NCASP

NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP

NCASP Annual Report

September 2022 to September 2023

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FOREWORD

NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP CHAIR

I am very pleased and privileged to be the first partnership chair for the Northumberland Children and Adults and Safeguarding Partnership.

Following the decision in 2021 to integrate our respective safeguarding partnership arrangements, underpinned by the view that this would add value to our safeguarding work, I am very proud of the progress that has been made to develop and implement that decision in a timely way, particularly given the size of the task.

This has been effective due to the committed partnership engagement with the developments and the significant work undertaken by the project lead, business managers and subsequently with the independent scrutineer.

I believe we have in place a structure and processes which will ensure effective scrutiny, oversight and development of our partnership safeguarding work, within which we will retain an appropriate focus on adults and children's work respectively alongside bringing opportunities for shared development and learning.

I am particularly proud of the approach we have developed for scrutiny with our independent scrutineer and the associated methods detailed in the report. This approach has been praised and validated by the DfE as an exemplar of good practice.

We have effectively maintained a focus on work and business during the developments detailed above and this annual report gives clear and detailed information and analysis of the safeguarding work in Northumberland. I believe we have a culture of honest engagement and constructive challenge across our partnership, which is crucial for effective safeguarding work. We want to extend gratitude to our partners who have provided the information collated within this report. The service pressures experienced by agencies, and particularly front-line workers, are not underestimated.

I believe we have shown great commitment and progress towards our vision to work together to provide added value across the safeguarding system, improve practice and outcomes and to safeguard, protect and promote the welfare of children, young people, adults and their families in our community.

It remains crucial however, that as safeguarding is everyone's business, we all maintain a focus on and professional curiosity about our work and strive to continuously improve our effectiveness in safeguarding our residents.

Graham Reiter
NCASP Partnership Chair

INTRODUCTION

This is the first Annual Report of the Northumberland Children and Adults Safeguarding Partnership which integrated in April 2022. This Report satisfies the statutory requirements for both Children and Adults Safeguarding and outlines our progress so far in integrating our new partnership arrangements.

ABOUT NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP (NCASP)

The Northumberland Children and Adults Safeguarding Partnership replaces both the Northumberland Strategic Safeguarding Partnership (NSSP) and the Northumberland Safeguarding Adults Board (SAB), which was formally a joint arrangement with North Tyneside SAB.

The new Partnership arrangements acknowledge that children and adult arrangements are underpinned by different legislation and statutory guidance, however, recognises the similarities and shared benefits of a joint safeguarding approach across the life course.

STATUTORY REQUIREMENTS:

Children's Safeguarding Partnerships must[1]:

- Prepare and publish a report on work that has been done as a result of their arrangements (at least once in every 12 month period), including on child safeguarding practice reviews;
- Report on how effective the arrangements have been in practice and progress against agreed priorities;
- Evidence the impact of the work of the safeguarding partners and relevant agencies (including training) on outcomes for children and families;
- Include ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision;

Safeguarding Adults Boards must[2]:

- Publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan
- Report on what each member has done to implement the strategy
- Detail the findings of any safeguarding adults reviews and subsequent action

OUR VISION

NCASP's vision is.. to work together and provide added value across the safeguarding system, improve practice and outcomes and to safeguard, protect and promote the welfare of children, young people, adults, and their families in our community.

MULTI-AGENCY SAFEGUARDING ARRANGEMENTS (MASA)

There is a shared and collective responsibility between organisations and agencies to safeguard and promote the welfare of children and adults. Responsibility for this joined up approach locally rests with three ***Safeguarding Partners***[3] who have a duty to have robust arrangements in place.

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[1] *Working Together to Safeguarding Children (2018)*

[2] *Section 43 of the Care Act (2014)*

[3] Lead partners for Northumberland are: The Chief Executive Officer (Northumberland County Council); The Chief Officer (NENC Integrated Care Board); Chief Constable (Northumbria Police)

New safeguarding arrangements have been developed to build on the strengths of the previous arrangements under the Northumberland Strategic Safeguarding Partnership (NSSP) and the Northumberland Safeguarding Adults Board (SAB)

Our ***Multi-agency Safeguarding Arrangements*** (MASA) sets out how the Safeguarding Partners will work together, and with other agencies, to safeguard and promote the welfare of children, adults and families.

See: **Multi Agency Safeguarding Arrangements (MASA)**

OUR JOURNEY SO FAR..

Review of Partnership Arrangements

- A joint Executive and Partnership Board ensured the Partnership continued to meet its statutory requirements, whilst a full review was undertaken to ensure the needs of both partnerships are met, and any new arrangements were carefully planned and implemented.
- Whilst the main focus has been on reviewing the parameters, themes and reporting arrangements, consideration has also been given to the supporting structure of NCASP and its alignment to wider Partnerships.

NCASP Structure Development

- The new NCASP structure represents a streamlined approach to enable us to evidence value, offer maximum effectiveness, and meet agreed priorities.
- Fundamentally, this will also support the Partnership to meet the statutory requirements and needs of both children and adult safeguarding arrangements – including the statutory duty to undertake case reviews.
- **It is important to note this model will continue to evolve in line with the needs of the Partnership and the wider safeguarding context.**

NCASP STRUCTURE – FROM APRIL 2023:

The new model and governance structure reduces duplication and allows for cross-cutting, cross-functional safeguarding practices impacting on children, young people and adults to be considered and improvement in practice to be progressed.

This approach is harnessed within the governance of each of the newly formed groups and the engagement of all statutory partner agencies within these structures will help ensure improved accountability and ownership of safeguarding working towards achieving improved outcomes for children, adults and families across the safeguarding pathway.

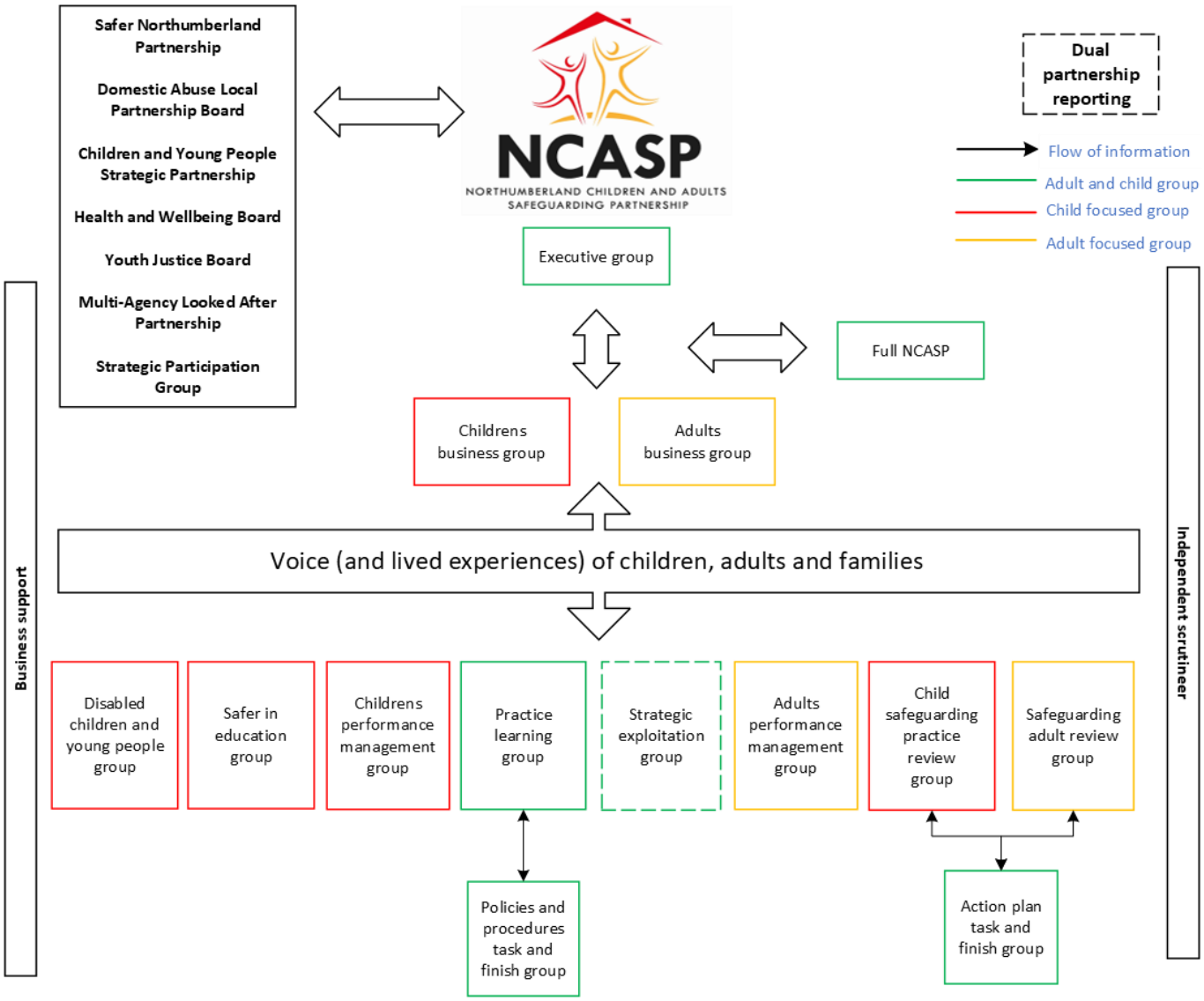
The partnership arrangements enable partners to support and challenge from within the multi-agency system and operate from within an environment where effective multi-agency practice can flourish.

The revised structure includes a range of both joint (children and adults) and separate arrangements which are accountable to the Business groups. A key consideration in the design of the new model has been to

facilitate the flow of information between groups via memberships and priorities. An outline of the subgroups and their purpose is set out in the Terms of Reference.

The Partnership will continue to be overseen by an Executive group which includes the three statutory safeguarding partners (Children/Adults Local Authority, Integrated Care Board, Police), and also Cumbria, Northumberland, Tyne & Wear (CNTW) and Northumbria Healthcare (NHCFT) NHS Foundation Trusts. Whilst the value of extending the membership of the Executive group is recognised, the responsibility for decision making remains with the safeguarding partners (in accordance with statutory guidance).

NCASP Structure:



SCRUTINY OF ARRANGEMENTS

When developing local arrangements, the NCASP considered a number of options (based on national learning[4]) and agreed a blended approach to scrutiny, these are:

- An **Independent Scrutineer**
- NCASCP **self-assessment**
- Partners' **safeguarding audits**

[4] ***WOOD REPORT – SECTOR EXPERT REVIEW OF NEW MASAs***

- Regional **peer review**/challenge arrangements – via Tyne, Wear & Northumberland Safeguarding Partnership, Association of Directors of Childrens Services (ADCS) and Association of Directors of Adult Social Services (ADASS)
- Independent scrutiny through the local authority and Integrated Care Board **scrutiny committees**
- **External inspections** and reviews

An Independent Scrutineer (IS) was appointed in June 2023. The chairing of the Business Groups forms part of the Independent Scrutiny role and will fulfil the objective to act as a constructive critical friend, promote challenge and reflection to drive continuous improvement. It will also help in seeking assurance and assessing whether the three safeguarding partners are fulfilling their statutory obligations.

A Scrutiny Framework for NCASP has been developed, setting out key objectives and descriptors (based on the Checklist for Independent Scrutiny); this applies to both children and adult safeguarding arrangements. For more information about scrutiny, see our MASA

The Independent Scrutineer in Northumberland provides scrutiny and challenge across the Partnership, hold partners to account, and provides an independent view of effectiveness of **both children and adults safeguarding arrangements**.

During their first 3 months (June to September 2023) the Scrutineer has met with (and sought the views of) Safeguarding Partners, Business Managers, and the chairs of sub groups. They obtained information from a number of sources, including the NCASP development sessions, chairing of the Business Groups meetings in June and September 2023, a review of meeting minutes and action logs, and NCASP processes and systems.

The scrutineer also attended and observed the work of the sub and task and finish groups and reported..

- Overall observation of the subgroups is positive. The groups are chaired by the right partners and all chairs report to the Business Groups (from September 2023) on their groups progress using an agreed report template, highlighting what is working well, where there are challenges and areas for improvement. Where there are challenges that cannot be resolved at the Business Groups these will be escalated to the executive team by the IS for consideration and intervention if required.

- The task and finish groups are identified through learning from case reviews, practice learning audits and performance management. Those observed to date have clear terms of reference, defined outcomes, and timescales for completion of the work. Draft reports from the task and finish groups will be considered at the Business Group meetings, after which learning will be shared with the PLG and executive team through the IS report.

The Scrutineer has provided NCASP with an appraisal of how the partnership arrangements have continued to develop and improve since implementation, acknowledging NCASP has moved forward at a pace and will continue to evolve over the year. The IS role is also evolving and will continue to do so.

See: Independent Scrutineer Report (June 2023 to September 2023)

Looking forward, key areas for development are:

How NCASP evidences its **impact** and **effectiveness** (for improving outcomes for children, adults and families)	Areas of practice requiring **independent scrutiny** (e.g. children missing education)	How the **voice and lived experiences** of children, adults and families inform the work of NCASP.

We have received national recognition for how we have developed our new safeguarding arrangements/partnership and our approach to scrutiny has been cited as a model of excellent practice.

SCRUTINY ACTIVITY DURING 2022-23

Interviews, Focus Groups, Learning Events, Workshops, Webinars

- Development sessions with partners and relevant agencies aimed at integrating/developing safeguarding partnersho[, and priorities.
- Multi-agency Webinars
- Learning Events
- Interviews and focus groups of sub-group members and leads
- Workshops to develop single agency and partnership action plans.

