Introduction to NCASP



December 2023

What is NCASP?

There is a shared and collective responsibility between organisations and agencies to safeguard and promote the welfare of children.

Responsibility for this joined up approach locally rests with three Safeguarding Partners who have a shared and equal statutory duty to have in place robust arrangements to work together..

NCASP is our key statutory mechanism for overseeing safeguarding arrangements and driving change in Northumberland.

It brings <u>Statutory Safeguarding Partners</u> and <u>Relevant Agencies</u> together at both a strategic and operational level to deliver a focused, co-ordinated response, to innovate system change, deliver efficiencies and support effective multi-agency practice.

The Statutory Safeguarding Partners are:

Local Authority – Executive Director of Children, Young People and Education (Audrey Kingham)

Integrated Care Board -Director of Nursing (Richard Scott)

Police - Detective Chief Superintendent Safeguarding (Lyn Peart)



See: WT2023 <u>Chapter 2 - Multi-Agency Safeguarding Arrangements</u> <u>Section 43: The Care Act 2014</u> Promoting the commissioning of services in a coordinated way and the co-operation and integration between universal services and specialist support services.

Co-ordinating their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning, including from serious safeguarding incidents.

Leading on system change to develop and implement new and innovative ways of working.

Developing learning and improvement activity to continually improve systems and multi-agency practice.

Providing robust scrutiny, challenge, and assurance in relation to the effectiveness of safeguarding arrangements

Driving a strong partnership with schools, colleges, early years, childcare and local agencies.

Publishing local safeguarding arrangements and report on the effectiveness of these at least once in every 12month period, seeking assurance from agencies that they are fulfilling their safeguarding responsibilities.



Safeguarding Partners are responsible for..

Our journey so far..



Review of NCASP Partnership arrangements:

- The Northumberland Children and Adults Safeguarding Partnerships integrated in April 2022.
- The new arrangements acknowledge that children and adult arrangements are underpinned by different legislation and statutory guidance, however, also recognise the similarities and shared benefits of a joint safeguarding approach across the life course.
- 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 – from April 2023:

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

Strategic Plan..

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.

The Partnership arrangements..

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

The production of a Strategic Plan is a statutory requirement..

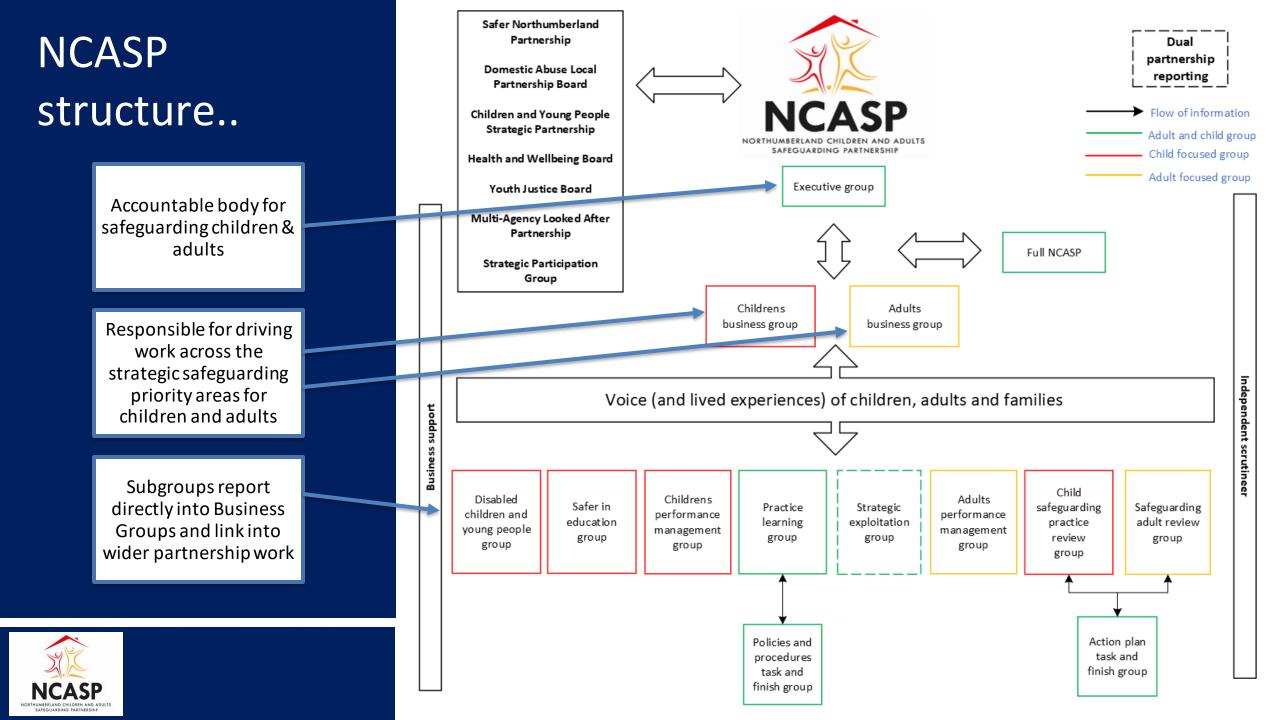
• The new streamlined plan should set out the Partnerships shared vision and actions that will help keep children, young people, and adults at risk safe from abuse and neglect.

