# Introduction to NCASP

NCASP
NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP

October 2024

# 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 Statutory Safeguarding Partners and Relevant Agencies 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.

## Lead Safeguarding Partners:

- **Local Authority** – Chief Executive (Helen Paterson)
- **Integrated Care Board** – Chief Executive (Samantha Allan)
- **Police** - Chief Officer (Vanessa Jardine)

## Delegated Safeguarding Partners:

- **Local Authority** – Executive Director of Children, Young People and Education (Audrey Kingham)
- **Integrated Care Board** - Director of Nursing (Richard Scott)
- **Police** - Chief Superintendent Area Commander (Sam Rennison)

**See: WT2023: *Chapter 2 - Multi-Agency Safeguarding Arrangements* & *Section 43: The Care Act 2014***

# Joint functions of Safeguarding Partners..

## LSPs

1. Set the strategic direction, vision, and culture of the local safeguarding arrangements, including agreeing and reviewing shared priorities and the resource required to deliver services effectively.

2. Lead their organisation's individual contribution to the shared priorities, ensuring strong governance, accountability and reporting mechanisms to hold their delegates to account for the delivery of agency commitments.

3. Review and sign off key partnership documents: published multi-agency safeguarding arrangements, including plans for independent scrutiny; shared annual budget; yearly report; and local threshold document.

4. Provide shared oversight of learning from independent scrutiny, serious incidents, LCSPRs and national reviews ensuring recommendations are implemented and have a demonstrable impact on practice (as set out in the yearly report).

5. Ensure multi-agency arrangements have the necessary level of business support, including intelligence and analytical functions, such as an agreed data set providing oversight and a robust understanding of practice.

6. Ensure all relevant agencies (including education settings) are clear on their role and contribution to multi-agency safeguarding arrangements.

## DSPs

1. Delivery and monitoring of multi-agency priorities and procedures to protect and safeguard children in the local area, in compliance with published arrangements and thresholds.

2. Close partnership working and engagement with education (at strategic and operational level) and other relevant agencies, allowing better identification of and response to harm.

3. The implementation of effective information-sharing arrangements between agencies, including data sharing that facilitates joint analysis between partner agencies.

4. Delivery of high-quality and timely Rapid Reviews and LCSPRs, with the impact of learning from local and national reviews and independent scrutiny clearly evidenced in yearly reports.

5. The provision of appropriate multi-agency safeguarding professional development and training.

6. Seeking of, and responding to, feedback from children and families about their experiences of services and co-designing services to ensure children from different communities and groups can access the help and protection they need.

# Multi-Agency Safeguarding Arrangements..

## Must include:

- arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area;
- arrangements for commissioning and publishing local child safeguarding practice reviews;
- arrangements for independent scrutiny of the effectiveness of the arrangements;

## They should also include:

- who the three safeguarding partners, their delegates and partnership chair are;
- geographical boundaries, including if the arrangements operate across more than one local authority area;
- the relevant agencies the safeguarding partners will work with, why these organisations and agencies have been chosen, and how they will collaborate and work together to improve outcomes for children and families;
- how all, schools (including independent schools, academies, and free schools), colleges, early years and childcare settings, and other educational providers (including alternative provision) will be included in the safeguarding arrangements;
- how any youth custody and residential homes for children will be included in the safeguarding arrangements;
- how the safeguarding partners will share information and data safely and effectively, using arrangements that clearly set out the processes and the principles for sharing;
- how the safeguarding partners will use data and intelligence to assess the effectiveness of the help being provided to children and families, including early help;
- how multi-agency training will be commissioned, delivered, and monitored for impact, and how they will undertake any multi-agency and inter-agency audits;
- how the arrangements will be funded;
- the process for undertaking local child safeguarding practice reviews, setting out the arrangements for embedding learning across organisations and agencies;
- how the arrangements will include the voice of children and families, including how to escalate concerns and how any disputes will be resolved, including whistleblowing procedures;
- how the local threshold document in place aligns with the arrangements;

# Our journey so far..

## Review of NCASP Partnership arrangements:

- The Northumberland Children and Adults Safeguarding Partnerships integrated in April 2022.
- The 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 were 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 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 practice 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.**