Questionnaires, Surveys, Case Studies

- Multi-agency audits
- Young People's feedback survey
- Early Help case study
- Targeted audits: Transitional Safeguarding; CPVA; Partner Assurance
- Partnership survey

Secondary Analysis of Data

- Performance Framework in place focusing on partnership priorities with multi-agency KPIs and soft intelligence.
- Local analysis/benchmarking of Police and LA Exploitation data

Observation

- Observations undertaken of all subgroup and Partnership meetngs, to inform formulation of integrated children and adults Partnership.

LEADERSHIP

The Safeguarding Partners provide strategic leadership for all those working together to safeguard children and adults. They set the strategic direction, vision and culture of the safeguarding arrangements, including shared priorities and resources required. Working in collaboration with each other and other partnership boards helps to ensure strong governance and offers additional systems of assurance and accountability (including single agency inspections).

NCASP's Partnership Chair also chairs the Domestic Abuse Local Authority Partnership Board (DALAPB) as well as the Children & Young People Strategic Partnership (CYPSP) and the Youth Justice Board (YJB). Safeguarding Partners and group members chair/attend other strategic boards and committees and understand (and appreciate) the importance of cross-partnership working.

There are often cross cutting priorities where collaboration is required to ensure there is a streamlined approach. Whilst developing our strategic priorities, we have considered areas of work being undertaken elsewhere (across the whole partnership) and how we can work together and support each other.

The lead members for children and adults are invited to observe the Business Groups. NCASP delivered training to elected members[5] to help them understand their role in relation to safeguarding adults and children and domestic abuse, how to recognise signs of abuse, how to report it and access support services.

Introduction to NCASP sessions have been included in induction programme for children's social care staff[6], the business managers are also attending team meetings across the partnership to update on developments and to further engage with practitioners.

REGIONAL COLLABORATION

There are a number of ways we work together regionally. There are established Business Manager Networks (regional and national) for both children and adults, and the safeguarding partners attend regional forums providing good links with NCASP. Two of our safeguarding partners work across 5 other LA areas, which is also a benefit to us.

The Tyne, Wear and Northumberland Safeguarding Partnership (TWNSP) brings together all business managers, independent scrutineers, organisation safeguarding leads and independent chairs across 6 areas. The partnership exists to share learning and collaborate on regional pieces of safeguarding activity (children and adults).

A sub-group of the Tyne, Wear and Northumberland Safeguarding Partnership (TWNSP) was established in October 2022 to look at regional collaboration in relation to the Independent Scrutiny role across Newcastle, Sunderland, Gateshead, North Tyneside, South Tyneside, and Northumberland.

The focus of the group is to:

- ❑ Establish a consistent approach to the Independent Scrutineer role across our region
- ❑ Establish a support network and protocol, including regular meeting arrangements, for Scrutineers to work together to maximise effectiveness; discuss and share practice strengths and learning and create opportunities to shape joint solutions and practice improvements.

Work so far has included mapping the 6 partnership role descriptions (against the checklist) and reviewing how each partnership undertook scrutiny, thematic analysis. The group has also considered and agreed areas of practice/scrutiny to develop some collaborative regional work**.**

The children's multi-agency procedures and practice guidance are shared regionally. Any amendments to procedures/protocols agreed locally are also shared across the six areas and incorporated into the shared procedures, where possible. This offers consistency for partner agencies working across the wider region. This also means that any changes as a result of learning from case reviews can also be implemented across the six areas.

WHAT HAS BEEN ACHIEVED

Although we have been working hard to develop and implement our new safeguarding arrangements, we have continued to make progress against our priority areas of work and operate business as usual to improve safeguarding of children and adults and meet its statutory obligations.

[5] Elected Members - Safeguarding Workshop

[6] Introduction to NCASP

AT A GLANCE..

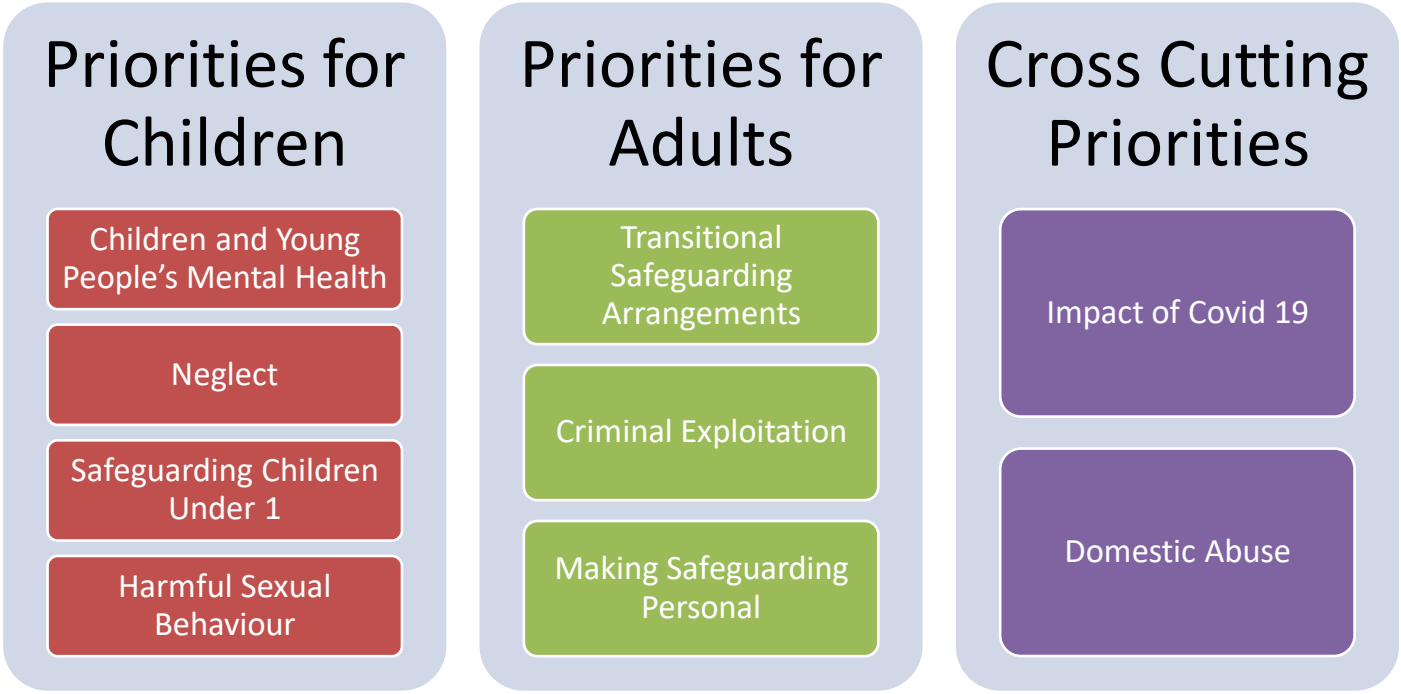
WHAT HAVE WE DONE AND WHAT IMPACT HAVE WE SEEN?

The following information seeks to evidence some of the work going on across the whole partnership, and the impact of that work.

STRATEGIC PRIORITIES

Prior to the formation of the joint partnership, Northumberland's Strategic Priorities were informed by separate Children and Adults Strategic Plans. The Safeguarding Adults Strategic Plan was joint with North Tyneside and was produced for 2021-24.

A new joint Children and Adults Safeguarding Strategic Plan has now been created for 2023-24 which supersedes the previous plans. Further information can be found in our **Strategic Plan 2023-2026**



PRIORITY 1: CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

What is the data telling us?

- Increased demand for mental health services – across all tiers of intervention.
- Increasing rates of self-harm, prevalence amongst young people. Repeat attendees and predominance of females
- Positive mental health service developments; Family Hubs, NEWST, Front Door, Schools
- Multi agency audit highlighted how to avoid missed opportunities in mental health cases and the need for more co-ordinated, SMART-er planning

There has been a significant increase in children social care assessments where child mental health has been identified as a factor. The rise would indicate that the need for referrals regarding mental health are well recognized and understood by agencies and referrals are being made at the appropriate time. There are increasing demands on all health services regarding child mental health.

The percentage of 0-18yrs urgent referrals seen by Universal Crisis Team within 24hrs remains stable and analysis shows that all were offered within 24hrs; however, non-attendance and cancelation have been the reasons for not reaching 100%. The percentage of children and young people within CYPS who have waited less than 12 weeks to access treatment continues to be 100 % within Mental Health pathways - impacted due to increasing demands within the Neurodevelopmental Diagnostic pathway. It is positive that those who are experiencing moderate to severe psychological / emotional distress are provided with prompt access.

CNTW have reviewed the demand and capacity of the Safeguarding and Public Protection (SAPP) team which has led to additional resource at Named Nurse level. We will continue to review demand and capacity in light of sustained increase in reported incidents and review processes and approaches as necessary to ensure this demand can be met whilst maintaining quality.

NHCFT self-harm data continues to increase with a 70-30% split in terms of more females. HDFT 0-19 service report that low lying mental health difficulties are increasingly featured in their work. The service works closely with early help lead at the front door to develop a single point of allocation for referral into their services.

A Self-harm task and finish group has been set up to explore the increase in numbers and consider any preventative actions to reduce the incidence of self-harming behaviours and to identify actions to improve understanding and communication regarding what leads young people to self-harm, how best to support them and improve their resilience. The key areas being - schools, communities (including councillors and key organisations), parents and young people.

There is a shortage of specialist inpatient CAMHS beds which is in part due to breakdown of community placements, this reflects the national picture. This has been escalated within the ICB and NCASP Executive. The challenge of implementing additional support for children and young people with complex mental health has been highlighted by Designated Nurse (Safeguarding Children) and Community Clinical manager (CYPS). A working group has been developed to look at developing a multi-agency framework for this vulnerable group, this will be reported on in 23/24 as it is in the very early stages of development.

NHCFT continue to build on pathways of care to support those with mental health needs. We provide a range of metrics which have allowed us to identify increasing trends of young people accessing our unplanned care settings due to deliberate self-harm. We are actively involved with partners to take a joined-up approach to exploring and addressing needs/risks.

Northumbria Police have an all-age Street Triage Service which is open to children across Northumberland. The CNTW nurses and police officers who work on the service deploy to incidents of children in mental health crisis and have continued to provide a face-to-face service throughout the COVID pandemic. In the last 12 months our Street Triage officers have undertaken training in ACE's, learning disabilities and child exploitation to ensure they have a more holistic understanding of children's presenting behaviours.
The Street Triage service also ensure they are sighted on the impact of parental mental ill health on children and young people's mental health and make safeguarding referrals for children impacted by a parent or carers mental health crisis.

Northumberland Adolescent Service (NAS) Health Hub provides physical health and wellbeing support for young people who have experienced Trauma and Adverse Childhood Experiences (ACEs). The goal of the service is to upskill young people and reduce the impact of past trauma on their future. The NAS health Hub is in a unique position as we work with some of the most vulnerable young people in Northumberland. Often these young people have not accessed support services and as a result may have unmet Health and emotional needs which impact on their current thoughts, behaviors and decision making.

The health Hub is made up of Specialist Services, multi-disciplinary workers and Targeted projects aimed at improving the physical and emotional health of young people that come into contact with NAS Services.
The specific role of the Health and Wellbeing worker is to provide low level mental health support and signposting them to specialist teams if needed. Currently the service is aimed at Young People who are involved with Youth Justice Service (YJS) or the substance misuse team. The plan is to expand this team to ensure that all aspects of health are addressed for the young people who need it most.

Early help service have developed a 'teens pad' to ensure services/strategies and support are more transparent and accessible to teens and families. This was in response to consultation with young people about what they wanted.

MULTI AGENCY AUDIT SUMMARY – CHILD MENTAL HEALTH

A multi-agency audit was undertaken in December 2022 which highlighted patterns and themes and report findings were reported in March 2023. The auditors acknowledged that difficulties with mental health is an increasingly complex issue for children and young people.

There were lots of strengths in practice when agencies had the confidence and skills to recognise significant concerns about a child's mental health early, which was supported by assessments that detailed the specific behaviours that made people concerned and what needed to happen. These judgements were based on meaningful and collaborative discussions with the child, their family and the professionals that knew them well. The actions of agencies reflected the needs of the child and knowledge of the graduated response to ensure the most appropriate support was in place, through referral pathways that worked well.

However, these strengths were not consistent across all of the records reviewed. Auditors found some missed opportunities to support children with their mental health. As some plans did not detail what they hoped to achieve (even though most children were engaging with support for their mental health) it was difficult to understand progress or the impact of the interventions. To scale higher, the auditors identified the following areas of focus:

1. Meaningful communication with families to understand lived experiences of mental health to confidently identify needs.
2. The use of a common language across agencies, to encourage and support meaningful collaboration.
3. Increase knowledge of available support and an awareness of the graduated response, promoting the right support at the right time.
4. The development of clear and meaningful multi-agency plans that address the concern(s), show what everybody will do and when, which through review can evidence what change has been made.

PRIORITY 2: NEGLECT

What is the data telling us?

- ❑ Ongoing higher than average neglect cases in child protection
- ❑ High prevalence of neglect reflected in health referrals

There is a strong association between a family's socio-economic circumstances and the likelihood of a child experiencing abuse or neglect. In Northumberland neglect continues to be prevalent with a high percentage of child protection plans for neglect.

Work has been undertaken with the IRO (Independent Reviewing Officer) Service to better understand the continuing high prevalence of neglect within the data. This alongside, the increased percentage of children entering care where neglect is a factor (55%) is of concern, however it may be due to the Neglect Summit

which took place in May 2022 which could have increased professionals' awareness further regarding the signs and indicators of neglect.