Strategic Plan will support and enable local agencies to work together in a system where:

- Excellent and innovative practice is the norm
- Partners work collaboratively (across the whole system) to achieve the same end goals
- Partner agencies hold one another to account effectively
- There is early identification of 'new' safeguarding issues
- Learning is promoted and embedded
- Information is shared effectively
- The public can feel confident that children and adults are protected from harm



Our Strategic Plan sets out our strategic priorities and areas of focus for 2023-2026 and will be reviewed annually



LEADERSHIP

- Providing strategic leadership for all who work together to safeguard children and adults.
- Setting the strategic direction, vision and culture of the safeguarding arrangements, including shared priorities and resources required.
- Ensuring strong governance and systems of assurance and accountability (including single agency inspections).
- Ensuring multi-agency arrangements have the necessary level of business support (including intelligence and analytical functions).
- Planning for and responding to national changes and developments.

LEARNING

- Identifying and embedding learning from case reviews, quality assurance work inc audits and performance data.
- Identifying emerging thematic safeguarding issues based on local data, case reviews and national learning (using task & finish as and when required to progress specific areas of work).
- Learning from the experiences of children, adults and families to influence improvement in practice and systems.

SCRUTINY

- The Independent Scrutineer acts as a critical friend and provides support and challenge to the Partnership.
- The effectiveness of the Partnership multi-agency safeguarding arrangements are continuously reviewed and improved.
- Engagement with children, adults, families and practitioners is effective and informs improvement of the Partnership multi-agency safeguarding arrangements.

IMPACT

- The Partnership can demonstrate it is being effective.
- Case reviews, audits and performance deep dives improve practice, systems and outcomes for children and adults.
- Training improves the quality of practice.
- Children, adults and families tell the Partnership their experiences are positive and have changed their lives.

These will inform our annual delivery plan actions (and thematic priorities) year on year. informed by safeguarding partners, business groups, sub groups and task and finish groups/workstreams



OUR STRATEGIC DRIVERS

Risks/harm outside of the home / extra-familial harm

links with CYPSP, SNP, DALPB, YJB

Initial areas for consideration:

ROTH/EFH describes the harm which occurs:

- Outside of the family home
- In places within the community
- From someone who is not a family member

Examples may include:

- Criminal exploitation, including county lines drug distribution and 'cuckooing' properties
- Trafficking and modern day slavery
- Child sexual exploitation, or other extra familial sexual abuse
- Serious youth violence / Knife crime (links with SNP)
- Anti social behaviour by and affecting peers (links with youth justice board)
- Gang affiliation
- Radicalisation and violent extremism
- Peer on peer abuse (outside of the family) including harmful sexual behaviours and domestic abuse among adolescent couples

1. Establish a partnership working definition for ROTH/EFH. This will support a greater understanding of its breadth and to support consistency in the use of terminology.

2. Consider the development of a partnership ROTH/EFH pathway, that will reflect each tier of need and address the response to identified risks to children and young people, as well as the contexts in which the risk exists.

3. Consider the best options to develop how concerns about the contexts in which the risk exists are managed. This may involve a review of the victim, offender location (VOL) forum, widening the remit of MSET, considering links within other partnerships or the development of new structures to support community safety planning.

4. Consider the best options to oversee and drive the required developments. This may include specific project capacity, a task and finish group (with oversight through Strategic Exploitation Group).



THEMATIC PRIORITIES 2023/2024

Complex Mental Health

links with CYPSP, HWB

Areas of focus:

Continuing to develop, promote and evaluate Trauma Informed Practice

Developing our partnership response across all tiers of intervention (including safeguarding those with complex needs but no mental health diagnosis) – right support at the right time

Considering impact of parental mental health

We will also consider impact of wider societal factors – in collaboration with other partnerships and workstreams. What is currently being looked at across the whole system? How can we support/strengthen that work..



