were concerns about how agencies worked together to protect Miss B from self-neglect. Specifically, Miss B was known not to adhere to her medication plan, including the administration of insulin. The information presented in the SAR referral indicated that agencies could have worked together more effectively to prevent harm resulting from the self-neglect occurring.

Regular review of the Action Plan will provide assurance to the SAB. The recommendations and actions include the following;

SAR Learning and Recommendation	CSAB response and actions
Empowerment	
<p>Many of the professionals involved with supporting Miss B knew her well including what was important to her. Despite this, there appears to have been a missed opportunity to utilise this knowledge and a determination to deliver support in the way that the professionals believed it should be delivered.</p> <p>The Integrated Care Communities (ICCs) should consider including a structured risk management approach in their complex case meetings when significant risk of harm is identified. To include the identification of each specific risk, its likelihood, potential impact and what mitigating actions can be deployed and by whom. The risk management document should be shared across all organisations involved and timescales for review agreed.</p>	<ul style="list-style-type: none"> ✓ CSAB will link with ICC Managers to ensure learning from the Miss B SAR is shared. ICC's will be encouraged to consider the recommendation and proposed actions regarding approach to risk management. ✓ This will be progressed during 2024/25.
Prevention	
<p>Unlike many scenarios involving self-neglect, Miss B was in regular and frequent contact with services. Although described as someone who would 'disengage', information submitted to the review highlighted many opportunities when Miss B actively sought the support or advice of professionals. Practitioners were concerned about Miss B's non-adherence to treatment plans, however there is little evidence to suggest that a flexible collaborative approach was developed to engage with Miss B.</p> <p>Cumbria Safeguarding Adults Board should seek assurance across the system in respect of professional's legal literacy in respect of Safeguarding Adults. Professionals need to be fully conversant with the Care Act 2015 statutory guidance relating to Safeguarding Adults.</p>	<ul style="list-style-type: none"> ✓ Through the L&D sub-group CSAB will seek assurance from partners that legal literacy is included in mandatory training programmes. ✓ The Safeguarding Adult Framework (SAF) assurance completed will inform completion and compliance across Primary Care. This is a contractual requirement to complete and submit the SAF, assurance will be reported back annually by Integrated Care Boards via P&QA sub group.

SAR Learning and Recommendation	CSAB response and actions
<p>Proportionality</p>	
<p>The professionals involved believed they were working in a proportionate way and were in their view respecting Miss B’s legal right to make ‘unwise’ decisions. However, given the significance of the recognised risk to Miss B, the reviewer suggested that this approach was misguided and a more proactive response to safeguard Miss B could have been considered.</p> <p>Cumbria Safeguarding Adults Board should support the organisations represented in this review to undertake a Reflective Practice event to focus on the learning from this review with a specific focus on considering the use of language and the impact of professional bias. Critically evaluate their responses to meeting individual needs which may require a flexible approach.</p>	<p>CSAB commissioned an external experienced facilitator to deliver a Reflective Practice Event for all practitioners involved. Feedback was gathered from participants to evaluate if the event had supported reflection and learning.</p> <p>100% felt it provided a safe space to reflect with colleagues from other organisations who worked with Miss B.</p> <ul style="list-style-type: none"> → Felt open and honest → Challenge seniority → Lovely to learn more about Miss B and share her memory really emphasised holding that person central → Listen to understand → Don’t seek permission to “ask why”

SAR Learning and Recommendation	CSAB response and actions
Protection	
<p>Opportunities were identified for some services working with Miss B to improve their legal literacy in relation to Safeguarding Adults to ensure that the support of other partners is sought in a timely way which could have protected Miss B from the anticipated harm resulting from the self-neglect. Learning was identified in relation to mental capacity. There was clear evidence that professionals believed that Miss B had capacity in respect of the management of her health needs and therefore felt that they could not challenge or intervene. However, irrespective of whether Miss B had the mental capacity to make decisions in respect of adhering to her treatment plan or whether the s42 safeguarding duties applied, Safeguarding is not a substitute for providers' responsibilities to provide safe, high-quality care and support. It appears that there was professional over-reliance on the capacity assessment, and this had an impact on what care they felt could or should be delivered. The reviewer also noted limited flexibility in the approach to care delivery.</p> <p>Cumbria Safeguarding Adults Board should develop a briefing in respect of the role and expectations of informal carers. This should include an outline of statutory duties towards carers and support an approach whereby informal carers views are sought and valued.</p>	<ul style="list-style-type: none"> ✓ CSAB supported raising raise awareness of the role of informal carers through briefings and resources during National Carers Week June 2023. Signposting and resources will disseminated across the system including on the website aimed at both informal carers and practitioners to raise awareness of the role informal carers play, access to support and responsibilities for carers assessments. ✓ In November 2023 NHS England delivered a lunch & learn session 'Commitment to Carers' to practitioners across Cumbria & Pan Lancashire SABs. ✓ Unpaid carers continues to be an area of focus for CSAB sharing messages to raise awareness.