All agencies have produced their own action plans following the summit and a Partnership Evaluation and Assurance Plan was devised to measure and evaluate any progress made. Assurance plans will be reviewed by November 2023 and further discussions will take place in the Practice Learning Group to outline the impact of the Summit. This will inform subsequent actions (as neglect remains a priority area for the NCASP)

The Designated Nurse Safeguarding Children and Specialist safeguarding practitioner have developed a training package for primary care staff to access.

NHCFT's safeguarding training and supervision offer have neglect and its impacts throughout the lifespan firmly at the core. We continue to capture and share information and data to support our understanding of neglect. We take a multi-disciplinary approach to regularly reviewing and supporting parents who misuse substances throughout pregnancy to recognise risks of substance misuse on unborn babies and make changes to keep themselves and their babies happy and healthy during pregnancy and following birth.

Northumbria Police are committed to reducing instances of child neglect. All reports are subject to daily oversight from the Detective Inspector within dedicated Child Abuse Teams. There is a drive to work with partners throughout the county to establish the root cause of the issues and provide help and support to prevent any reoccurrence. When a prosecution is justified these are driven by supervisory oversight to make the process as quick as possible to limit the impact to victims throughout. All investigations are conducted by specialist investigators within Child Abuse Teams who are trained in interviewing children.

The issue of self neglect amongst adults and its impact on children was raised for consideration, following a case discussion at SARG. It is not felt that this is a big concern, however agreed work would be undertaken (looking at referrals from Adult Social Care) to help us understand to breadth of the issue.

Neglect (including self-neglect) is a priority focus of work for us – see: **Strategic Plan 2023-2026**

PRIORITY 3: SAFEGUARDING CHILDREN UNDER 1

What is the data telling us?

- Continued significant proportion of s47s, ICPCs and CP cases involve under 1s; short duration of plans indicate planning for young babies is robust and timely
- Continued significant proportion of CP cases are re-plans within 2 years, but low numbers for under 1s

There has been a slight increase in referrals for under 1s and (from the rapid reviews) under 1s remains the highest category for significant incident notification. In response to the increase in children under the age of 1 going through front door with physical injuries, a task and finish group has been set up to explore the increase and consider any wider determining factors. In particular those cases that were not known to statutory services.

Reassurance was provided that in rapid reviews, a lot of good practice was seen to be delivered. Preventative programmes including ICON and safe sleep messages are embedded in practices, resources are shared with parents at multiple touch points to ensure that key messages around infant crying and the dangers of shaking a baby are understood. However there is little evidence of evaluation of parental understanding or impact, in particular for parents with learning difficulties. NHCFT now have a pathway to ensure that parents with learning disabilities have access to all information, and additional support needs are identified as soon as possible.

A new initiative eyes on the baby is being implemented in Northumberland which will include training for all agencies to deliver this message.

All reports of non-accidental injuries are brought to the attention of specialist police child abuse teams (CAP) and scrutinised and reviewed at Detective Inspector level. Staff attend and share information at all levels of multi-agency meetings to ensure accurate interventions and safety plans are in place.

Detective Inspectors attend all rapid review meeting for serious injury and SUDI and continues with the child death review panel and joint learning review processes (CSPR) where any identified learning will be embedded. Lessons learned are disseminated and staff attend formal delivery sessions as part of their CPD for the SCADIP accreditation. All reports of this nature are investigated by Child Abuse specialist detectives who have a national SCADIP qualification. (Specialist child abuse qualification from the College of Policing).

A pre-birth team is now operational and assessments are being undertaken at an early stage for babies in cases that are likely to require legal intervention. Review of the pre-birth team will give us additional information regarding the impact of this on families and outcomes for those children.

We have developed and embedded our pre-birth team in one of our Family Hubs and a multi-agency pre-birth team meeting monitors progress of the team. The evaluation of the first year undertaken in August 2023, highlighting outcomes that are extremely positive. The work undertaken by the team is viewed positively, particularly the engagement with fathers and we are engaging with Newcastle University to evaluate this area of work.

Feedback regarding intervention from the pre-birth team from families outlined the following:

- **Family A:** "W*e were ashamed and scared that our baby was going to be taken away, but we are now learning new things."*
- **Family B:** "W*e were initially annoyed as we were not informed that they were going to be involved but they were absolutely honest with us from the beginning and that others should be open minded about involvement."*
- **Family C:** "T*he baby was at the forefront for everyone."*

Within the work completed in children's social care, there is an under use of preventative resources and courses that are available and there is a real drive on ensuring that resources available are factored into any plan for children. The ongoing development of Family Hubs is expected to support this.

ANALYSIS FROM MULTI AGENCY AUDIT REGARDING UNDER 1'S

Audit undertaken to gain better understanding of referrals regarding Unborn's and children under the age of 1. **The audit was to consider the following:**

- ❑ Is vulnerability considered?
- ❑ Are relevant professionals consulted?
- ❑ Is harm and strengths identified
- ❑ Is learning from previous reviews considered?

In summary, the referrals looked at have highlighted good evidence of information sharing which has clearly been considered and has informed decision making, which was felt to be appropriate and proportionate. Also, that the actions from the referrals had made a difference for the children.

Vulnerability of Unborn's and children under 1 was recognised in over half of the cases seen and there was some evidence that learning from previous reviews had been considered. Overall, there was good identification of factors that impact on a child's vulnerability and numerous referrals to support agencies had been made. It should be highlighted that when these referrals were made to First Contact, thorough exploration of history was considered; vulnerability was highlighted and gaps in information were sought before decision making was finalised.

Agreed further work across agencies regarding the inclusion of fathers and completion of the Multi Agency Referral Form to ensure relevant information is considered and recorded. This should include vulnerability of babies and use of history to inform decision making.

ANALYSIS FROM MULTI AGENCY AUDIT REGARDING ABSENT FATHERS

Although not exclusively an issue relating to under 1s, it is appropriate that the work around absent fathers is shared here. There remains an ongoing gap which has been identified in several case reviews previously, it was decided that this would be further explored.

What has been highlighted from this multi-agency audit is that records are not always accurate or include basic information regarding the child's father and what role he may play in the child's life. Alongside this when we are informed that parents are separated, there is sometimes a lack of curiosity as to whether father plays an integral part in caring for, safeguarding and everyday life for the child.

There appears to be a different approach to ascertaining information about father's role depending on the age of the child and (with the use of networks) father's role and part in plans needs to be strengthened.

Agencies understanding about absent fathers was highlighted in the dialogue following completion of the audits and in line with the findings, it could be determined that our systems sometimes make fathers absent, place more emphasis on what mother is not doing meanwhile mainly providing services for mothers. Fathers are much more than a biological person and there needs to be a multi-agency approach to better understanding this, what we mean by absent fathers and how this might be recorded consistently across all agency's records.

Learning about absent fathers (and hidden men/partners) is included in training and a briefing for practitioners has been developed (7-min guide: Working with Dads)

SiRS (sharing information regarding safeguarding) is in place to ensure any potentially concerning history in relation to fathers is shared as soon as possible within the antenatal period to enable full assessment and safety planning.

Dad's Pad: Family hub staff trained to be **fathers champions** so we can support and promote fathers being involved in their child's development including contact with professionals from conception right through to adulthood.

Free 'DadPad' app launches to support dads in Northumberland

- Dads-to-be and new dads in Northumberland now have free access to the DadPad app to help them give their baby the best start in life.
- The DadPad is packed with trusted advice and support specially tailored for dads to help them gain confidence and practical skills at what can often be an overwhelming time.
- It was first developed by Inspire Cornwall CIC together with the NHS and is now fast becoming the essential guide for dads.
- Northumberland County Council has invested funding from its trailblazing Family Hub programme and worked with the team at Inspire Cornwall CIC to make the DadPad app free for all dads in the county.
- Watch on YouTube: find out how the DadPad is making a difference to families

More information is available on the dad and male carers zone of the Family Hubs website.

PRIORITY 4: HARMFUL SEXUAL BEHAVIOUR

It was a priority of the Schools' Engagement sub-group to ensure that schools are prepared and resourced to take appropriate action in their own school communities to challenge sexual abuse, violence and harassment. The aim is for children to feel safe in school and feel confident to speak out about sexual abuse; schools have better information to prevent and act on incidents; schools involve other appropriate agencies when needed; parents have confidence in school systems; the statutory RSHE curriculum combats sexual abuse, violence and harassment effectively.

Ofsted amended the inspection handbook (from September 2021) and this provided a framework for the actions of SEG, mainly delivered through the Schools' Safeguarding Team.

The main changes are:

- Schools and colleges should assume online sexual abuse, violence and harassment take place within the school community, even if there are no reported cases.
- Inspectors will ask what schools and colleges are proactively doing to combat this, including preventative measures, the curriculum including implementation of the statutory RSHE curriculum, and responses to allegations.
- Where adequate processes to combat sexual abuse are not in place, Ofsted is likely to deem safeguarding ineffective, which in turn will likely result in an inadequate overall grade.

Good progress was achieved in fulfilling our aim, for example:

- We Identified, gathered and shared good practice examples from schools/settings of effectively managed cases involving sexual abuse, violence and harassment. Findings were shared more widely with schools.
- We provided a summary of 'Multi-Agency Response to Sexual Harassment and Abuse of Learners: emerging practice' and ensured appropriate actions were taken in response.
- We co-ordinated the NSPCC audit of sexual harassment and violence in schools with Northumberland settings and reported the findings to NSSC (now NCASP).

The Youth Justice Service manage young people accused or convicted of Harmful Sexual Behaviour (HSB) offences. The team are all AIM 3 trained and work closely with both Police Online Investigation Team (POLIT) and Management of Sexual or Violent Offenders (MOSOVO) to manage both risk to the child and those around them. YJS take a child first approach to better understand underlying causes of HSB and interventions are tailored to non-judgmental change.

NHCFT include HSB in Level 3 training and this is discussed within supervision on a case-by-case basis.
HSB and child on child abuse is included in safeguarding training to raise awareness for primary care staff.

PRIORITY 5: TRANSITIONAL SAFEGUARDING ARRANGEMENTS

Ensure robust and consistent responses are in place to manage safeguarding for vulnerable young people

What is the data telling us?

- Need to continue to develop intelligence to support transitional reporting
- Findings of audit of 18-25 year olds referred to Safeguarding Adults to inform our work

Transitional Safeguarding continues to be a strategic priority within Northumberland; this aligned with a Think Family/Life course approach with local drivers coming from several joint adult and children learning reviews. Reviews identified areas of learning and improvement (which has been acted upon):

1. The need for a Transitional Safeguarding Protocol
2. Joint workshops to help people understand each other's roles and responsibilities
3. Improving legal literacy of practitioners
4. Early identification and response to trauma

There are several initiatives already available within Northumberland to support good transitional planning such as an all age Strategic Exploitation sub group, exploitation training on a number of different approaches. We have a joint transitional safeguarding protocol which sets out pathways for young people (particularly those not known to child protection services), a transitions policy and transitions panel that reviews the support of young people who are 14+.

A Transitional safeguarding 7-minute guide has been developed and workshops have been held with staff.

C.A.R.E (Caring about Adversity, Resilience and Empowerment) Northumberland provides a multi agency approach to trauma-informed resilience.

C.A.R.E Northumberland is a multi agency strategy across both children and adult services to reduce children's experience of adversity and minimize the impact of adverse childhood experiences on the health and wellbeing of both children and adults.

We have implemented a Trauma Informed Learning Framework which aims to develop practitioner understanding and recognize the impact of trauma as being widespread and across the life course.

Adult Services are currently reviewing our approach to social care transition. This includes self-assessing ourselves using the NICE Guideline 43 'Transition form children's to adult' services for young people using health or social care services'. We have used this assessment to help develop a themed audit of adult social care records for 18 – 22 year olds. Learning from this audit, and the NICE Guideline baseline assessment, will support us to develop an evidence based plan to improve our approach to all social care transitions including transitional safeguarding.

NHCFT have an integrated safeguarding service working from the antenatal period right across the lifespan. The trust has an established young person's transition group, which includes representation form the safeguarding team. The group works to ensure that robust transition processes are in place across Trust services and lead developments in this area.

NAS Service hold monthly transitions panel with senior managers from adult social care to discuss young people who have identified needs and would benefit from post 18 support from adult social care. Young people can be discussed at this panel from the age of 16 years and over. If it is deemed that they do not meet threshold of need from adult social care at the current time, there is a review date identified or other services/information offered.

One of the ICB's safeguarding priority workstreams is 'transitional safeguarding' with a particular focus on mental health and children in care, promoting a trauma informed approach. This will be a long-term plan over the next 3 years and is being led by Assistant Director of Nursing for the North (NL, NT NCLE & GH), with support from Des nurse and wider ICB colleagues. The team will work closely and consistently with providers/partners to ensure smooth transition between children and adult services.

The initial plan is to explore and identify what is working well, where there are gaps and how the ICB can work differently. This will inform the first year plan and organisation can decide who is placed to continue in the ongoing workstream, this is currently a health led workstream as identified in the ICB joint forward plan with the intention of bringing partners onboard at a later date as the plan progresses.

A comprehensive guide for partners has been developed to support the Care Leavers Accommodation & Support Protocol (CLASP). The guide will be used by front line workers and managers and outlines the agreed joint-working agreements between Northumberland County Council, Children's Services, Housing Services and Housing Providers within Northumberland. We also have a joint Housing Protocol for homeless 16 and 17 year olds, which was reviewed in April 2023.

Protecting vulnerable people is a force strategic priority for Northumbria Police. To support this, a Force Vulnerability Strategy was launched last year with four key pillars:

Working Together	Our People	Leadership	Early Intervention and Prevention

Our aim is to achieve a safe environment for people, their families, and wider communities to thrive without fear of harm, and to ensure perpetrators are identified and targeted with further harm removed or minimised. Harm Reduction Teams are now embedded across the force and will play a key role in tackling emerging issues identified with vulnerability, working with partners to adopt a problem-solving approach.