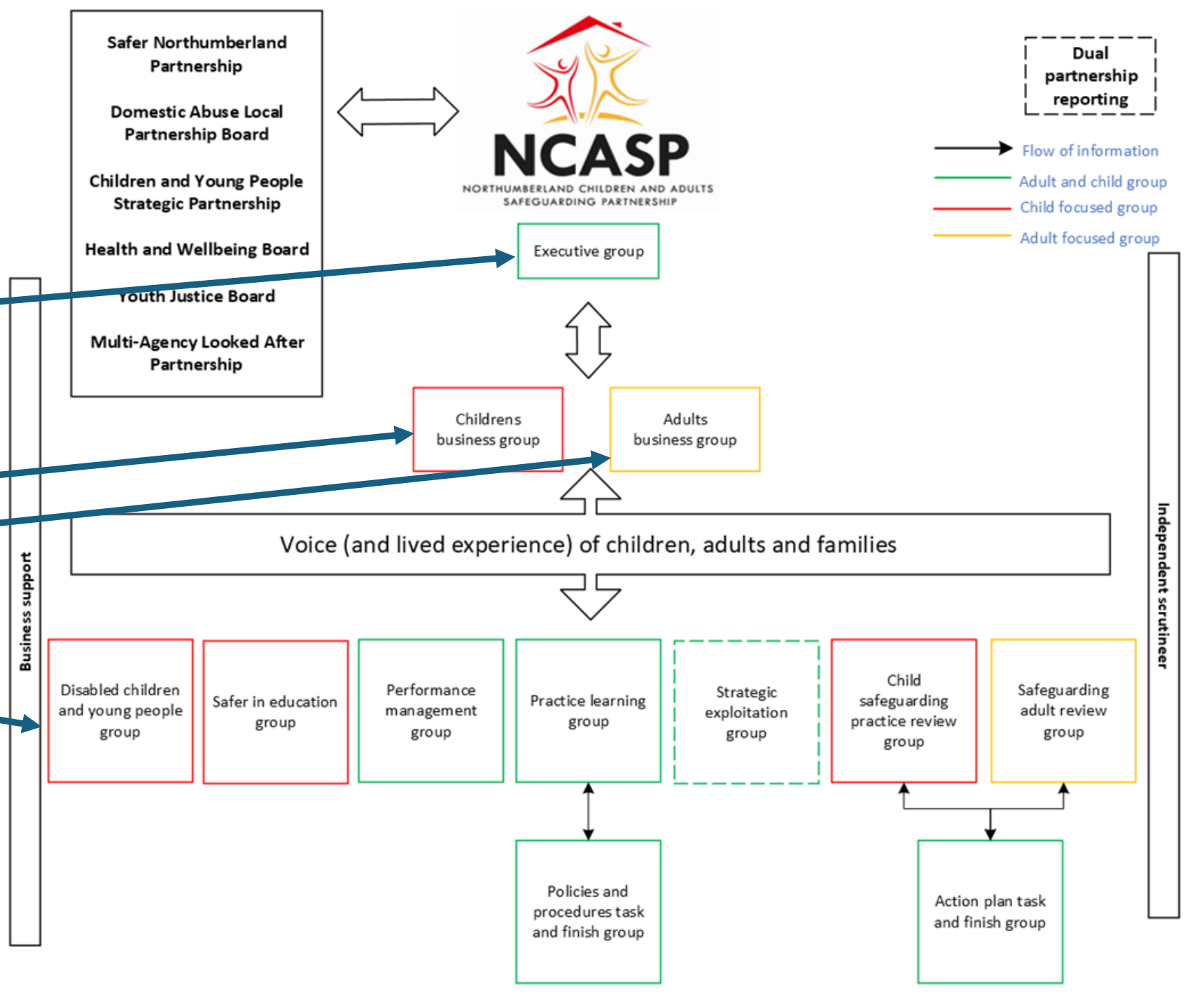
NCASP vision is to work together and provide added value across the safeguarding system, to improve practice and outcomes, and safeguard, protect and promote the welfare of children, young people, adults, and their families in our community.

# NCASP structure..

Accountable body for safeguarding children & adults

Responsible for driving work across the strategic priority areas for children and adults

Subgroups report directly into Business Groups and link into wider partnership work



# Strategic Plan

The Strategic Plan sets out our priority areas of focus for 2023-2026

We agreed to review and update these annually – informed by our 4 strategic drivers..