SAR Learning and Recommendation	CSAB response and actions
<p>Partnership</p>	
<p>There was clear evidence of regular liaison between individual professionals who knew Miss B well. The professionals involved understood each others' roles and predominantly shared the same views and perceptions with regard to the extent of and limitations to, the way Miss B should be supported. However, the approach adopted did not prove successful in achieving the desired outcomes and there was a missed opportunity to explore views, perceptions or an alternative approach with a wider multi-agency group. The formal raising of a Safeguarding Concern with the Local Authority may have provided this opportunity. In addition, engaging a wider group of professionals via a referral to the Integrated Care Community (ICC) complex case and multi-disciplinary meetings, may also have resulted in a more comprehensive risk management or health and care support plan for Miss B.</p> <p>Cumbria Safeguarding Adults Board should support the partnership to improve their knowledge and understanding of trauma informed care and how it can strengthen a person-centred response to Adult Safeguarding.</p>	<ul style="list-style-type: none"> ✓ During NSAW 2023 CSAB collaborated with Trauma Informed Lancashire & Pan Lancs SAB to deliver an Introduction to Trauma Informed Practice. The session was recorded and available to view, briefings regularly encourage and signpost to recorded sessions for independent learning. ✓ This learning offer and awareness raising was further enhanced through the CSAB Conference in 2023 which included a session by experts by experience, Lad's Like Us, highlighting the impact trauma can have on how an individual engages with professionals and their behaviours. ✓ Feedback from both sessions was positive and reported back to L&D sub group. ✓ A programme of activity and learning in relation to Professional Curiosity has been delivered and available on the CSAB website.

SAR Learning and Recommendation	CSAB response and actions
Accountability	
<p>The findings in this review identify areas for learning and improvement with respect to working in a person-centred way which could have explored how Miss B would have wanted to be supported. This in turn would have required professionals to be accountable to Miss B in exploring whether this could be achieved. The formulation of a multi-agency risk or case management plan could have resulted in clearly identified roles, responsibilities and action owners. Wider inter-agency involvement via the ICC would create the opportunity for professional challenge and scrutiny where normalisation of behaviours or unconscious bias or misconceptions may be present.</p>	<ul style="list-style-type: none"> ✓ CSAB have shared the report and learning briefing with agencies involved for practitioners learning. ✓ CSAB will host and facilitate a SAR lunch & learn session during 2024 to disseminate learning widely across the system.

How do we share SAR learning?

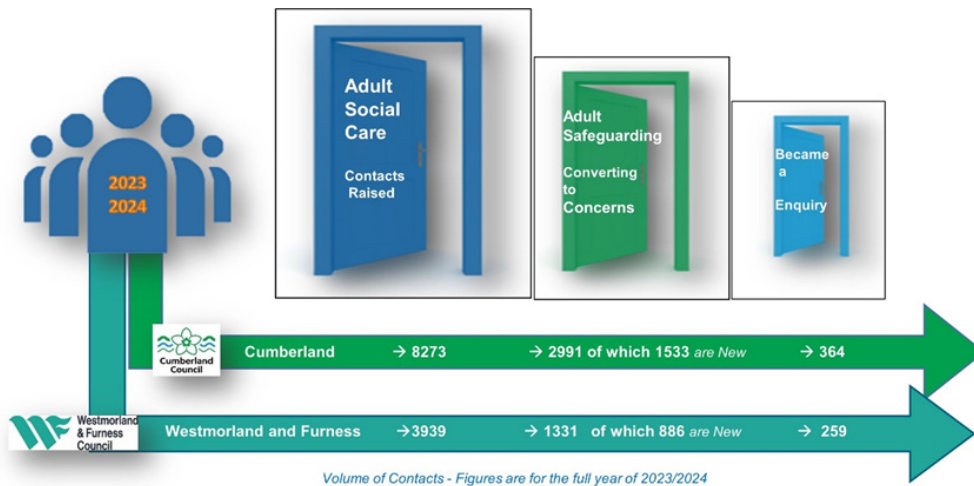
As a Board we have adopted the following methods to share learning and ensure this is embedded into practice;

- SAR lunch & learn sessions to share learning, stimulate multi-disciplinary discussion based on the key learning themes identified in SARs
- Review and launch updated guidance where relevant
- Publish Learning Briefs for practitioners to provide a summary of the SAR and the learning identified in the report
- Develop Action Plans and seek to receive assurance and evidence from partners on how learning has been implemented

10. Safeguarding; our year in data 2023/24

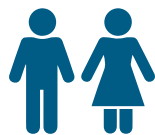


This map illustrates the number of referrals received across the 2 Council footprints where either the referrer or the SPA Officer identified 'safeguarding'. **8273** contacts for Cumberland Council, **3939** contacts Westmorland & Furness Council.