Key to our focus on vulnerability is our Early Intervention Strategy, which focusses on prevention and building community resilience. In support of this strategy, the force has launched an Adult Out of Court Disposal Team (TREAD). This team looks at opportunities to divert low level offenders from the criminal justice system and focus on the root causes of their offending. The team have developed links with charities and have pathways for support for veterans, female pathways, substance misuse pathways and a specific pathway for support for the 18 - 25-year-old cohort, exploring employment and training opportunities. This team are successfully tackling underlying vulnerabilities which draw individuals into the Criminal Justice System.

PRIORITY 6: CRIMINAL EXPLOITATION

What is the data telling us?

- Developments in recording of Criminal Exploitation abuse types will enable better monitoring by the LA in 2023/24
- Further work identified with Multi-Agency Exploitation Hub for comparative data.

Tackling Criminal and Sexual Exploitation continues to remain a priority for Northumberland throughout 2022-2023 to improve the lives of all vulnerable people in Northumberland who are at risk of being sexually or criminally exploited.

NCASP's 'Tricky Friends' animation developed to provide support to adult and young people, in response to learning from case reviews. This was added to our website and a 7-minute guide was circulated across the partnership. Scrutiny of data has highlighted a slight decrease in numbers from the previous year.

Several Operations have been ongoing across Northumbria area. Close links between Adult Safeguarding and Northumbria Police along with partner agencies have been maintained to provide **identification and intervention at the earliest opportunity** to reduce risks to vulnerable adults within Northumberland.

NCASP has continued to drive the exploitation agenda with an all age response and has continued the delivery plan focusing on engagement and awareness. This has included continued data sharing across agencies to assist in identifying emerging themes and areas of concern within the locality.

NHCFT have embedded criminal exploitation and into our Level 3 safeguarding training for adults. This is also routinely discussed within supervision sessions with staff throughout the trust and have focused on community teams such as District Nurses who may have more access to adults at risk in their homes and the community. We have developed **robust multi-agency plans** if an adult at risk accesses A&E so we can alert relevant professionals and engage in safety plans for those most at risk.

Criminal Exploitation training continues to be delivered on a multi-agency basis. Sessions are co-facilitated by the Social Care Training Team, safeguarding practitioners and the Safer Northumberland Partnership.

Recognising vulnerability to Extremism and Radicalisation

A new Prevent Pathway was established (in 2021) and is being embedded into practice. This ensures that any individual referred into safeguarding as a result of a concern around vulnerability to being radicalised or adopting extremist views has a robust and prompt response from services to identify appropriate support. The Prevent Pathway created a clear process and improved understanding within social care teams about the appropriateness of referrals, resulting in:

- A rise in Prevent referrals from Social Care staff.
- Counter-Terrorism Policing North East highlighting this as good practice.. 'partners and their staff are knowledgeable around Prevent and recognise their collective duty in protecting those susceptible to extremism and radicalisation.'
- Northumberland's Channel Chair and Prevent Co-ordinator receiving a commendation from Northumbria Police for their contribution and commitment to ensure processes are in place and awareness is raised.

Tackling Organised Exploitation (TOEX) are part of the North East Regional Crime Unit (NEROCU) who support front line investigations such as modern-day slavery and human trafficking, organised immigration crime, adult and child sexual exploitation and county lines.

This targeted approach has so far seen the following results regionally:

Northumberland Housing teams have been actively attending training to ensure that they have an improved knowledge of these issues, how they can be identified, and how young people and their families can be signposted to the correct support. This training has included:

- ✓ Transitional Safeguarding
- ✓ Contextual Safeguarding
- ✓ Exploitation

Grace Northumberland Rape Crisis works with women and girls aged 13 plus who have experienced any form of sexual violence, at any time in their lives. We offer specialist sexual violence counselling, practical

and emotional support (including an ISVA service) and a specialist helpline. We have a specialist Independent Sexual Violence Advisor who concentrates on rural areas. Grace works from a number of outreach bases throughout Northumberland.

- Thank you so much.. without your help, I would not be here.
- In this journey you were with me, the only person, you fight for me..
- Thank you for all your help, you're the first worker that I felt I could trust. After everything that's happened.. it's very hard for me to trust someone.

Link to NCASP Exploitation Strategy 2023-24

7-Minute Guide to National Referral Mechanism (NRM)

PRIORITY 7: MAKING SAFEGUARDING PERSONAL

What is the data telling us?

- Difficult to evidence MSP by partners via data.
- LA report high proportion of cases where the desired outcomes were achieved. (Dec 22 99%)

We are committed in Northumberland to Making Safeguarding Personal (MSP) by promoting a person-centred approach, recognising the individual is the expert on their own life, by ensuring our practices are designed to engage the person or their family to enable choice and control.

Our 2021-22 report highlighted the need to focus upon involving and hearing the voices of people who use services in the work of the Boards. This continues to be an identified area of development moving into the new NCASP arrangements within Northumberland.

The **Making Safeguarding Personal Toolkit** has been distributed and embedded within Northumberland to support best approaches and effective applications of safeguarding and support people to work through what their desired outcomes and purpose of safeguarding might be.

In 2022-23:

80% of adults (or their reps) were asked for their desired outcomes

99% of those who expressed their outcomes had them fully or patially met

These are some of the highest rates across the region and the principles of MSP continue to be embedded across a range of safeguarding training programmes.

A 7-minute guide has been produced and an 'access anytime' webinar is available. Attendance at the Adult Social Work forum allowed us to share the MSP Tools and Resources more widely.

MSP is incorporated into the NHCFT value **'Patients First'** which is a fundamental part of all the care and treatment we provide. It is embedded into our training and supervision within the trust, and within our safeguarding referral form, which asks the practitioner to consider this and engage the adult at risk in the referral form and ask the patient what they want from the referral.

MSP is also included in GP and Primary Care training and all MSP tools and resources are now shared widely across the Social Work forum.

Northumbria Police **Victims Code of Practice** ensures that the views of our victims are considered when decisions are made regarding safeguarding and investigation. The recent force wide **"Vulnerability Matters"** campaign will increase and improve identification & recognition of all forms of vulnerability ensuring victims views are captured.

Adult Services have introduced **Storyboards** as a mechanism to evidence the impact of our services and interventions. These are easy to understand and highlight the key measures and outcomes whilst demonstrating person centred practice, in this example it is clear that supporting the client to ensure their cat was well cared for was central to ensuring they achieved their desired outcome.

MULTI-AGENCY AUDIT OF SAFEGUARDING ADULTS REFERRALS

These audits are focussed upon Making Safeguarding Personal, robust decision making, legal frameworks, quality of practice, recording of strength-based practice, improving outcomes, effectiveness of partnership working. The audits identify recurring key issues and themes. These are benchmarked regionally and nationally.

What did we find?

- ❑ Quality of recording was inconsistent
- ❑ Meeting process was not always being followed
- ❑ Organisational Safeguarding procedures were not always robust
- ❑ Non completion of S42 Enquiry Reports

What difference have we made?

- ✓ Improved safeguarding recording helps to support decision making and identify patterns of concern. *Good quality recording is vital should the case progress to any future learning reviews including statutory Safeguarding Adult Reviews*
- ✓ Positive feedback has been received from safeguarding staff following training and new guidance
- ✓ Notable improvements in our response to organisational abuse – positive feedback received from providers
- ✓ NCASP have been assured that actions have been taken as a result of audit.. it's difficult to measure impact at this stage but this will be picked up in future audits.

The audit demonstrated that most of our recording was in line with Northumberland Safeguarding Adult Policy and Procedures which is a marked increase from the previous audit. There was evidence to suggest that decision making was proportionate and Making Safeguarding Personal was evident (although inconsistent).

Our Multi-agency Safeguarding Hub (MASH) information is robust and well recorded. Triage workers demonstrated analysis of concerns via their recording.

Case Study example: the Decision Maker (Safeguarding Manager) and Triage Worker demonstrated professional curiosity, identified risks and subsequently ensured the safety of the victim by arranging a safe place to talk to her on her own.

PRIORITY 8: IMPACT OF COVID 19

What is the data telling us?

- ❑ Increasing demand over the last 3 years reported by partner agencies

- Continuing impact of the pandemic and increased pressures on individuals and their families
- Increasingly complex cases
- Numbers subject to a CP plan increasing over the year and above the regional average; in last quarter seen a decrease in CP numbers.

Our partners have continued to work together to develop an understanding of the impact of Covid 19 on safeguarding children and adults by:

- Capturing and sharing key information
- supporting and training our staff to identify and manage the significant and complex mental health difficulties and domestic abuse rises which we have seen during and following Covid.

Partners have continued to see high levels of demand on services since covid, however there has been a slight decrease in referrals. Whilst most service delivery has returned to pre-pandemic practices, the increased pressures on individuals and their families *continues* to have an impact.

Throughout 2022 – 2023 we have continued to work on our referral processes and a new system was implemented ensuring that appropriate safeguarding referrals were identified. This is likely a contributing factor in the reduction of referrals, ensuring referrals are proportionate and meeting safeguarding threshold.

Self Neglect

- remains prominent in Northumberland
- training to be provided to staff and partner agencies
- audits to be completed to evidence impact of training and outcomes

Physical harm

- continues to increase
- is now the top category of abuse within Northumberland occurring within the family home

Following the recent cost of living crisis, further understanding of the impact on safeguarding referrals is required throughout the next year.

Dispersed Temporary Accommodation

Self-contained accommodation was developed during COVID-19 to help protect and safeguard children, young people and vulnerable adults. This model has continued post covid with additional units being brought forward to increase options for accommodating families. This has proved suitable for effects of Long Covid and enabled increased awareness of infection control in Temporary Accommodation.

We conducted a survey of staff to ask if they would prefer to continue with virtual or face-to-face training and the results highlighted face-to-face as a preference with the option of virtual in some situations. As a result, we now offer a **hybrid model of training** utilising both face to face and virtual delivery methods.

The Wider Impact:

- mental health problems are more common in vulnerable and disadvantaged groups following individual or community-wide periods of social isolation
- the disproportionate impact among vulnerable and disadvantaged groups extends to other outcomes like income, employment, access to food and discrimination, this also includes criminality in some cases.
- these disparities are especially pronounced at the intersections of multiple vulnerabilities and disadvantages, for example, those with low income, insecure employment, and minority ethnic group status

- social restrictions that confine people to their homes for extended periods increase the risk of abuse and exploitation, particularly among girls and women
- Further inequalities are evident in people's capacity to comply with social distancing measures, with this being most difficult for those on low incomes, in insecure employment and living in overcrowded homes.

FOCUS ON… IMPACT ON EDUCATION

What is the data telling us?

- Attendance at school remains below pre – pandemic levels - emerging attendance strategy should be NCASP's business
- CME numbers increased sharply, reflecting effective tracking. Use of part time-tables is high, possibly reflecting need to manage behaviours and re-engage children with school. EHE numbers increased in 2022/23.
- Identification of children not in school full time is robust.

Attendance

In Northumberland (and nationally) the pandemic had an adverse impact on school attendance.

A significant number of children and young people are struggling for a variety of reasons to re-engage with education, there are increasing numbers of children at risk of missing education, and the number of parents choosing to home educate their children has risen.

From a safeguarding perspective this gives us cause for concern, and through school/professional networks and the partnership we have continually asked the question that ***if children are not in school then where are they and are they safe***? This has been a priority for the Schools' Engagement sub-group.

Local data (as of 1st August 2023) tells us that:

	Overall absence			Persistent absence		
	Primary	Secondary	Special	Primary	Secondary	Special
Northumberland	6%	8.8%	9.4%	16%	23.5%	40.9%
North East	5.6%	9.5%	12.5%	17.3%	29.3%	35.3%
National	5%	9.3%	12.3%	17.5%	27.1%	39%

Northumberland is performing better in all measures and all phases against North East and National averages, apart from overall absence in Primary and persistent absence in Special schools. This is a better position than at the beginning of the academic year and demonstrates the positive impact of education support services and multi-agency working.

The direction of travel is encouraging. At the beginning of the pandemic Northumberland was ranked in the 45th percentile of all local authorities in England for persistent absence, rising to 88th when the pandemic was at its height, and improving now to 43rd.

There are many varied and complex reasons for school absence. In Northumberland at the moment the main reasons are:

- Emotionally-based school avoidance or EBSA (wellbeing issues)
- Social and emotional and mental health needs (primary special need SEMH)
- Refusal/parentally condoned absences - some parents' views of school's importance has shifted significantly since Covid and some don't see the importance of attending school as much following being allowed to stay at home during Covid.

A focus for us is the attendance of children with a social worker. Education Welfare Support Officers are deployed to support these children, with appropriate links with Early Help and social workers. There is a

good understanding amongst professionals about how education is a protective factor and being in an education setting can be a source of safety for children who are having adverse childhood experiences.

Schools are encouraged to take a 'support first' approach before considering legal action against parents whose children are not attending school, and from September are re-introducing parent contracts to positively influence parental behaviour regarding school attendance. However schools are taking legal action as a last resort, in the form of warning letters and penalty notices, as one of several strategies to improve attendance.

The hoped for positive momentum during the year has been achieved, and it is hoped will continue from September 2023 when the new Northumberland multi-agency attendance strategy is launched.

Children missing from education in Northumberland

There are a small proportion of children in the UK who are not on a school roll and are also not receiving adequate home education. These children are referred to as 'children missing education' (CME).