THEMATIC PRIORITIES 2023/2024

Neglect (including self-neglect)

links with CYPSP, HWB

Areas of focus:

-[Adults	
	 Raising awareness of self-neglect and its impact Hoarding Substance misuse Informed decision making + behaviours Consider pathway for those that don't meet threshold (and/or non-engagement?) 	
-	Children	
	 The impact of and the response to complex chronic neglect Impact of parental substance misuse 	

We will also consider impact of wider societal factors, including cost of living – in collaboration with other partnerships and workstreams.



THEMATIC PRIORITIES 2023/2024

Our work will also include focus on:

Mental Capacity Act (16+)

- Embedding across systems
- understanding and application
- transition from children to adult services
- (Continue with task & finish group)

Domestic Abuse

- Adults older people (joint working group with DALPB) Training, raising awareness, communication, support services.
- Children health relationships, recognising harmful behaviour, awareness raising (information and support) training re DA in teenage relationships, its impact, how to recognise and referral routes (including use of YPRIC).
- Ensure links with DALAPB to strengthen and support partnership work (and avoid duplication)Whole system approach

Safeguarding Under 1's

- Explore the increase in numbers (under 1's with injuries) and consider any wider determining factors.
- Consider possible preventative actions to reduce the incidence.

Family (and community) Networks

- Considering how we can maximise the use of family networks and how we engage the family network at every stage.
- Recognising a family network can be a blood-relative, or a non-related connected person (such as a family friend or neighbour).



OUR ASSURANCE WORK..

Self evaluations

• To understand how well partners understand their respective roles and responsibilities towards safeguarding children, young people, families and adults

Multi agency audits

• To assess the compliance of case files and quality of safeguarding outcomes for children, young people, families and adults

Conversations & surveys

• To gain knowledge to assess thoughts, opinions and insight to safeguarding practice from professionals working directly with children, young people, families and adults

Service user engagement

• To work with children, young people, families and adults to understand their experience of safeguarding practice

Data & analysis

• To identify patterns and trends and measure safeguarding performance.



OUR LEARNING JOURNEY..

We will use information gathered through our assurance activities and reviews to:

Celebrate and share good safeguarding practices Inform changes in Policy, Procedures and Practice Guidance Drive continuous improvement in safeguarding practice Promote learning from reviews work Create multi-agency training opportunities



Statutory Multi-agency Reviews Procedures **Responsibilities** Managing Thresholds As set out in statutory guidance: Allegations Working Together to Safeguard Children Training

Includes..



Statutory Case Reviews

Domestic Homicide Reviews (DHRs)

• A multi-agency review of the circumstances in which the **death of a person aged 16 or over** has, or appears to have, resulted from **violence**, **abuse or neglect** by a person to whom they were **related** or with whom they were, or had been, in an **intimate personal relationship**, or a member of the **same household** as themselves.

The purpose of a Domestic Homicide Review (DHR) is to:

- establish the lessons that can be learned from the homicide, apply these lessons to inform local and national policies and procedures, as appropriate, and to highlight evidence of best practice.
- The cases are referred to the Safer Northumberland Partnership and although the progress of the review is managed through the SNP, learning dissemination is also shared with our Domestic Abuse Local Partnership Board (and NCASP, where relevant).

A Safeguarding Adult Review (SAR) must be undertaken when:

- An adult or adults with care and support needs die as a result of abuse or neglect and there is a concern that partnership agencies could have worked more effectively to protect the adult(s); OR
- An adult or adults with care and support needs has not died, but the NCASP knows
 or suspects that the adult has experienced serious abuse or neglect with a concern
 that partnership agencies could have worked more effectively to protect the adult.
- SARs are not enquiries into how an adult died and who is responsible. That is a matter for the Coroner or criminal courts.

The purpose of a SAR is to:

- Learn from cases where agencies could have worked together more effectively;
- Consider whether serious harm could or could not have been predicted or prevented, and develop learning that enables the partnership to improve its services, and prevent abuse and neglect in the future;
- Identify any issues in multi or single agency policies and procedures;
- · Agree on how the learning will be acted on, and what is expected to change; and
- Publish a summary report, which is available to the public.
- SARs help to improve services, multi-agency working, share best practice and lessons learnt, and to better safeguard adults from risk of abuse and neglect

Notification	Rapid Review	CSPR
 LA knows or suspects that a child has been abused or neglected AND The child dies or is seriously harmed 	 Gather facts Identify immediate learning or action Determine whether a CSPR is appropriate 	 Potential to identify improvements to practice Consider potential for national learning



See: <u>LCSPR Framework</u> & <u>Improving child protection and safeguarding practice (WT)</u>

Child Safeguarding Practice Reviews (CSPRs)

Learning from reviews..