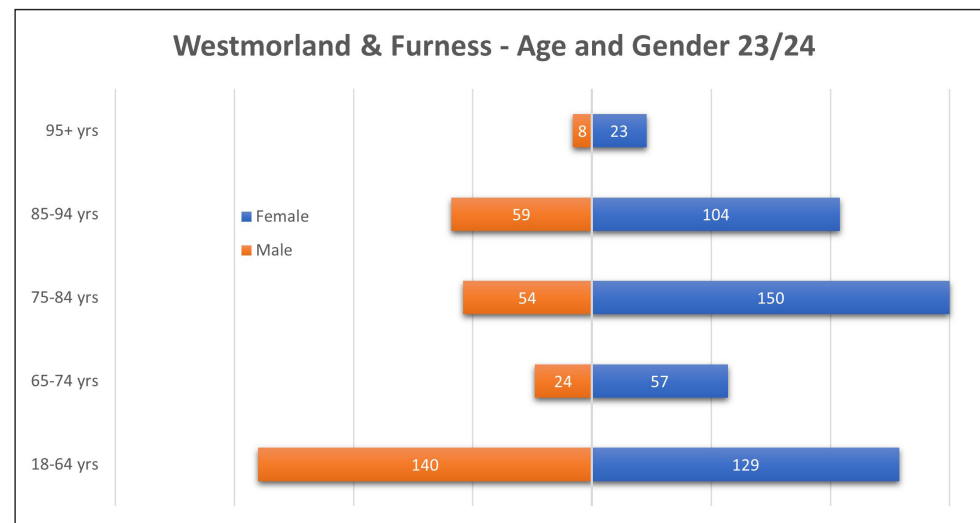
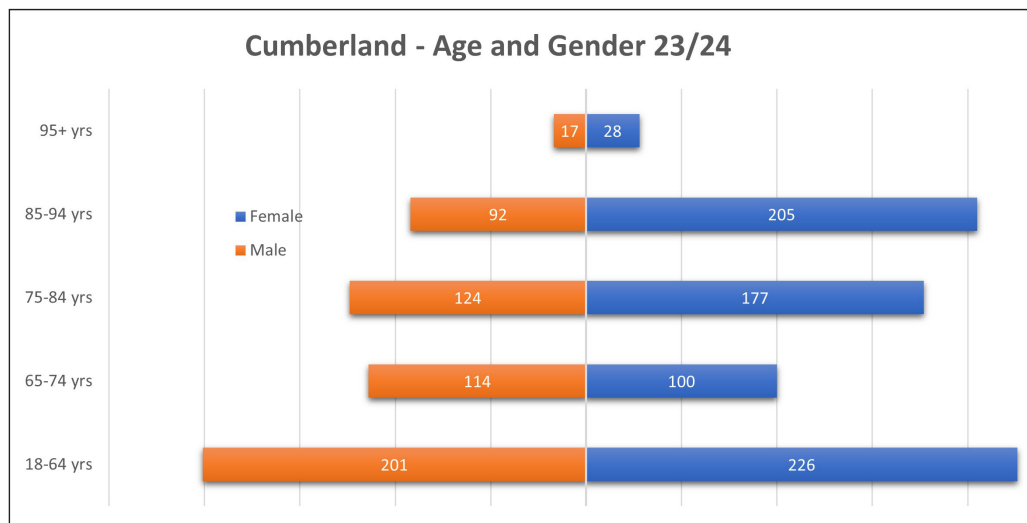


This diagram illustrates referrals made to the Single Point of Access (SPA) Adult Social Care 'Front Door', those which are triaged to Safeguarding as a 'concern' for further information gathering and which then progress to a Safeguarding Enquiry.

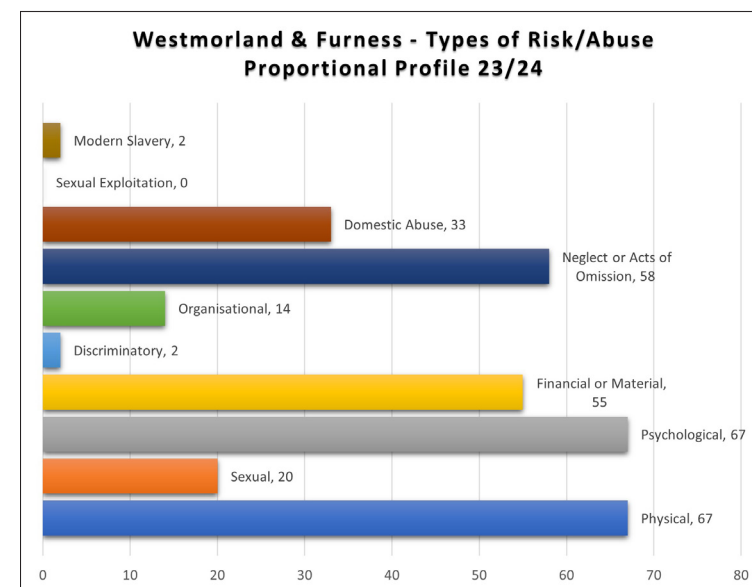
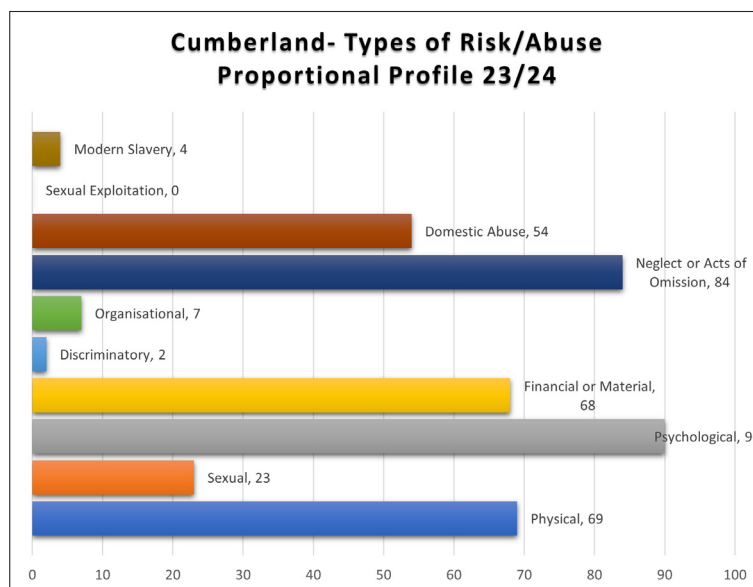
Safeguarding; our year in data 2023/2024



The age and gender table is based on the concerns raised with Adult Social Care, Cumberland Council.