In the academic year 2021/22, only 10 children were reported missing from education in Northumberland, the lowest of any LA that had >0 children missing from education (N=23). Proportionally, this corresponds to 0.02% of children in Northumberland being missing from education in 2021/22 (DfE, 2023c). Unfortunately, 'Children missing education' is a new dataset collected by the government, and there is no open-source data published prior to 2021/2022.

As expected, the number of children being tracked through our CME process, identified as at risk of missing education, is higher this year than last year, although numbers towards the end of the academic year have started to fall. In June 2023, 799 children were being tracked, and 55% of those pupils have SEND.

The main reasons for CME continue to be non-attendance, attending alternative provision and the use of part time timetables. The latter comprises a combination of pupils struggling to engage in education, and those being re-integrated back into school and eventually full time timetables. This is a gradual process that is monitored through the monthly multi-agency CME tracking panel. Numbers of pupils who are CME are expected to remain high next year and follow the same pattern of peaking during the Spring term before reducing towards the end of the academic year.

The Principal Education Welfare Officer is a member of the Safer in Education sub-group (previously Schools' Engagement sub-group) and provides multi-agency partners intelligence regarding CME so that school attendance is understood as a protective factor and 'everyone's business' to promote it with the children and families we support.

Children with a Social Worker: The education of children with a social worker has a high profile across children's services and with schools. A successful Relationships Matter conference (a collaboration between the Virtual School, Be You and NEWST) launched a local authority approach to relational and trauma-informed practice and we are working to develop and embed this learning.

Training has been delivered to social workers and a Task and Finish group is developing resources and strategies to strengthen school-social care relationships. A performance monitoring framework has been developed, and case file audits are in place to evaluate the integration of barriers to education in children's safety plans.

Children in elective home education (EHA) in Northumberland

Another explanation as to why children and young people are not in school is that their caregivers have elected to home-school.

The DfE records these instances and publishes statistics on what they have named 'elective home education (EHE) every year. In the academic year 2021/22, 420 children were in EHE in Northumberland. This corresponds to 0.91% of children in Northumberland, which is lower than the national average for elective home education (1.36%) (DfE, 2023b).

The number of children being electively home educated in Northumberland peaked in June 2023 at 467, the highest that has been recorded. The proportion of those children with SEND has however remained constant over the last 5 years at approximately 25% (with less than 10% having EHCPs). 201 children are new to EHE this academic year, and a small number have returned to school places.

Pathways into education, training and employment at age 16 for EHE learners are becoming better understood and indicate positive education outcomes for the majority of those young people.

In September 2022 the DfE introduced a termly reporting system for local authorities to gather intelligence about CME and EHE at a national level. This has provided us with helpful contextual data, although not yet validated. This return defines reasons for EHE which have now been adopted by the Education Welfare Service to provide more insight into why parents in Northumberland choose EHE for their children. At the same time we have undertaken our own deep dive investigation into EHE that concluded in August 2023 and the findings will be presented to the Safer in Education sub-group.

It will be a priority in 2023-24 to review the existing multi-agency EHE strategy, and recommendations from the current DfE consultation into CME/EHE will be adopted once they are published.

Operation Endeavour

Operation Endeavour is Northumberland's local agreement with Police to notify schools when child concern notifications are received regarding children going missing. The process works in the same way as Operation Encompass (re domestic abuse) and has allowed schools to act swiftly to safeguard children and better understand individual children's needs. The number of CCNs recorded through Operation Endeavour during this year has increased significantly, by 66%, and is indicative of the ongoing impact of Covid.

PRIORITY 9: DOMESTIC ABUSE

What is the data telling us?

- Continued increase in Domestic Violence, rising around national holidays and events.
- DA for older people emerging theme from DHRs/SARs - joint T&F group with DALAPB
- Increase in DA incidents involving children and overall offences against children. Recent increase in repeat incidents, high risk cases, and those involving 16/17 year olds and ethnic minorities
- CPVA work demonstrates effective use of tools and training and work in this area feels ahead of others

Domestic Abuse continued to be a priority for NCASP and DA Partnership Board developing service provisions for advocacy and advice, specialist support for those with complex needs and protected characteristics, housing-related support, support for children and counselling and therapy.

NHCFT launched a young person's **sexual violence pathway**. This was developed in conjunction with specialist regional health services and provides a consistent supportive pathway to ensure that young people who are victims of sexual violence receive a consistent and robust package of support and care.

- NHCFT have another IDVA now trained (taking total to 2).
- Outreach work has been undertaken by our IDVA/ISVA to ensure that services in rural areas are aware of indicators of DA and CPVA and the pathways to follow.

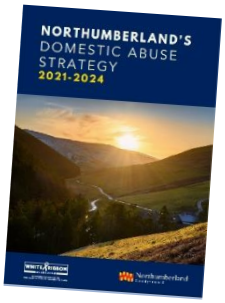
During the 16 days of Action and other key events (e.g. World Cup) NHCFT undertook extensive awareness raising among our workforce and the public - including a projection onto the exterior of our NSECH site, Social Media posts, Diva Walk.

At NHCFT's annual safeguarding conference, we delivered a session on domestic abuse (violence against women and girls) and the link to Terrorism and the INCEL movement which was well received and then cascaded to other partner agencies.

Domestic Abuse Summit

The DA Local Partnership Board facilitated a multi agency domestic abuse summit in October 2022 to review the progress of the strategy along with consulting on the priorities. Challenges identified included ensuring the availability of resources, staffing levels and managing waiting lists.

In line with the Local Authority commitment to ending violence against women and girls and recognizing its White Ribbon Accreditation, the **DA Strategy** sets out its vision:



'Northumberland is a county committed to having a zero-tolerance approach to domestic abuse and sexual violence. Everyone matters and for that reason our vision is to make it everyone's business to help prevent and put a stop to domestic abuse and sexual violence in the county. We will listen and learn from victims, survivors and their children. We will be proactive, provide support and raise awareness in our communities. We will seek to change culture. Our vision is a vision for all and by working together we can make a difference.'

Northumberland have completed a Domestic Abuse Needs assessment to sit alongside our DA Strategy. There has been a particular focus on rural areas within the North and West of the locality along with a focus on adult counselling.

We have an **integrated Domestic Abuse service** for support in Northumberland.. #YouAreNotAlone visit: http://nland.uk/DomesticAbuse. **Download: POSTER**: Northumberland Integrated Domestic Abuse Support Service

White Ribbon Accreditation

The Northumberland White Ribbon steering group met in November 2022 to review year one of the three-year plan.

A number of achievements were identified..

- Established network of White Ribbon Ambassadors and Champions.
- Domestic Abuse services recommissioned from 1st April 2022, including a Changing Behaviour service.
- A timetable of events for the 16 days of action to raise awareness of domestic abuse, and violence against women and girls, and the support available.
- Domestic Abuse and Child to Parent Violence and Abuse training strategy in place.
- White Ribbon Ambassador and Champion network events.
- A Northumberland Education padlet platform of regularly updated and quality assured teaching resources for schools to address themes such as gender-based violence, safe and respectful relationships, sexual abuse and harassment in place

An overview of year two priorities..

- Development of resources for White Ribbon Ambassadors and Champions, with regular opportunities for feedback.
- Promote White Ribbon accreditation to local partners, groups, and businesses, and include as an option within the social value framework for commissioned services.
- Ongoing development and delivery of the training offer.
- Develop confidence in the school's workforce to recognise, respond and incorporate themes relating to sexual harassment and abuse into teaching and learning cross the curriculum and visibly within PSHE.
- Working in partnership with the Office of the Police and Crime Commissioner to improve women's safety in public places.

CNTW: Domestic Violence training package has been developed by Named Nurses informed by learning from local reviews. Over 300 staff have accessed the training so far, and this will continue to be rolled out.
We have shared the learning from Domestic Homicide Reviews undertaken within the year with particular focus on addiction services who have received the Trust DV training. The impact has been an improved understanding of recognizing and responding to domestic abuse concerns.

Operation Encompass

Continues to be co-ordinated by the Virtual School's Schools' Safeguarding Team and was monitored through the Schools' Engagement sub-group. CCNs for children witnessing or experiencing domestic abuse remain high (slightly higher than last year) following the pandemic.

Schools value this protocol. An indication of this is that **69** Northumberland schools were inspected by Ofsted during the academic year and only one was judged to be ineffective for safeguarding (emergency support measures are in place for this school as required by the DfE and NCASP).

'No Excuse for Domestic Abuse'.

An intensive engagement initiative took place in partnership with the Office of the Police and Crime Commissioner (OPCC) to coincide with the FIFA World Cup, International Day for the Elimination of Violence Against Women and the Christmas period. Northumbria Police aimed to target DA perpetrators and engaged with a group of perpetrators who participate in behaviour change via a local DA support service, to seek feedback on proposed social media content.

The force's Communications & Engagement Team advised that interaction with social media content was high and public feedback positive.

Child to parent violence (CPVA)

CPVA project uses therapeutic approaches to engage parents in a program of work which aims to change their response to their child, in turn changing the child's behaviors. It can include physical violence from a child to a parent or other behaviors like damage to property, emotional abuse or financial abuse.

Parents are often reluctant to discuss the abuse due to fear of being blamed or misunderstood by professionals, alongside the risk of their child being criminalized. CPVA overlaps with the victim perpetrator dynamic and is therefore a complex area of work. The underlying causes for CPVA are often misunderstood.

The project has been successful in reducing violence in the home, improving communication and reducing the need for Police involvement. As the project is based in YJS the team can complete OOC assessments where CPVA is the main issue. This allows a holistic assessment with interventions which reframe ideas around offending. Since the project was established, **97** cases have progressed.

Child to parent violence and abuse (CPVA) continues to be embedded within Northumberland with a clear pathway in place whereby cases are identified and discussed between Adult Safeguarding and Children's Safeguarding within the Multi Agency Safeguarding Hub. The partnership continues to be committed to raising awareness of a coordinated approach in response to CPVA though data tells us that identification is improving as reported issues have increased highlighting:

- There is a 70-30% gender split (male: female)
- The majority of young people referred are aged 11-15 years

A multi-agency audit was completed via the CPVA steering group and a multi-agency action plan was devised, actioned and reviewed. The impact of the CPVA training toolkit has been evaluated and the quantitative and qualitative evidence showed that it has been effective in supporting good practice. CPVA briefings continue to be delivered on a virtual basis to a multi-agency audience.

Case Study
Narrative and impact of intervention of CPVA worker:
[YP] was referred to the service for showing violence and aggression towards his parents and damaging the family home. He was showing controlling behaviours and has even threatened his dad with a knife. Mum had become very fearful of [YP]. I completed NVR with both parents with a lot of focus on parental presence empowering them to challenge [YP's] behaviours in a more considered and supportive way, not putting in place punitive consequences and boundaries that the parents were unable to keep.

I completed work with [YP] around expressing his emotions in a different way and positive friendships. It was noticed that [YP's] behaviour would heighten when certain friends were around.
After all work was completed, [YP] had a new friendship group and was engaging back in education. Parents both felt more empowered and reported a much more settled home with no more damage to the property.

Feedback from young person and family about the intervention:

- "Helped me with my anger" - young person
- "How to use different ways of dealing with my child's anger issues and ways of coping" – parent/carer
- "It's great to help families out with children with challenging behaviour" – parent/carer

Example of good practice: Great communication between CPVA team and youth justice allocated worker.

OTHER UPDATES..

CHILD EXPLOITATION

National Child Exploitation Awareness Day 2023 (#CEADay23) – 18th March 2023
A briefing was circulated across NCASP to raise awareness and encourage everyone to think, spot and speak out against abuse - **National Child Exploitation Awareness Day 2023 - NCASP Briefing**.

We also took part in the #HelpingHands social media campaign.

Northumbria Police continue to support any victims of sexual exploitation and recognise the long-term impact offending of this nature can have on victims. Specially trained officers from CAP are deployed to respond to reports of this nature. An example of where this approach supported the model in Northumberland is a male who was recently convicted of numerous historical sexual offences resulting in a

25-year sentence. This was a testament to the patience and work put in by dedicated officers who were able to support the victims through an arduous process.

On National CEA Day, we took the opportunity to highlight the importance of using appropriate language and terminology when discussing children and young people strengthening our commitment to capture the voice of the child.

North East Learning Session - Child Financial Exploitation - October 2022

The Children's Society ran an online learning session[7] in the North East which was attended by 375 participants, including frontline practitioners (such as Social Workers, Probation Officers and Family Workers) and senior managers. Some of the key findings and insights from this session are presented in this report: Key findings from learning session.

Missing and Exploitation support sits within the Northumberland Adolescent Service with far reaching input across the county. Input includes practical responses to missing episodes in the form of Return Home Interviews (RHI). Exploitation support is multi-faceted including practical 1:1 intervention with young people, consultations for Social Care and Early Help, training, contribution to wider service delivery including multi-agency groups.

Missing, Slavery, Exploitation and Trafficking Group (or MSET), coordinates and ensures the effectiveness of multi-agency arrangements for safeguarding children and young people who go missing or are at risk of exploitation. MSET is not about care planning, partners are encouraged to manage risk within existing multi-agency safeguarding structures prior to escalation to the MSET with the meeting offering added value to reduce risk (alongside wider contextual disruption of perpetrators and places) and provide oversight of patterns and trends

The MSET covers children and those young people in transition to adulthood. The meeting is chaired by Northumbria Police and co-chaired by Senior Management from Children's Social Care.

The Strategic Exploitation Group receives an annual report (for scrutiny and assurance) about the local offer of support and risk management. The annual report provides **data** (and supporting narrative), highlights **key issues and emerging themes**, and **identified actions**.

Some key issues and emerging themes:

- increase in the use of the **National Referral Mechanism (NRM)** for young people. It is believed that recent training has increased staff awareness, which is the cause of this increase rather than an increase in trafficking.