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.

Summary of themes (all reviews)

Adults

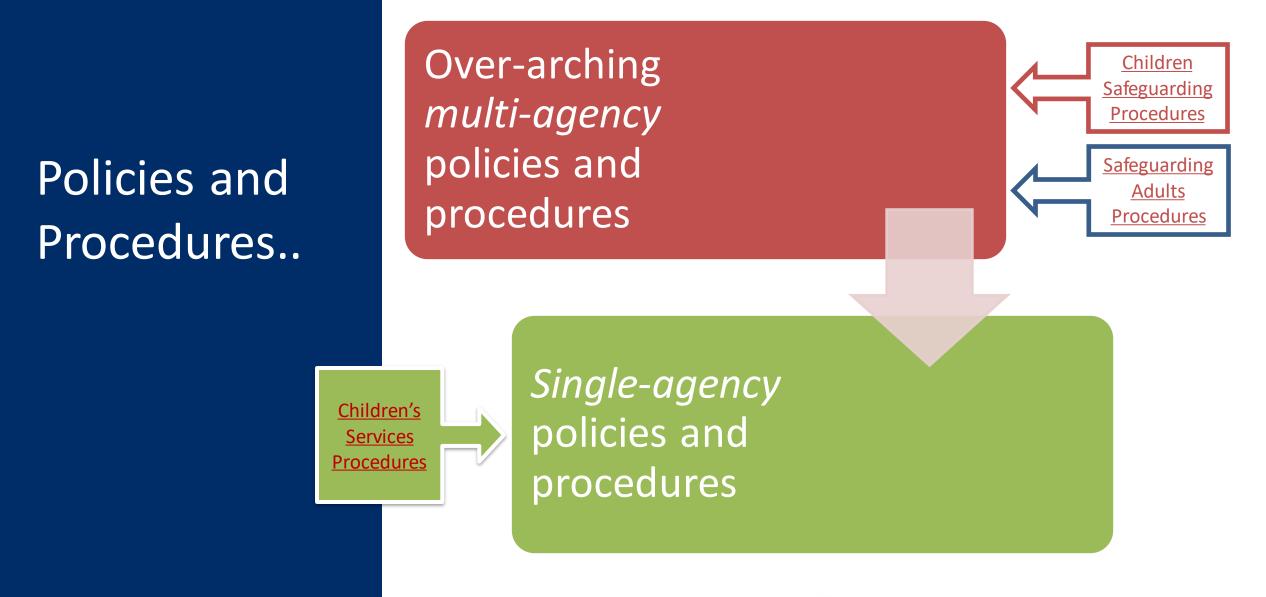
- Mental Capacity area of focus (T&F)
- Policies and Procedures now have online manuals managed by BMs and overseen by PLG
- Lived Experience mapping current participation groups (children and adults) and how agencies seek and use feedback
- **Professional Curiosity** 7-minute guide developed. learning incorporated into training and resource pack being developed
- Identification of Needs and Vulnerabilities review and promote training
- Impact of Trauma CARE (Caring about Adversity, Resilience and Empowerment) Northumberland provides a multi agency approach to trauma-informed resilience (children and adults)

Children

- Engagement with fathers audit completed and learning included in training.
- Professional curiosity 7-minute guide
- Parental mental health this is being considered under Complex Mental Health priority
- Healthy relationships young people, explore dynamics & risk area of focus (domestic abuse and ROTH). T&F being set up
- Capacity to understand preventative messages (parental learning needs/difficulties) resources reviewed and new pathway developed.
- Voice and lived experience of children practice guide developed following rapid review. Further developments coming out of current LCSPR (some already implemented).



The <u>annual report</u> includes a summary of findings from reviews, how learning has been implemented and how it has informed service development.