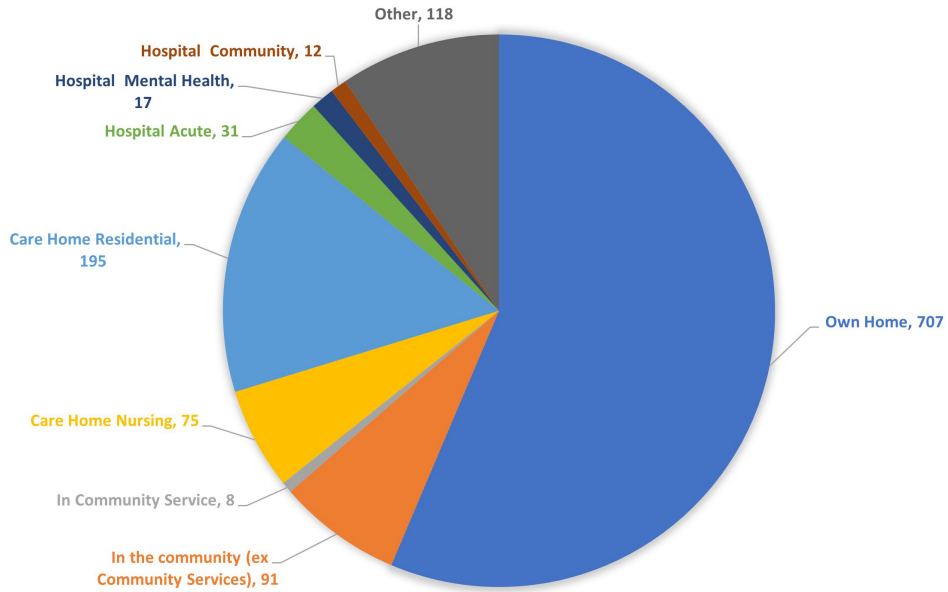


The information to the right relating to types of abuse and the location is based on closed safeguarding enquiries.

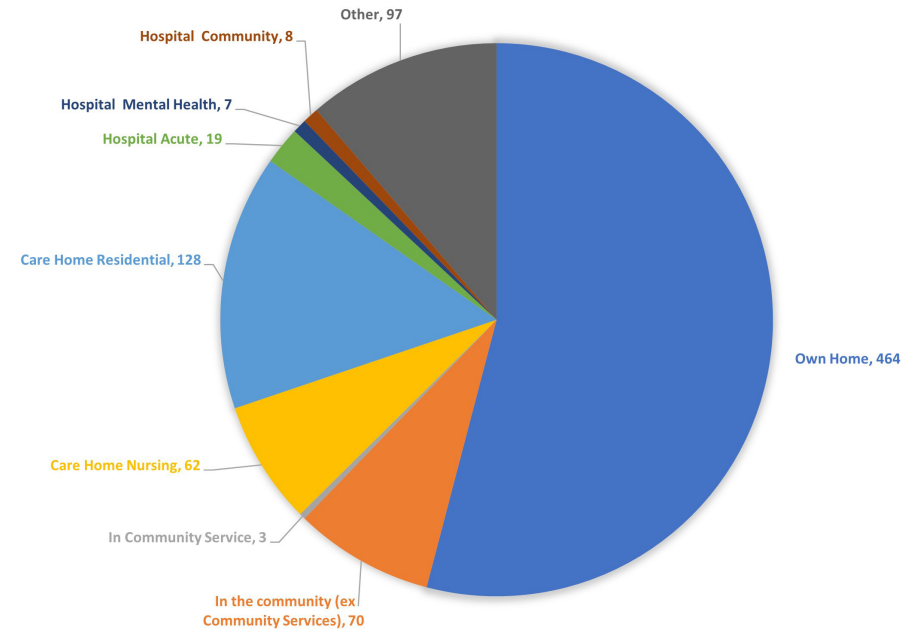




CUMBERLAND - LOCATION OF THE ABUSE 2023/2024





WESTMORLAND & FURNESS - LOCATION OF ABUSE 2023/2024






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 4 strategic objectives in the 5-year plan


Agency	What’s working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>Cumberland Council</p>	<ul style="list-style-type: none"> ➔ Maintaining safe delivery during the process of Local Government Reorganisation. This involved the disaggregation of the service across the two new authorities. The process of disaggregation required the establishment of new management and team structures within the new Council. ➔ Responding to demand relating to safeguarding following disaggregation. Data shows that 2/3 of all safeguarding activity in Cumbria is located within Cumberland. The Council has looked to align skills and knowledge with areas of expertise. 	<ul style="list-style-type: none"> ➔ There is a need to consider management of resources against demand in the new Council given the data that Cumberland accounts for 2/3 of all activity. ➔ Need to develop strength based and trauma informed practice to ensure our staff fully understand and achieve the best outcomes for individuals at risk. As an example, addressing self-neglect is not exclusively located within the safeguarding service area. However, knowledge raising around these issues will have a positive impact for the adult as well as strengthen practitioner responses to such concerns. 	<ul style="list-style-type: none"> ➔ All three of the above points cover the need for the system to develop a co-ordinated strategy in relation to modern day slavery and sponsorship abuses. This strategy needs to have a direct connectivity with the Community safety partnership, given that exploitation sits within the CSP. The safeguarding board could act as a vehicle to include partners such as the Home Office to engage in enquiry processes where there is a concern linked to MDS and sponsorship abuses.


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>Cumberland Council</p>	<p>→ culture of continuous learning and improvement across the safeguarding partnership:</p> <ul style="list-style-type: none"> - Implementation of a Mental Capacity Act forum. This is available to systems partners including health and Children's services. - Delivery of the self-neglect strategy. This has included 8 direct learning sessions attended by 156 practitioners. - Instigation of task and finish group linked to PQ&A around development of a collective partnership data capture for safeguarding activity. - Introduction of the domestic abuse internal practice forum. 	<p>→ Need to develop knowledge and skills in the context of prevention. This is in order to reduce the amount of cases that progress to full enquiry in the absence of alternative measures designed to reduce risk. We need to lead on prevention, so responses are proportionate to the risk and are MSP led.</p> <p>→ Direction and leadership – embrace and embody the statutory role of being the lead agent around safeguarding concerns, whilst fully utilising system expertise and resources around enquiries and concerns.</p> <p>→ Empowering practitioners to own risk management around safeguarding concerns and understand that safeguarding is core to the practice of social work – a good social work intervention is to safeguard.</p>	<p>→ The endorsement of the VARMM process – Sandwell Council developed tool. The benefit of endorsing this tool is that it will encourage the restoration of MDT processes out with of S42 enquiry as a primary means to consider and manage risk.</p> <p>→ Development of guiding principles to support practice around the management of risk as a key social work function. The objective is to ensure that safeguarding is the golden thread that runs through all social care interventions, therefore developing confidence within teams, that practitioner assessment, support planning and reviews can, in themselves, be measures to reduce risk and ensure person centred responses to a concern.</p>