- **Additional Needs** - increase in young people with additional needs at risk of exploitation/going missing. ADHD, ASD and Dyslexia have all be discussed in RHI's. This has raised a discussion around hidden disabilities and the importance of early intervention. ELKLAN training has been delivered to a large proportion of RHI workers.

- Increase in **weapons related offending** in the past 12 months (from 14 in 2021 to 21 in 2022). We see a sharp rise around the time of serious incidents in the county. For example, following the murder of a young person, in the west of the county, 4 offences for carrying offensive weapons were reported by schools and Police in one weekend. A key theme for this type of offence is younger children displaying curiosity in weapons with no establish intent to use. Diversion and prevention efforts are managed via the Youth Justice Service.

[7] Slides from session

- **Online Exploitation** – increased use of screentime has coincided with an increase in reports of online grooming, sharing and distribution of indecent images. Parents also tell us they do not always feel well equipped with sound knowledge of technology to monitor and disrupt these concerns. The police have led on a campaign with schools to raise awareness

- Continued increase in girls being referred for exploitation support, predominately where there are concerns around online communication and relationships. In addition, we have noticed an increase through missing episodes of girls being reported missing together. To support with this, a successful bid was submitted to the Home Office, and (through the Young Women and Girls Fund) we have secured a young women's worker. This role is to work with young women and girls who are at risk of exploitation and/or gang related harm. Within the first two months seven young women were receiving one to one support from the worker.

- Prominent areas for substance misuse continue to be focused in the south-east. The substances most frequently reported are Alcohol and Cannabis. Nitrous oxide (NOS) cannisters continue to be found in areas known for youth congregation (i.e parks).

A number of police investigation to address specific concerns around organized crime are ongoing across our region.

Police Harm Reduction Team have built and maintain close links with the Missing From Home Coordinators, and the LA with daily contact to share information on repeat and concerning missing people (children and adults). This enables more effective response to missing people at an operational level. It also allows professional challenge to decision making partners ensuring incidents are dealt with applying appropriate risk rationale.

Contextual safeguarding training has been offered to all Social Workers and Managers within Northumberland County Council. Local partner agencies including fire service, police and housing were also in attendance. We are in the early stages of adopting this approach in Northumberland and a pathway (which considers young people within their own contexts as well as harm outside of the home) has been developed and will be piloted soon.

There is a Regional Contextual Safeguarding Board, which is focussed on driving this approach forward regionally.

LOCAL AUTHORITY DESIGNATED OFFICER (LADO)

The role of LADO is set out in statutory guidance[8].

Summary

Over the past reporting year, referrals made to LADO have increased by **112.6%** with the complexity also increasing. In response to this increase, the decision was made to make the LADO a standalone bespoke role.

We are seeing the impact of LADO awareness sessions being delivered to different agencies, this is reflected in the increase in referrals. Understanding of the referral criteria has been strengthened across agencies and the quality of referrals is improving, resulting in more robust information being gathered (in terms of referral information). The highest number of referrals to LADO continue to be from children's social care (this category includes referrals from children's homes). There has been an increase in referrals regarding volunteers or adults who are working across multiple settings.

[8] Chapter 2: Organisational responsibilities (workingtogetheronline.co.uk)

The impact of covid on services working practices and adult's own coping mechanisms continues to be a key theme. The highest referral category type is 'Physical' with a noted increase in the 'Online' category being used (with many online concerns linked to 'Sexual' category).

Areas for further development include:

- Continuing to improve use of children's social care recording system
- Developing forms for recording and reporting purposes.
- Continuing to offer LADO awareness sessions (to as many services as possible) to ensure process for managing allegations is shared and understood.

See: Local Authority Designated Officer (LADO) - Information Sheet and Flowchart

LEARNING FROM REVIEWS

Our case reviews are adequately resourced to enhance learning, to embrace contextual as well as individual and family concerns and to involve the full range of strategic and operational staff to extract and embed learning. Learning from local and national reviews is cascaded and used to improve outcomes for children, adults and families. Learning from case reviews is integrated into safeguarding training, policy and practice.

A Learning Review Toolkit has been developed to support those who are leading on any type of case review in Northumberland.

The toolkit has been designed to be used as a reference tool and the review stages have been mapped against national and regional Quality Markers. The aim is to increase confidence in undertaking reviews and provide a consistent approach to producing good high-quality reviews.

See: Northumberland Learning Review Toolkit

LEARNING FROM SAFEGUARDING ADULT REVIEWS

In accordance with the Care Act 2014 Safeguarding Adult Boards have a statutory duty to carry out Safeguarding Adults Reviews (SARs). The SAB is required to undertake reviews when an adult in its area has died as a result of abuse or neglect, and there is concern about how the partner agencies have worked together to safeguard the adult.

During 2022-23 Northumberland have not undertaken any SARs however the safeguarding Adult Review Group (SARG) has considered 6 referrals in this period. Three of these cases are awaiting a decision by the group whether they meet the criteria and these decisions will be made imminently. The remaining three cases did not meet the criteria for a SAR however in two instances it was determined that some multi-agency lessons could be learned and a Lessons Learnt exercise is currently being undertaken and will be reported in next year's report.

LEARNING REVIEWS

Two Learning Reviews were undertaken in 2021-22 and we can now update on their findings:

Learning from 'Harry'

A Safeguarding Learning Review was commissioned by both the Northumberland Safeguarding Adults Board and the Northumberland Strategic Safeguarding Partnership following the death of Harry, age 19. The aim of the review was to highlight good practice and identify opportunities for learning from the way that agencies worked together to support Harry. This was a joint Children and Adults Learning Review.

A 7-minute guide was developed and shared for practice learning.

Learning from 'Jill'

Whilst the Safeguarding Adults Review Committee (SARC) decided that the SAR criteria had not been met for Jill, the circumstances potentially identified a number of opportunities for multi-agency learning and therefore warranted a Learning Review.

The purpose of the Safeguarding Adults Learning Review was not to apportion blame but to promote effective learning and improvement action plan for future interventions. The aim is that lessons can be learnt from the case, and those lessons can be applied to future cases.

A 7-minute guide was developed and shared for practice learning.

Summary of themes from reviews:

Mental Capacity	Policies and Procedures	Lived Experience	Professional Curiosity	Identification of Needs and Vulnerabilities	Impact of Trauma

The Safeguarding Adult Review Group (SARG) collates the findings from Safeguarding Adults Reviews (including learning reviews), evaluates the learning/findings, and provides further audit and scrutiny to gain a broader view of the findings on behalf of NCASP. The group also oversees and monitors recommendations and action plans.

Findings from all reviews are shared with the Practice Learning Group to consider the implications for training/procedures, and how learning will be shared across the partnership.

FOCUS ON.. MENTAL CAPACITY ACT

Reviews locally, regionally, and nationally continue to highlight Mental Capacity Act (MCA) as area of challenge for partner agencies. Northumberland Safeguarding Adults Board published a Safeguarding Adults Review in 2019 which included key learning in relation to the application of the MCA. This has also continued to be a recurring theme in subsequent Learning reviews as highlighted above.

NCASP has a key role in ensuring that learning from these reviews is embedded in front-line practice and with the aim of preventing recurring learning being identified in subsequent reviews.

Mental Capacity Act (adults) is a key area of work for NCASP. Complex Mental Health is also one of our priorities – see Strategic Plan 2023-2026

A working group has been established with the aim of achieving the following:

- ❑ Ensure that learning from Reviews where MCA has been highlighted, is embedded in front-line practice
- ❑ Ensure that practitioners have a thorough understand of MCA and are confident in its practical application
- ❑ Empower staff to be confident in their decision making
- ❑ Ensure that MCA is appropriately applied during transition from children to adult services where applicable

NORTH EAST SAR CHAMPIONS

The North East SAR Champions group is a collaborative partnership committed to ensuring that Learning from SARS and other enquiries is shared across the North East Area.

In 2022-23 the group have undertaken the following activity:

SARs Links to Parallel Processes (including LeDeR)

- ICB developing work - very early stages but will include effective collaboration across reviews in terms of reducing repetition and sharing of learning.
- SAR champions were invited to have conversation with their local ICB reps to determine whether this can be replicated across the region.

Independent Reviewer Training

- Key points highlighted were: lack of experienced reviewers, duplication of learning, appropriateness of reports, other methotdologies for reviews (learning)

Rapid Review

- SCIE have developed SAR in Rapid Time training - methodology could be adopted but still requires substantial commitment in terms of time and resources.
- Some Rapid Reviews conducted across the region will be uploaded to the SAR Library (regional).

SAR / Review Learning Toolkit

- Work continues to develop the SAR / Review methodology toolkit held in the NE SAR Library.

SAR Spotlight

- Provides an opportunity to share updates and highlight any emerging themes / learning.
- A key issue highlighted in 2022-23 is **Fire Deaths** where the common themes are Immobility, Smoking, and Self Neglect.
- task and finish set up (by North Tyneside) with regional representation (aims to establish a regional approach).

Quality Markers

- SAR champions have created the NE Quality Marker Checklist with the aim of providing a consistent approach to producing good high-quality SARs.

LEARNING FROM CHILD SAFEGUARDING PRACTICE REVIEWS

Serious Incident Notifications (SINs)

The LCSPR framework has recently been updated to incorporate the Child Safeguarding Practice Review Panel's guidance for safeguarding partners. This has strengthened understanding of the criteria for Serious Child Safeguarding incidents and the rapid review process. There is an effective system in place for the notification of all incidents meeting the criteria and a clear process for rapid reviews to be held. This process has been implemented and is overseen by the NCASP business manager. Partners and relevant agencies understand the purpose and are fully engaged with (and contribute to) rapid reviews and LCSPRs.

Well-conducted rapid reviews (which identify immediate learning) avoid the need for an additional lengthy review which may result in only limited additional learning. However, where a case is particularly complex,

or the potential for further learning is identified, a LCSPR will be considered. The LSCPR Framework and Practice Guidance sets out the process and ensures consistency, whilst allowing flexibility with methodology.

There has been an increase in serious cases being notified, these have been reviewed and agreed to be appropriate referrals. We have noted increase in numbers of under 1s with injuries to babies and have set up a task and finish group to look at the cases and consider any wider determining factors. The publication of CSPR Panels data has also prompted regional discussions.

RAPID REVIEWS & CHILD SAFEGUARDING PRACTICE REVIEWS

A **Rapid Review** meeting is convened following notification of a Serious Incident[9]. All agencies who have (or had) involvement with the child or family are required to contribute to the Rapid Review and attend the meeting.

During this reporting period, we have submitted **6** SINs. Rapid reviews were held for all cases, with learning identified and acted upon. A Local Child Safeguarding Practice Review (LCSPR) recommended for one case (Sophia). We were also involved with Rapid Review undertaken by Leeds.

- Baby with subdural haematoma
- Baby found unresponsive co-sleeping
- 1 young person fatally stabbed & 1 assaulted
- Baby with unexplained injuries
- Young person admitted to hospital severely malnourised
- Baby with head injuries

The national panel have agreed with all of our recommendations and have commended our rapid reviews for being well written with clear action plans. Ongoing work and actions have continued in relation to previous reviews. We completed a joint Children and Adults Learning Review (see learning from Harry).

LOCAL CHILD SAFEGUARDING PRACTICE REVIEW – SOPHIA

We have appointed a Lead Reviewer who is being supported by a multi-agency review team. The lead reviewer is from within our own system so we have been able to progress quickly. **Sophia is being supported to be involved with review** (and chose the pseudonym).

This review is using an Appreciative Inquiry (AI) approach. As an approach, AI does not apportion blame. It embraces professional curiosity and challenge, by asking open questions about what worked well alongside what might and should be different in the future. Practitioners learning event is scheduled for October after which a report will be drafted and considered. The aim is to have final report signed off and published by end of Jan 24.

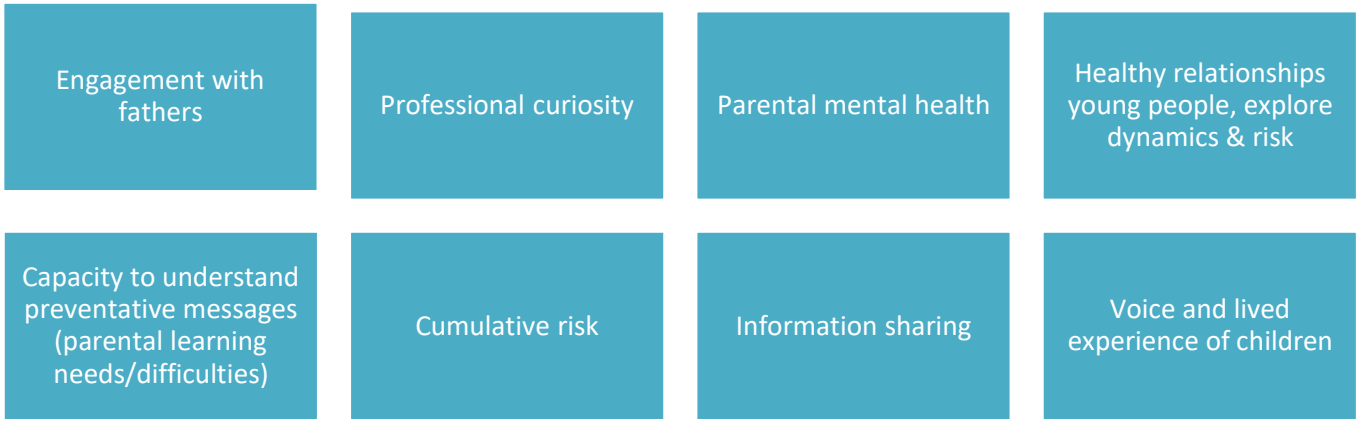
A **Voice and Lived Experience of a Child - Factsheet** has been developed (and shared) following learning identified by rapid review.