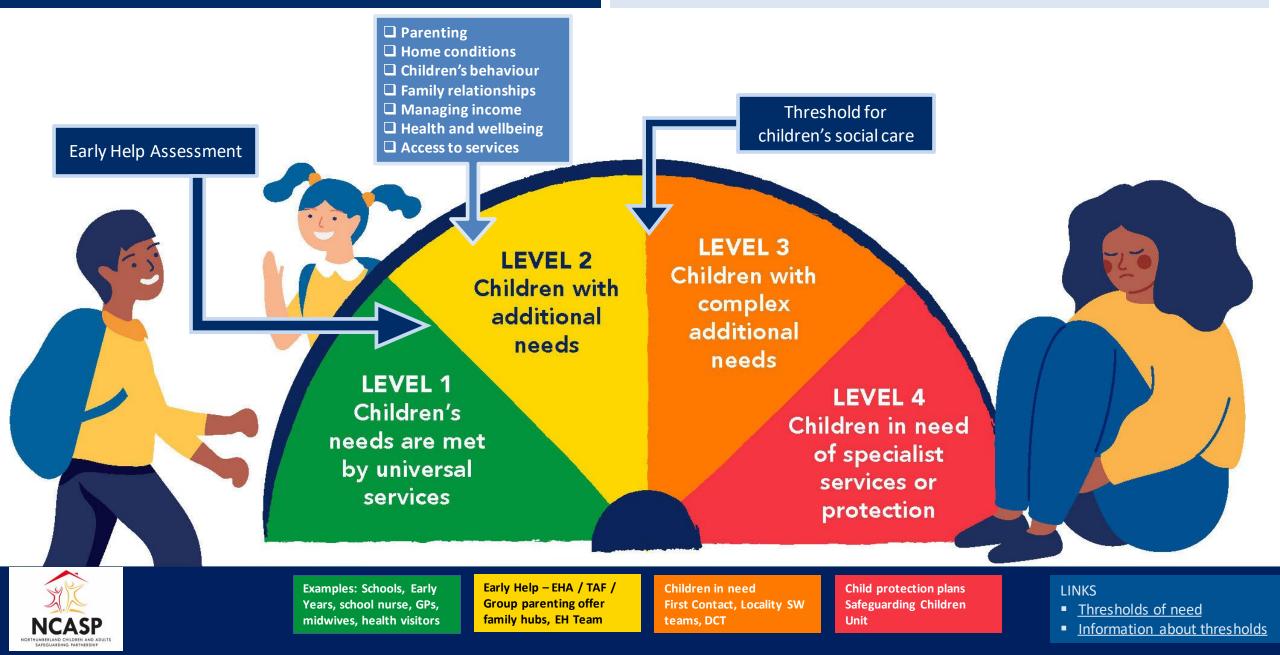




See: How to navigate the online procedures manuals

Thresholds of needs..

NOT a single service, but an offer, an environment, a continuum



Allegations against staff and volunteers

See: <u>LADO - Information Sheet</u> <u>and Flowchart</u> <u>LADO Referral Form</u>

Statutory guidance requires every Council to manage allegations and concerns about any person who works with children, including staff and volunteers.

The LADO is the lead officer for this duty managing all child protection allegations, coordinating a multi-agency response and providing advice and guidance

The role of the LADO is set out in <u>WT2018</u> - The NCASP has <u>procedures</u> for managing allegations against people who work with children

The LADO should be alerted to all cases in which it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed, a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they may pose a risk to children/be unsuitable to work with children.

Allegations procedures may also be used where concerns arise about:

- A person's behaviour in their personal life which may impact upon the safety of children to whom they owe a duty of care;
- A person's behaviour with regard to his/her own children;
- The behaviour in the private or community life of a partner, member of the family or other household member.

Allegations against staff working with adults

Should be reported to the Safeguarding Adults team (who undertake a similar role to LADO for those working with adults)

Multi Agency Training..

NCASP provide number of E-Learning and training courses via Learning Together

- see: <u>Learning Together Safeguarding Adults and</u> <u>Children</u>
- The training reflects lessons from case reviews and the outcomes of national enquiries.
- All training is multi-agency.

How do I access the training?

- Application is via <u>ncc.learningpool.com</u>.
- or email: learningandod@northumberland.gov.uk



NCASP

 NCASP Annual Report - Sept 2022 to Sept 2023 Multi Agency Safeguarding Arrangements (MASA) NCASP Groups - Terms of Reference Strategic Plan 2023-2026 	 Statutory Guidance: Working Together to Safeguard Children 2023 – REVISED Summary of changes - Dec 2023
Children	Adults
Children's Social Care Procedures (single agency) & resource library (forms etc)	Northumberland Safeguarding Adults Board Procedures
Children Safeguarding Procedures (multi-agency) & resource library (including briefings)	Safeguarding Adult Reviews
Thresholds of need - <u>DOCUMENT</u> & <u>Information about</u> <u>thresholds (SWAY)</u>	Mental Capacity Act 2005 Resource and Practice Toolkit
Local Child Safeguarding Practice Review (LCSPR) - <u>FRAMEWORK AND PRACTICE GUIDANCE</u> & <u>FLOWCHART</u>	Contacts and Practice Resources



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