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
	<ul style="list-style-type: none"> ➔ Successfully transitioning to a stand-alone service, establishing an in-house Safeguarding team and building links with other agencies. ➔ Playing a key role in the development of the Modern Slavery partnership. ➔ Carrying out full DBS checks on all members of staff. 	<ul style="list-style-type: none"> ➔ Communication between agencies should be a focus, ensuring that information around referrals and referral outcomes is quickly and effectively shared to inform service operations. 	<ul style="list-style-type: none"> ➔ Maintaining and developing safeguarding best practice remains a priority. ➔ Partnership working within sectors and bringing best practice from sectors to CSAB itself. E.g. learning from National Fire Chiefs Council (NFCC) safeguarding practitioner meetings can be passed on to CSAB, with the same coming from other sectoral equivalents.
	<ul style="list-style-type: none"> ➔ CNTW have supported with the delivery of the Northumbria Stalking Interventions Programme (NSIP) & Partners, Stalking awareness week. The program includes briefings and events from 22/4/24 to 26/4/24 with this year's theme "Join forces against staking". ➔ Continued focus on safeguarding training at all levels. ➔ Embedded Trust wide safety group meeting which include oversight of safeguarding and learning including all trust localities. ➔ Continue the embedding of CNTWs new approach to risk assessment that focus on a narrative bio psycho social approach rather than numerical scoring. 	<ul style="list-style-type: none"> ➔ We have 4 x inpatient services (2 in Cumbria) involved in the forthcoming National Mental Health Inpatient Culture of Care Programme. This programme aims to improve the culture of inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work. Initiative links directly to the work we are undertaking on culture as part of our organisational strategy 'With You in mind'. ➔ Continued emphasis on Professional Curiosity which links well with our CNTW "stop the line approach". 	<ul style="list-style-type: none"> ➔ Following CNTW reorganisation ensure that new Board member from CNTW is supported in role. ➔ Delivery of Trust wide Domestic Abuse training informed by learning from local reviews. ➔ Develop, strengthen and embed Professional Curiosity skills for all clinical staff. ➔ Develop audit schedule reflective of local learning themes aligned to ICB priorities of Domestic Abuse and Self-neglect.


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
	<ul style="list-style-type: none"> ➔ Learning from Cumbria SAR's shared using Trust Bulletin and internal dissemination processes. ➔ Presentations provided for Cumbria specific SAR to Cumbria Quality Standard meetings. 	<ul style="list-style-type: none"> ➔ Going forward number of areas of focus including - Recognising and responding to Domestic Abuse ➔ Continued Mental Capacity Act work – awareness and training. ➔ Maximising learning from SARs. ➔ Preparing and ensuring our safeguarding approaches are not impacted upon by our Trust reorganisation (April 2024) – Safeguarding leads and practitioners reviewed and it is clearly identified who is covering North Cumbria services from a Trust perspective. 	


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
<p>NHS Lancashire & South Cumbria NHS Foundation Trust</p>	<p>→ The implementation of a new incident reporting system (IRIS) provides an opportunity to promote MSP. Each incident flagged as a safeguarding concern is reviewed by a named Nurse/Professional on a daily basis. Feedback is given as to whether all safeguarding actions have been completed in support of the incident. Where there is no evidence to support MSP practitioners are contacted with advice and guidance as to how to procedure. There is also further opportunities within the Networks Serious Incident Review Panel and Integrated Governance meetings to highlight areas where lack of MSP has been identified.</p> <p>→ We have continued to promote understanding and key messages in relation to domestic abuse via organisational communications, focused supervisions and training initiatives. Deliver monthly lunch and learn sessions as a way of cascading key messages across the organisation. Trust wide learning sessions have been undertaken in collaboration with partner agencies that have included North West Ambulance Service (NWAS) and Substance Misuse services.</p>	<p>→ LSCFT recognise the challenge of supporting service users where self-neglect is a feature of their presentation. Good evidence in applying the principles of MCA allows for multi-agency responses and shared care planning. Service users with a dual diagnosis (Mental Health and Substance Misuse) can experience disproportionate features of self-neglect, there has been a targeted focus on establishing forums where these complexities can be discussed.</p> <p>→ Mandatory training compliance has seen a significant improvement, currently over 80% across the trust. Although it is not where we want it to be. We have worked hard to offer more accessible training for staff. Think Family is a theme we see in our SI's and safeguarding reviews, therefore we will continue to embed this approach across the Trust, staff will think about family rather than an individual. This approach will support LSCFT to meet both local and national requirements, competences, standards and safeguarding responses.</p>	<p>→ Improved practice in relation to self-neglect and adult neglect including interface with MCA and Adult Risk and Dual Diagnosis.</p> <p>→ Embedding Making Safeguarding Personal.</p> <p>→ Safer recruitment and retention of staff.</p> <p>→ Improved oversight of Mental capacity Act (MCA) and evidence of implementation in practice.</p>