Reflective learning workshops

There have been 2 reflective learning workshops for cases which did not reach the criteria for SIN however partners agreed these cases considered further reflection to identify any learning and good practice.

[9] Chapter 4: Improving child protection and safeguarding practice (workingtogetheronline.co.uk)

Summary of themes from all reviews:



The Child Safeguarding Practice Review Group (CSPRG) collates the findings from LCSPRs (including rapid reviews), evaluates the learning/findings, and provides further audit and scrutiny to gain a broader view of the findings on behalf of NCASP. The group also oversees and monitors recommendations and action plans.

Findings from all reviews are shared with the Practice Learning Group to consider the implications for training/procedures, and how learning will be shared across the partnership.

Some briefings developed following learning from reviews:

- Voice and Lived Experience of a Child - Factsheet
- Self Harm (CYP)
- Transitional Safeguarding
- Professional Curiosity
- Trauma Informed Practice

LEARNING FROM OTHER REVIEWS

All national reviews and regional case reviews are discussed at NCASP and any learning relevant for Northumberland is implemented. This includes reviewing our procedures and training offer and making changes, where necessary. As we share regional safeguarding procedures, we can make sure this is implemented across the six areas.

An example of this is the national panels review re bruising in immobile babies. We reviewed our pathway which already reflected good practice highlighted in the review, and we made sure this was covered in training. The National CSPR Panel's reviews are also used to inform learning for our rapid reviews (where relevant).

LEARNING FROM MULTI AGENCY AUDITS

We carried out a number of multi-agency audits during this period. Those linked to our priorities have been included in the relevant sections above.

MULTI AGENCY ANALYSIS OF THE EFFECTIVENESS OF CORE GROUPS

As a result of a learning review (Daniel), one of the actions identified was to explore this theme and to give reassurance to the partnership.

This audit was completed to explore whether the use of core groups was effective in our child protection systems. The findings outlined were only a random sample of cases that only covered the first three months of there being a child protection plan in place. The themes that have been identified however give a snapshot of practice within this framework in Northumberland and therefore analysis needs to incorporate these patterns and themes.

In most of the cases seen, the relevant agencies were invited to Initial Child Protection Conferences and whilst they were sometimes assigned tasks within a plan, the use of first names in some instances may have been confusing not only for the core group but also for parents. Plans were not always contained within agencies records and were seen as variable in quality which may impact on the understanding and implementation of actions identified.

Core group meetings in the main were held however agencies were not always invited and there was no evidence from any agency that the focus was on the plan and identifying whether actions were being progressed. Core groups were seen to be a general update and minutes of these meetings were not always received by other agencies and the process around this was unclear within records. There was however some evidence of challenge within core groups.

What was of concern was that GPs were not always invited to ICPCs and reports were not always being completed, however there has already been some work completed between the ICB and the Safeguarding Unit and improvement has already been noted in these areas.

In conclusion, this audit highlighted a number of areas that could be strengthened and within this, we need to be mindful of the families we are working with and if plans are vague and unclear and child protection processes are not always being followed (core groups not always being held and appropriate agencies not always being invited) then it could be argued that this may set the families up to fail.

The purpose of this audit was to explore the effectiveness of core groups, and this has been a real learning opportunity for agencies and some measures have already been put in place to improve the effectiveness.

ANALYSIS FROM MULTI-AGENCY AUDIT OF THE MULTI-AGENCY SAFEGUARDING HUB (MASH)

What is working well? (Children and Adults)

- Good sample size with 10 adult and children's cases audited by a good mix of partner agencies.
- In all cases partner agencies agreed that the worry met the threshold for partner agency information gathering.
- In 8 of the 10 cases, RAG rating was agreed as appropriate. (Children's)
- In 10 cases RAG rating was agreed for all as appropriate (Adult's)
- In all cases partner agency research is said to be clear, relevant and in the right boxes. Evidencing training to partner agencies has been affective
- In all cases partner agency research is said to be well pulled together by children's services. There was some really helpful feedback that came alongside this for how we might strengthen this even further.
- Strong analysis identified in Adult's MASH with clear safety planning and easy to establish what was happening next
- In half of the children's cases, the views of the child was heard. We are committed to hearing every child's voice but not every child needs a same day visit and at times we are not able to contact the family on the same day. In all cases where the child's voice was not heard that day (as it was assessed as not being needed imminently for safety) they were heard within the assessment that followed.

- ❑ In the majority of the cases for adults, the clients views were achieved. Rationale was provided on the cases where the client was not spoken with and attempts made to speak with them.

Children's: The audit narratives said lots of really positive things like..

- good quality pulling together of information
- information was clear, relevant and easy to read
- I knew exactly what the plan was and agreed with this

If the case was not going for strategy there was clear rationale and evidence of multi-professional discussion. Information sharing evident and good communication seen throughout..

- Can see that MASH pulls together all the information to ensure that opportunities to keep children safe are not missed
- clear oversight seen
- this work has really highlighted how well MASH works and all the good quality multi-professional working that happens

Partner comments about Adult MASH..

- Good information sharing
- Clear processes
- Clear decision making
- Clear identification of harm
- Good analysis from social workers and decision makers
- Majority of MASH had no gaps in information
- Limited use of abbreviations or jargon and information is clear to read
- Good partner agency contributions
- Management oversight is really helpful to explain how decisions are being reached
- Northumberland Threshold tool highlighted within rationale and decisions
- Process flows through MASH form
- Strategy discussions held on each MASH episode

Partner agencies commented that they like that children's services do a family and relationships section so they understand who everyone is, where they live, who they live with and what contact the have with the children. They also commented that the use of headings and bullet points helped them to understand the information and seems to keep everyone focused.

What are we worried about?

Children's:

- ❑ Importance of historical information – Signs of Safety (First/Worst/Last) might not always fully capture the history.
- ❑ Disagreement about RAG rating - partner agencies should meet to review the RAG rating criteria.
- ❑ Clear safety plans – a template with headings (like we have for partner agencies) may help.
- ❑ Outcome of social worker's visit not always known (when case closed).

Adults:

- ❑ Scaling in line with Children's to be considered
- ❑ Consider how family can support in safety planning

- Rationale around visits not being completed needs to be clearer
- Voice of the family not just the client not consistently gathered during the MASH

Next Steps:

1. Partners to discuss and agree benefits of regular audit work in MASH and frequency of this. This should be done annually and include at least 1 worker from each partner agency.
2. Children's Safeguarding Team Manager to arrange MASH training to be completed every 2 years for new starters. Training slides (and notes) will be shared with new starters.
4. Partner agencies will meet to discuss RAG ratings and develop a clear guide so that there is shared agreement to urgency of work.
5. Children's Safeguarding Team Manager has already arranged for an AP to lead a group supervision around the use of first, worst and last for family history and the importance of a paragraph that explains the worries and patterns not captured in this.
6. Children's Safeguarding Team Manager has already arranged for an AP to lead a group supervision around mapping of partner agency information but also the importance of using what we know to analyse the information.
7. Children's Safeguarding Team Manager and partner agencies to meet to agree a template for the final page of the MASH to include what they need to know from the MASH.
8. Children's Safeguarding Team Manager will speak to CSC management group about discussions with health and police being clearly documented (if not having a strategy).
9. Adults to consider using Signs of Safety scaling
10. Adults to provide rationale around visits during the MASH episode
11. Adults to consider family support (not just the views of the client).

Child Death Reviews

There is a statutory requirement[10] for Child Death Review Partners[11] to ensure arrangements are in place to carry out child death reviews, including the establishment of a CDOP. The merged CDOP panel (North and South of Tyne) has been functioning for three years. CDOP met 10 times (between April 2022 - March 2023)

Child Death Overview Panel – Annual Report (2022-2023)

This is the third annual report of the joint N&S Tyne CDOP, which contains a summary of the activity carried out by the panel across the 6 LA areas represented: Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside and Sunderland.

In 2022/23 there were a total of **106 child death notifications** (compared to 91 last year). 14 (13%) notifications for Northumberland (19 last year). The highest number of child deaths were below the age of 27 days. A child is most at risk of death within the first year of life, and particularly within the first 27 days of life. **Child death reviews**: The panel reviewed and closed 103 cases in 2022/23 (compared with 73 cases last year), 20 (19%) for Northumberland.

The number of cases notified to the CDOP differs from the number of cases which the panel reviews during a given year as the child death review process, prior to the CDOP meeting, can take several months, particularly if there are police or coronial processes to be concluded.

It is worth noting that the child death process also creates an opportunity at the meetings held before the panel review (Joint Agency Response Meetings, Morbidity and Mortality and Child Death Review Meetings) for services to identify other smaller, micro-changes to practice, e.g. a need for workplace training or amendments to internal policies and procedures.

See: CDOP Annual Report 2022-2023 for more information, including examples of modifiable factors and action taken to reduce child deaths.

MULTI-AGENCY TRAINING & IMPACT EVALUATION

Annual Reports on Multi-Agency Training (April 2022 – March 2023):

- ❑ Safeguarding Children
- ❑ Safeguarding Adults
- ❑ Early Help and Prevention
- ❑ Children's Social Care
- ❑ Domestic Abuse

Evaluation and Impact reports:

- ❑ Trauma Informed Practice - Training Impact Evaluation
- ❑ Child to Parent Violence and Abuse (CPVA) Toolkit Training: Impact Evaluation
- ❑ Change Star Training Review
- ❑ Talking Toolkit - Project Evaluation

- [Trauma informed practice] This is the most thought-provoking training course I have attended and I have been a social worker for many years. The use of VIRTUAL REALITY and you being that person is such a

[10] Child Death Review Statutory and Operational Guidance / Chapter 5 of Working Together to Safeguard Children 2018

[11] Local Authority & ICB (6 Local Authorities and 1 ICB in our footprint)

strong way of feeling someone's lived experience. It was emotive, emotionally exhausting but so powerful. It has shaped my perspective, I cannot recommend this type of training enough..

- [Trauma informed practice] I understand the mechanism of trauma better now, and I can see the ways it has been affecting me, and what I could be doing about it now. If I can care for myself better, I will be able to respond better to those I work with.
- [talking toolkit] it made me think more creatively, gave me ideas and confidence to use more interactive activities'
- [CPVA toolkit] The feedback from the triangles was really positive. Especially from mam, she totally understood the change in family dynamic when using a visual tool.

CNTW have made substantial progress rolling out level 3 training across the organisation. The Academy continues to offer this training on a weekly basis (via Microsoft Teams) to ensure consistent compliance. This has resulted in a sustained increase in safeguarding reporting which demonstrates an increased awareness of safeguarding and public protection issues in Trust staff. A Vulnerability not age awareness session is being developed.

SOME CASE EXAMPLES HIGHLIGHTING MULTI-AGENCY WORKING

Case Study A

A complex adult patient spanning multiple agencies regarding, safeguarding, mental health, MCA, exploitation, homelessness and frequent attends with NEAS, Police and NHS. Due to the number of agencies involved the patient often felt disillusioned with the support they are being provided as it wasn't joined up and was therefore contacting multiple agencies seeking support. Professionals felt frustrated due to the lack of communication between agencies and any progress for the patient, but also the impact the contact was having on their and other service resources.

NHCFT chaired several meetings with multiple agencies (LA, NHCFT, CNTW, NEAS, Police, probation and third sector agencies) to determine the best way to support the patient and manage the presentation and attends at services. A bespoke management and support plan was developed, in conjunction with the patient, for agencies to refer to which defined for them how to best to respond and support the patients when they were contacting and attending services. This subsequently redirected services into a more proactive and consistent approach and allowed services to understand the most updated needs for that patient.

This resulted in the patient feeling more secure and a reduction in attends for all services, which has been maintained.

Case Study B

An elder of the Gypsy, Roma and Traveller (GRT) community passed away and disputes arose within the family regarding the Will and arrangements for the funeral. This escalated into threats of violence and damage and resulted in the Police attending and a family moving from the location temporarily.

The family groups involved included vulnerable adults and a child aged 12. Multi-agency work, involving NCC Housing Operations, Homelessness & Housing Options and GRT Liaison as well Childrens Social Care and Northumbria Police, enabled the families at risk to gain an offer of temporary accommodation and support.

The Police neighbourhood team put a patrol plan in place around the location to deter any potential for disorder. A multi-agency safeguarding meeting was held, Children's Services took the lead on safeguarding of the child, with meetings facilitated with the child's mother, the plan being to suggest safe accommodation for the child and one of either the parents or elder sibling in the short term.

Through proactive, collaborative working across all agencies, a young person and their family was safeguarded from an escalating situation.

VOICE AND LIVED EXPERIENCES OF THOSE WHO USE OUR SERVICES

EARLY HELP / FAMILY HUBS – YOUNG PEOPLE'S VIEWS INFLUENCING SERVICE DEVELOPMENT

Family hubs in localities consulted with young people asking questions to unpick what they felt young people would benefit from in the community in their area, as a result some family hubs have introduced:

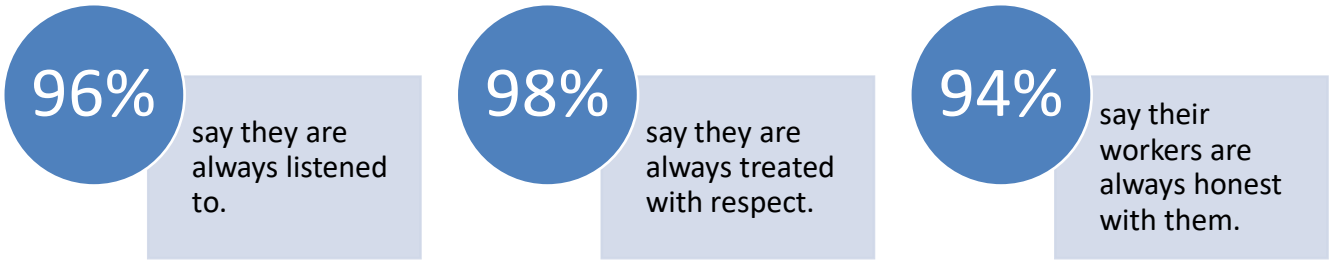
- drop in for young people (south-east) to help provide a safe, stimulating enjoyable environment which included a sensory room for young people and social education.
- After school group (central) in partnership with Learning Hive and Full Circle Food to provide learning opportunities for parents while children engage in arts and crafts and the whole family are supported to cook and healthy food.
- Family Help and Family hub staff collaborate with agencies/schools and partners to ensure a holistic approach in combating issues such as bullying, exploitation, self harm and social media.
- Family Hub and Family Help staff work closely with parents and caregivers to ensure they are provided with support and guidance to provide the best start in life and support their child with their emotional development and look out for worry indictors.
- 4 staff trained to be children's well being practitioners who receive clinical supervision from Primary Mental Health Service managers.
- Staff trained across the 0 – 19 Health service and Family Help / hubs to co- deliver Relax kids and Charge up emotional well being group support for young people
- Primary Mental Health Workers (PMHWs) based in the family hubs so Children and young people who need more targeted wellbeing support can receive this in a warm and friendly family hub in their own community.

NORTHUMBERLAND ADOLESCENT'S SERVICE (NAS) - YOUNG PEOPLE'S FEEDBACK

Since the Young People's Feedback Form went live in January 2021 there have been a total of 420 responses from Young People, Parents/Carers and Professionals. There were a total of 236 responses received during the May 2022 – April 2023 period. This equates to a 123% increase in responses on the previous year.

The feedback form asks young people to rate the overall service they have received out of five, with one being "Poor" and five being "Brilliant". Over the 12-month period the average score was 4.57 out of 5. This highlights that most young people are happy with the service they are receiving.

The feedback highlighted a number of Key points:



The Feedback form also provide young and families an opportunity to comment on what has worked well for them. Below are a number of quotes and comments made during the past few months:

- *"16 plus and the support workers.. have supported me with understanding independence and also supported me with any worries i have had and been there to answer any questions i have asked the best they could. They've helped me gain confidence in my independent life skills."*

- *"(Workers name) helped me realise the important things in life. She never once told me to stop, she advised me otherwise and lead me in the right direction. (workers name) showed me she cared and one of the main reasons I engaged was because she showed me she cares and she does the job she does because she wants to help. I couldn't be more grateful for everything she has done and helped me with. She has*

watched and help me grow from an immature 14 year old girl who thought drugs and alcohol were fun, to a young mother. She forever tells me how proud she is, I think so much of her and will forever be grateful for everything because I wouldn't be where I am without her."

- *"Helped me in understanding the opportunity's I have and about moving into somewhere on my own."*
- *"They have helped me become more confident in speaking out about issues that are important to me."*
- *"It was amazing and helped a lot they provide lots of opportunities to do stuff I would never have been able to do without the option. VMC is a great way to connect with friends and it's also a great way to help other young people to get through their struggles."*
- *"The accommodation team were very adept at responding to my problems and working with me to find appropriate solutions."*

CHILDREN'S VOICES PILOT – RESEARCH PROJECT (DFE FUNDED)

- ❑ We are currently working with North Tyneside to contribute to research around highlighting the child's voice within records and the use of gathering feedback wherever possible and appropriate to do so.
- ❑ The staff have embraced this and have utilised the equipment to more effectively record interventions in 'real time'.
- ❑ This has given opportunities to utilise a different way of working and has contributed to a further strengthening of understanding from children and young people about intervention in all cohorts.
- ❑ The next steps are currently being explored as the pilot ends at the end of September.

FEEDBACK FROM PARTNERS..

We asked partners..

What has *worked well* over the year?

- ❑ Involvement in the review of partnership arrangements
- ❑ Collaboration to identify priorities going forward
- ❑ Improved status of education in refreshed arrangements
- ❑ Appointment of business managers and re-instatement of business groups.
- ❑ The development of the new NCASP structure and the setting of the new priorities under this new structure offers a more proactive and streamlined approach, an example being areas of concern which have been identified in subgroups led to the development of task and finish group to further explore these areas. Thus, offering the opportunity to identify, assess and evaluate impact.
- ❑ The identification of early help measures through collaborative working within our MASH facilities. This area of business is held up as a model across the country for best practice this needs to be built on moving forward.
- ❑ Sharing of ideas and things that have worked well, whilst not being afraid to challenge each other to ensure that progress is made.

Practice Days and quality assurance activity has identified good multi agency working and contribution to outcomes (for children, adults and families) as well as opportunities for constructive challenge when required, which has strengthened working relationships across the partnership.

Development of the family hubs:

- ✓ Strengthened relationships with health teams – 0 19 Service, midwifery, Primary Mental health
- ✓ Birth registrations now routinely carried out in the family hubs which supports with the hubs being accessible for all

- ✓ Early Help education team is strengthening links with schools. Since the introduction of this team there has been a significant increase in the number of EHA's completed by schools as the lead professional.
- ✓ Family hubs being 0 – 19 (25 SEND) so families can receive multi agency support and sign posting throughout their child's life from conception until adulthood when needed. Families therefore able to receive the right support at the right time.

What could be *developed* in 2024?

- ❑ Multi Agency Information sharing. This area is the focus of numerous reviews both children and adults.
- ❑ Ongoing development of the family hubs especially young people's offer and SEND offer
- ❑ A system / process in place to prevent families bouncing between Early Help and Social work teams but which ensures children have the appropriate support and safeguards in place so they are not at risk of harm.
- ❑ More frequent face to face meetings. It's often a better format to share thoughts and ideas and gain involvement from all attendees.

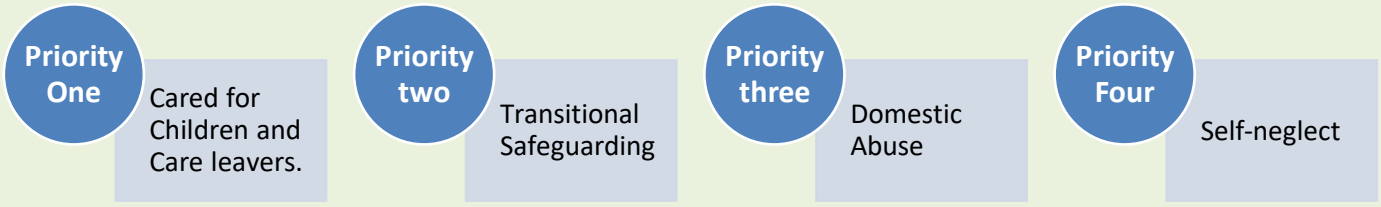
LOOKING FORWARD

OUR STRATEGIC PLAN 2023-2026

The Strategic Plan sets out our shared vision and actions that will help keep children, young people and adults at risk safe and protected from abuse and neglect. This should be read alongside our Safeguarding Plan, which sets out our Multi-Agency Safeguarding Arrangements (including how we work together to safeguard children and adults).

The Strategic Plan sets out our strategic priority areas of focus for 2023-2026 and will be reviewed annually.

NENC ICB: Within the Strategic Framework four key priorities have been agreed by Designated Professional Leads for 2023/24: these have been shared in the Joint Forward Plan to support the delivery of the Integrated Care Strategy; these will be further developed in the strategies and workplans that will underpin this Strategic Framework.



A senior Safeguarding Professional will be identified to lead the workstreams for each of the 4 priority areas developing strategies and work plans as required and where coproduction will be a central tenant.

The work will be coordinated in the Senior Safeguarding Leadership Group which will report quarterly into the Health Safeguarding Executive. To support the enablers task and finish groups from the Safeguarding Forum will be established and report into the Senior Safeguarding Leadership Group.

INDEPENDENT SCRUTINEER'S CONCLUSIONS

The first report of the new Independent Scrutineer covers the period June 2023 - September 2023 and provides an appraisal of the effectiveness of partnership joint arrangements.

The report follows the Checklist for Independent Scrutiny and the Bedford University six steps for independent scrutiny framework for safeguarding partnership arrangements and provides comments on how we are doing against the following standards:

1	•Safeguarding partners are involved in strategic planning and implementation
2	•The wider safeguarding partners, including relevant agencies, are actively involved in safeguarding children and adults
3	•Children, young people and adults are aware of and involved with plans for safeguarding them for abuse, neglect and exploitation
4	•Quality assurance processes are in place for data collection, audit and information sharing
5	•There is a process for identifying and investigating learning from local and national safeguarding case reviews
6	•There is an active program of multi-agency safeguarding training

Some observations..

- Governance and structural arrangements of the partnership are embedding, and the work of the subgroups are strengthening their individual infrastructures and functions based on the terms of references
- The Business Support Unit functions well. The two Business Managers are enthusiastic and work closely together; the business support officer is very competent in co-ordinating the business.
- Quality assurance processes are developing and strengthening – QA Framework is being developed.
- The PLG is exploring the development of a multi-agency learning hub to ensure learning from case reviews, multi-agency audits and performance data is effectively disseminated.
- There are robust processes in place for identifying when a serious safeguarding incident requires a rapid response and consideration of whether a local Child Safeguarding Practice Review (CSPR) or a Safeguarding Adult Review (SAR) are required.
- There is an active multi-agency training programme for both children and adults. Evaluations of the impact of the training on practice is gaining momentum with some excellent examples presented to PLG.

In summary, the Independent Scrutineer highlights that the new joint NCASP arrangements have developed at a pace since April 2023. There is strong partner engagement and a culture of positive relationships and partnership working, with a strong appetite for the success of joint children and adult arrangements.

FULL REPORT: Independent Scrutineer Report - June 2023 to September 2023

HOW TO CONTACT NCASP

If you have any queries about this report (or about NCASP) you can email: ncasp@northumberland.gov.uk

APPENDIX 1

MEMBERSHIP

Although the partnership has three Statutory Safeguarding Partners (the Local Authority, Integrated Care Board and the Police) our membership is also made up of additional co-opted and designated members from a range of partner agencies.

Membership for 2022-23 included:

Independent Safeguarding Scrutiny and Assurance Chair / Independent Scrutineer

Northumberland County Council (Children & Adults)

- Children's Services (including Children's Social Care)
- Adult Services (including Adult Social Care)
- Housing
- Public Protection
- Public Health

North East North Cumbria Integrated care Board (Children & Adults)

Harrogate and District Foundation Trust (0-19 Service)

Northumbria Healthcare NHS Foundation Trust (Children & Adults)

Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (Children & Adults)

Northumbria Police (Children & Adults)

Northumberland Fire & Rescue Service (Children & Adults)

Probation Service (Children & Adults)

CAFCASS (Children)

APPENDIX 2

USEFUL LINKS AND RESOURCES

- Multi Agency Safeguarding Arrangements (MASA)
- NCASP Groups - Terms of Reference
- Strategic Plan 2023-2026

Children	Adults
Working together to safeguard children Chapter 3: Multi-agency safeguarding arrangements Chapter 4: Improving child protection and safeguarding practice Chapter 5: Child death reviews	**The Care Act 2014** Section 43: The Care Act 2014 (SABs)
Multi-agency procedures and practice guidance	
North and South of Tyne Safeguarding Children Partnership Procedures Manual Core Procedures Safeguarding Practice Guidance Thresholds of need - DOCUMENT & Information about thresholds Local Child Safeguarding Practice Review (LCSPR) - FRAMEWORK AND PRACTICE GUIDANCE & FLOWCHART Local Authority Designated Officer (LADO) - Information Sheet and Flowchart & Referral Form Resource library (Northumberland)	Northumberland Safeguarding Adults Board Procedures Core Procedures Practice Guidance Safeguarding Adult Reviews Mental Capacity Act 2005 Resource and Practice Toolkit Contacts and Practice Resources

APPENDIX 3

GLOSSARY

ACEs	Adverse Childhood Experiences
ADASS	Association of Directors of Adult Social Services
ADCS	Association of Directors of Childrens Services
ASC	Adult Social Care
C.A.R.E	Caring about Adversity, Resilience and Empowerment
CAFCASS	Child and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Services
CME	Children Missing Education
CNTW	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
CP	Child Protection
CPVA	Child to parent violence and abuse
CSC	Children's Social Care
CYPS	Children & Young People's Service
CYPSP	Children & Young People Strategic Partnership
DALAPB	Domestic Abuse Local Authority Partnership Board
DHR	Domestic Homicide Review
HDFT	Harrogate and District NHS Foundation Trust
HSB	Harmful Sexual Behaviour
ICB	Integrated care Board
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advisors
IRO	Independent Reviewing Officer
IS	Independent Scrutineer
LADO	local authority designated officer
LCSPR	Local Children Safeguarding Practice Review
MASA	Multi-agency Safeguarding Arrangements
MASH	Multi Agency Safeguarding Hub
NAS	Northumberland Adolescent Service
NCASP	Northumberland Children And Adults Safeguarding Partnership
NEWST	Northumberland Emotional Wellbeing Support Team
NHCFT	Northumbria Healthcare NHS Foundation Trust
NRM	National Referral Mechanism
RCPC	Review Child Protection Conference
RHI	Return Home Interview
SAPP	Safeguarding and Public Protection Team
SAR	Safeguarding Adult Review
SEND	Special Educational Needs and Disabilities
SNP	Safer Northumberland Partnership
TWNSP	Tyne, Wear & Northumberland Safeguarding Partnership

UCT	Universal Crisis Team
YJB	Youth Justice Board
YJS	Youth Justice Service