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>NHS Lancashire & South Cumbria NHS Foundation Trust</p>	<p>→ The safeguarding team have a learning lessons portfolio group, all learning from SAR and other statutory reviews are considered within this group. It is not just the learning from reviews that LSCFT have supported that this group considers but also local and national reviews where there is transferable learning that will support services within the trust.</p> <p>Summary and Learning on a page briefing are developed and shared throughout the trust, via network operational boxes, safeguarding champion's network and network governance meetings. These are also available on the safeguarding SharePoint pages on the trust intranet. Themes from SAR's and other statutory reviews are fed into the trust wide learning lessons forum and reported on within the monthly patient safety bulletin.</p> <p>→ Safeguarding Policies and Procedures are again reflective of learning, these are reviewed and updated on a 3 yearly basis. Where identified standard operational procedures and guidance are updated on the back of learning.</p>	<p>→ LSCFT have a key role in supporting prevention activity aligned to the Domestic Abuse Act to fulfil core safeguarding responsibilities. Training packages have been reviewed to promote understanding of Domestic abuse, its links to emotional well-being, trauma, mental health and impact. There has been targeted activity in the promotion of routine enquiry and undertaking the DASH risk assessment.</p> <p>→ Briefings on MSP have been developed and shared throughout the organisation. An MSP trust wide lunch and learn session has been developed roll out of which commences in May 2024.</p>	


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
<p>University Hospitals of Morecambe Bay NHS Foundation Trust</p> 	<ul style="list-style-type: none"> ➔ Following a number of self-neglect cases within the trust, we have developed a monthly self-neglect specific safeguarding supervision session for colleagues utilising a trauma-informed approach. ➔ Daily quality assurance of Deprivation of Liberty Safeguards applications, in the last year there was a 34% increase in the number of applications. Through our quality assurance work we are able to evidence that our staff have a good understanding of legislative frameworks. 	<ul style="list-style-type: none"> ➔ We will continue to work alongside our partner agencies pro-actively and engage in CSAB activity. ➔ UHMBT review of our safeguarding offer to colleagues is on-going in line with the new intercollegiate guidance and focused on our colleagues being able to access the right training for their area of practice and we will be re-introducing learning passports to support our staff. ➔ We will continue to support our colleagues to be trained as safeguarding supervisors to enable staff across the organisation to access safeguarding supervision on a regular basis. 	<ul style="list-style-type: none"> ➔ Improved practice in relation to safeguarding supervision and support for our colleagues. ➔ Embedding making safeguarding personal and professional curiosity within our day-to-day contact with patients. ➔ To develop a safeguarding adult's champion model within the organisation to promote and embed learning.



Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
	<ul style="list-style-type: none"> ➔ Throughout 23/24 Lancashire and South Cumbria Integrated Care Board (LSCICB) underwent a redesign of our safeguarding model. This process has strengthened and supported cross Local Authority and partnership working, enhancing the opportunity to align and share learning/best practice across the South Cumbria footprint. This process has increased the connectivity at place, enabling the team to embed safeguarding practice ensuring the wider teams are considering safeguarding as part of usual business. ➔ LSCICB has committed to promoting a culture of continuous learning and improvement across the health system. Following learning recommendations from published SARs across South Cumbria there has been a number of key learning opportunities which have taken place. ➔ LSCICB provided training for Primary Care to strengthen arrangements, knowledge and understanding around Carers. We hosted a 'Commitment to Carers' event which was facilitated by NHSE and evaluated well. 	<ul style="list-style-type: none"> ➔ LSCICB is in the process of developing a Safeguarding System Assurance Framework. This will ensure a consistent approach to data collection for health and enable the ability to monitor impact of activity. ➔ Due to changes within the workforce across LSCICB organisation, there is a planned focus on the Person in a Position of Trust process (PiPOT). Revision of LSCICB PiPOT Policy is ongoing at this time. This will need to align with the current Cumbria SAB PiPOT process review. ➔ LSCICB will continue to invest in the health and wellbeing of its staff, support career developments, supervision model and take steps to work more collaboratively in recruitment alongside health partners. ➔ LSCICB have identified within its governance structure research and innovation, both in terms of increasing awareness of its value into practice and confidence in its practitioners. This refreshed approach will facilitate the SG team to build on what is known about good and excellent practice for making safeguarding personal. This will include promoting wellbeing and preventing safeguarding issues arising in the first place. This links directly into the ICB Objectives for improving outcomes for its populations. 	<ul style="list-style-type: none"> ➔ Ongoing focus on PiPOT process. ➔ Safeguarding workforce health and wellbeing and resilience. ➔ Safeguarding workforce retention and recruitment. ➔ Continuous learning to improve and assurance processes to check and challenge successful implementation of learning.


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
	<p>→ LSCICB have also developed a network of Trauma Informed Health Champions across the system. This is to promote collaborative and earlier preventative intervention as a result of an enhanced understanding of the impact of trauma amongst our vulnerable population. This also supports a person-centred response to safeguarding as this is inclusive of the principles of listening to those with lived experience, and to ensure continuous improvement in training/ supervision.</p> <p>→ LSCICB has the principles of making safeguarding personal within the delivery of complex case management support/advice and challenge. The ICB Court of Protection Deprivation of Liberty Safeguards (COPDOL) delivery has a focus on advocacy and patient voice to ensure MCA principles and Best Interests processes are embedded in practice.</p>	<p>→ The challenge is driving this forward as safeguarding continues to be in a large part reactive with a significant resource requirement.</p> <p>→ Other ongoing priorities for 24/25 includes further enhancing/improved:</p> <ul style="list-style-type: none"> - Response to complex safeguarding challenges. - COPDOL activity. - Workforce health and wellbeing, recruitment and resilience. <p>→ Research developments and application and review of best practice.</p>	


Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
	<ul style="list-style-type: none"> ➔ Development of response to concerns about the use of the Mental Capacity Act, with ward and service-based audits and subsequent development and training plans; with escalation routes for those situations which need senior management oversight. This demonstrates developing understanding and application of the Mental Capacity Act. ➔ How Safe Do You Feel project has led to over 500 staff from NCIC and another 80 from other health organisations receiving training on Domestic Abuse, including the use of 'Sadie's Story' – a real story from a survivor of Domestic Abuse which shows the contacts she had with services and the response she got. This demonstrates a 'Making Safeguarding Personal' approach and using the voice of a survivor to inform practice and improvements. ➔ Case examples of exceptional joint working between NCIC staff and colleagues- one shared at Board to demonstrate good practice around self-neglect. Another situation centred around the inter-relationship of physical and mental health and risks of severe physical harm without urgent treatment. 	<ul style="list-style-type: none"> ➔ Some concerns about late escalations of concerns to the Safeguarding team and then through the CSAB escalation route. This is being addressed through requests to attend service level Governance meetings across the Trust, to remind staff of the routes for escalation. ➔ MCA improvement project remains ongoing. This will offer support to all the wards/services where there has been concern about MCA practice, with clinical educators supported to be 'champions' for MCA practice within the ward settings. 	<ul style="list-style-type: none"> ➔ Key area for us is around escalation – timely and appropriate and effective, and whether this can be monitored and evaluated for effectiveness and frequency of use.

Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>HM Prison & Probation Service</p>	<p>→ MAPPA arrangements and the partnership working between Probation and Adults Services has resulted in robust risk management of the most risky and vulnerable individuals. We have successfully implemented the MAPPA Level 1 Framework in Cumbria. Referral data for 2023-24 is demonstrative of this with 2023-24 having seen a percentage increase of 26% in referrals to Level 2, a 15% increase in those accepted for Potentially Dangerous Person / Level 2 / Level 3 Management. Referral of Category 3 offenders has remained static (31 referrals received in 2023-24); the largest increase has been in referrals of Category 2 (Violent offenders) - from 5 in 2022-23 to 12 referrals in 2023-24.</p>	<p>→ Probation Service Cumbria have been operating in Probation Prioritisation Framework Amber Delivery since February 2022 (with a short break between May and July 2022). This has meant we've had to make some difficult decisions to deprioritise activity that supports our ambition to be high performing, as well as regarding staffing, but we've ensured we do this transparently and with a focus on keeping people safe.</p>	<p>→ Wider partnership and CSAB may not be aware but a Written Ministerial Statement to Parliament was laid earlier this month (April 2024) which announced the 'Probation Reset' to reduce demands on probation and strengthen our capacity to engage offenders in the community at the points in their sentence when it matters most.</p> <p>→ From 29 April, we will re-set probation so that practitioners prioritise engagement and supervision at the points in the sentence where it has the most impact on people on probation.</p> <p>→ Cases that continue with Probation contact in the final third are:</p> <ul style="list-style-type: none"> - MAPPA Cases of all Categories (1-4) and Levels (1-3) - All cases directly managed by a Specialist Probation Practitioner in the National Security Division (NSD) - All cases identified as very high risk of serious harm. - All cases with current active child protection procedures in place. - Those subject to an Intensive Supervision Court pilot (until such time as the evaluation is complete)

Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>HM Prison & Probation Service</p>	<p>→ June 2023 seen the introduction of the Health and Justice Partnership Coordinator role to Probation in Cumbria. These are newly created strategic roles within the Probation Service, with the aim of working with partners and services to develop relationships and pathways to promote better health outcomes for prison leavers and people on probation. The HJPC has worked in tandem with relevant local partners and HMPPS operational policy leads to develop practice related to substance misuse and health-related release planning, designing and consulting on process to enable information sharing, the use of substance misuse and health-related requirements / licence conditions and understanding of health and substance misuse resettlement pathways. Positively, this has seen a 145% increase in the imposition of Community Sentence Treatment Requirements (Alcohol Treat, Drug Rehabilitation and Mental Health Treatment Requirements) across the County in 2023-2024.</p>		<ul style="list-style-type: none"> - Active supervision appointments with individuals subject to licence will cease after the two-thirds point. One further follow-up appointment is required for licence cases only midway through the final part of the licence. - Active supervision appointments under post-sentence supervision will also cease to be delivered unless cases fall under the exemption criteria. For these exempt cases PSS will continue at current frequency. → For Community Orders or Suspended Sentence Orders with a Rehabilitation Activity Requirement (RAR), RAR appointments and delivery of activity days will cease to be delivered after two-thirds of the order has passed. → Upon implementation, it will be critical that Probation receives information provided by other agencies and organisations to consider and instigate reactive management in relevant cases. → At Probation Delivery Unit level, we have undertaken a review of our Deaths Under Supervision and it would be useful to share our findings at Board level, given cross over with partner agencies and organisations.

Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>HM Prison & Probation Service</p>	<p>→ We have rolled out safeguarding and domestic abuse checks in all cases from February 2023. Available data indicates that 98.98% of cases have had a child safeguarding check returned, and of those cases flagged as having domestic abuse concerns, 84.14% have had a police check returned. The focus of this work is to support us in keeping people safe by ensuring informed risk assessment practice.</p>		
	<p>→ RSC have worked hard to strengthen its oversight and management of safeguarding incidents and referrals across the service. RSC has a robust reporting and oversight process, which has supported assurance of an effective and timely response to the safeguarding needs of those we care for. This has enabled demonstration of increased safeguarding activity across the service to commissioners, public health and wider service partners.</p> <p>→ In response to Kate SAR, RSC worked with our colleagues in The Youth Substance Misuse Service to review and strengthen joint working pathways. This revised pathway, now includes improved identification of higher risk substance use, what effective transition for young people should include and the introduction of monthly interface meetings to support effective case discussion, sharing of knowledge/resource and joint working.</p>	<p>→ Increased level of safeguarding activity across RSC and demand vs capacity.</p> <p>→ Joined up working system wide still needs to be embedded in practice.</p>	<p>→ Cooccurring needs, mainly physical health (alcohol dependence relayed or injecting related infection are a high proportion) and understanding for the immediate risk they face and response required to safeguard and at times avoid catastrophic outcomes.</p> <p>→ Understanding of the needs of those using substances across system, the challenges they can face tin accessing service and appreciation of the increased risks they often face.</p> <p>→ Developing better understanding of MCA across they system including when and how legal powers should be used to safeguard.</p> <p>→ Development of a process or pathway to support those at significant risk, who may not meet statutory threshold for safeguarding (referenced in Kate SAR).</p>

Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
	<ul style="list-style-type: none"> ➔ RSC recognised a key safeguarding challenge facing the service was the level of self-neglect concerns being identified. In response RSC developed an internal Self Neglect Pathway, to support staff to identify and respond to self-neglect proactively, whilst identifying and managing risk. In addition, RSC have undertaken internal training in safeguarding and risk response for all staff and updated safeguarding clinical recording templates, which have all contributed to improved practice across the service. ➔ Include examples of how as a single organisation have you supported CSAB to deliver the 5 strategic objectives during year 2 of our Strategic Plan. ➔ Provided relevant partner assurance and contributed to CSAB check and challenge assurance event. ➔ Developed and delivered internal record keeping training and enabled staff to access organisational defensible documentation training ➔ Provide representation at CSCP Missing Exploited and Trafficked Sub Group to ensure adult addiction service represented in discussion relating to child exploitation. ➔ Represent addictions services at relevant sub groups including SAR, Learning Development and Performance and Quality. ➔ Ensure learning from SAR, DHR and LSPR is shared across service and wider organisation. This is monitored and reviewed internally. 		

Agency	What's working well	What needs to happen next	CSAB Strategic Plan 2022-25
 <p>Westmorland & Furness Council</p>	<ul style="list-style-type: none"> ➔ Following the publication of the Kate SAR we have worked closely with Childrens services to launch the Transitional Safeguarding Pathway. This is now embedded in practice, and we have achieved positive outcomes for individuals. ➔ The Large-Scale Safeguarding procedures and guidance has been developed by the LA and starting to be rolled out over the coming quarter to support full system approach to safeguarding enquires in this arena. ➔ Westmorland and Furness Adult council have reviewed and launched new social work case file audit which are fully inclusive of safeguarding adults practice standards. ➔ Team Members of the Westmorland & Furness Safeguarding Team have supported the roll out of Learning from SARs and presented positive case examples at the board and associated subgroups. 	<ul style="list-style-type: none"> ➔ Continued joint working between adults and children's services so that the transition between services is safe and seamless. ➔ This will be launched in the coming weeks with the IT infostructure to support. ➔ Monthly analysis findings to inform service improvements. ➔ Further examples of practice to be gathered via Westmorland & Furness's Serious Success Reviews. 	<ul style="list-style-type: none"> ➔ We will work together with partners to ensure we understand the themes, issues and trends relating to specific needs, and tailor our work accordingly to safeguard adults at risk of abuse or neglect in Cumbria. ➔ We will ensure the voice of our staff, customers and wider communities is heard in respect of safeguarding adults at risk of abuse or neglect in Cumbria. ➔ We will learn from experience to ensure we have a workforce that is knowledgeable and confident in its adult safeguarding roles and responsibilities.

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 2023/24, statutory partners made varied levels of contributions agreed on the size and footprint of the organisation. There was increased contributions to support the recruitment of additional officer support for the SAB. Following a successful recruitment process the postholder will commence in May 2024/25.

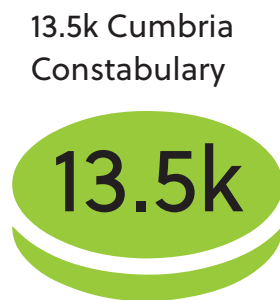
The following statutory partners contributed financially to support delivery of Board business;

- Cumbria Constabulary
- North East & North Cumbria Integrated Care Board
- Lancashire & South Cumbria Integrated Care Board

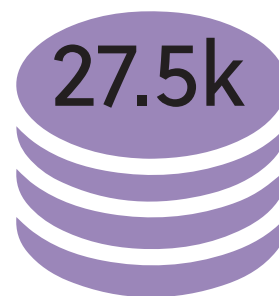
Total income from the above partners for 2023/24; 59k

Cumberland Council and Westmorland & Furness Council contributed through provision of dedicated staffing for the Board Business Management function with further commitment for the increased staffing.

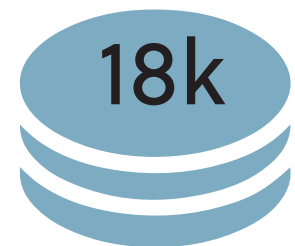
63k funding for dedicated Board Manager staffing, provided by Cumberland and Westmorland & Furness Council. Access to administration was also provided by the Council's.



27.5k North East & Cumbria Integrated Care Board



18k Lancashire & South Cumbria Integrated Care Board



13. What will we be doing during 2024/25?

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.

2024/25 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

 [@cumbriasab](https://twitter.com/cumbriasab)

Further information can be found by visiting 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**.

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**