## 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.**

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

| Area of focus: | What we have done: | What we need to do: |
| --- | --- | --- |
| • Developing contextual safeguarding approach to understand and respond to children and adults risks of significant harm experienced beyond their families.<br>• Ensuring effective multi-agency practice to protect those at risk of extra-familial harm, in all its forms.<br>• The particular vulnerabilities of disabled CYP to extra-familial harm should be recognised and evident in multi-agency strategy, training and practice | • Contextual safeguarding pilot (children) – agreed by executive.<br>• Learning from the pilot will be shared through the SEG.<br>• MSET review – new PREM (all age) includes ROTH.<br>• DCYP audit – findings shared with SEG and used to inform delivery plan.<br>• Multi-agency training re contextual safeguarding rolled out – this has been extended.<br>• Other training has been updated to reflect ROTH (including transitional safeguarding)<br>• DA&YP task and finish established | • Finalise SEG delivery plan – make sure ROTH is properly reflected (for both children and adults).<br>• SEG to oversee CS pilot<br>• Continue to develop our training offer re CS<br>• DCYP to continue to work with SEG re disabled CYP<br>• Promote and support the implementation of PREM<br>• Improve partnership links with Safer Northumberland for joint delivery against this priority area |

# Complex Mental Health

| Area of focus: | What we have done: | What we need to do: |
| --- | --- | --- |
| • Continuing to develop, promote and evaluate Trauma Informed Practice.<br>• 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.<br>• Considering impact of parental mental health.<br>• Safeguarding disabled children and young people with complex mental health needs, including in residential settings. | • Understanding Trauma training has been reviewed and updated to include recent learning from SAR's/CSPR's.<br>• Currently looking to link the shame containment theory into this (Sophia).<br>• Strengths based assessment (adults) and assessment and analysis (children) training includes being trauma informed.<br>• Hoarding Disorder training developed by CNTW and training team<br>• T&F group has been set up to consider learning from the National Panel's review (*Safeguarding Children with Disabilities and Complex Health Needs in Residential Settings*) – this will inform our work re CMH. | • Explore how we can evaluate impact of training and trauma informed practice<br>• Agree who will lead on this priority and who will attend T&F group (and set up meeting asap).<br>• DCYP T&F will report into the CMH T&F group.<br><br>• We will continue to ensure that trauma awareness/strengths-based practice is embedded in other training subjects *(for example, Mental Capacity Assessment in Practice; MCA & Substance Misuse; Alcohol Change; Are you Writing for me; Record Keeping in ASC, SA Sec. 42 Training; Child Protection, Sec 47 etc)* |

# Neglect (including self-neglect)

**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
- Learning from neglect summit and multi-agency audit to inform focus of work
- Impact of and response to chronic neglect of disabled children and young people

## What we have done:

- Neglect T&F group established (children and adults)
- ToR agreed and an action plan in place.
- Partnership neglect audit planned (children) – KLOEs agreed.
- Thematic SAR review agreed
- Developed a 6 month plan with area of focus for each month
- SA Training for Managers (Adult Services) has recently been completed with the focus on self-neglect.

## What we need to do:

- Learning from audit and reviews to inform work..
- Introduce impact measures
- Update resources and training - go back to basics
- Promotion of 'safeguarding is everyone's business' and importance of professional curiosity - focus of Safeguarding Adults week?
- Further develop MA training for practitioners (as part of the Neglect/Self-Neglect T&F group)

# Other areas of focus for 2023/24..

## 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).

# Next Steps..

## NCASP to review priorities..

- What else can we evidence we have done so far?
- Are the areas of focus still what we want to focus on for the next year?
- Are there any emerging or escalating concerns that need to be an additional area of focus?

## Suggested areas of focus for 2024/2025:

- Agree data indicators/measures for each priority – how will we know we are making a difference and/or evidence impact
- Gender Identity
- Role of carers (inc young carers)
- Transitional Safeguarding (this was previous priority, where are we at now? Have we achieved what we set out to do? What has been the impact? What next?

# 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 and practice reviews

- To assess the compliance of practice 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.

# Learning..

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

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

# Statutory Responsibilities

As set out in statutory guidance: Working Together to Safeguard Children

## Includes..

- Reviews
- Multi-agency Procedures
- Thresholds
- Managing Allegations
- Training

# 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*

## Child Safeguarding Practice Reviews (CSPRs)

### Notification

- LA knows or suspects that a child has been abused or neglected
- AND
- The child dies or is seriously harmed

### Rapid Review

- Gather facts
- Identify immediate learning or action
- Determine whether a CSPR is appropriate

### CSPR

- Potential to identify improvements to practice
- Consider potential for national learning

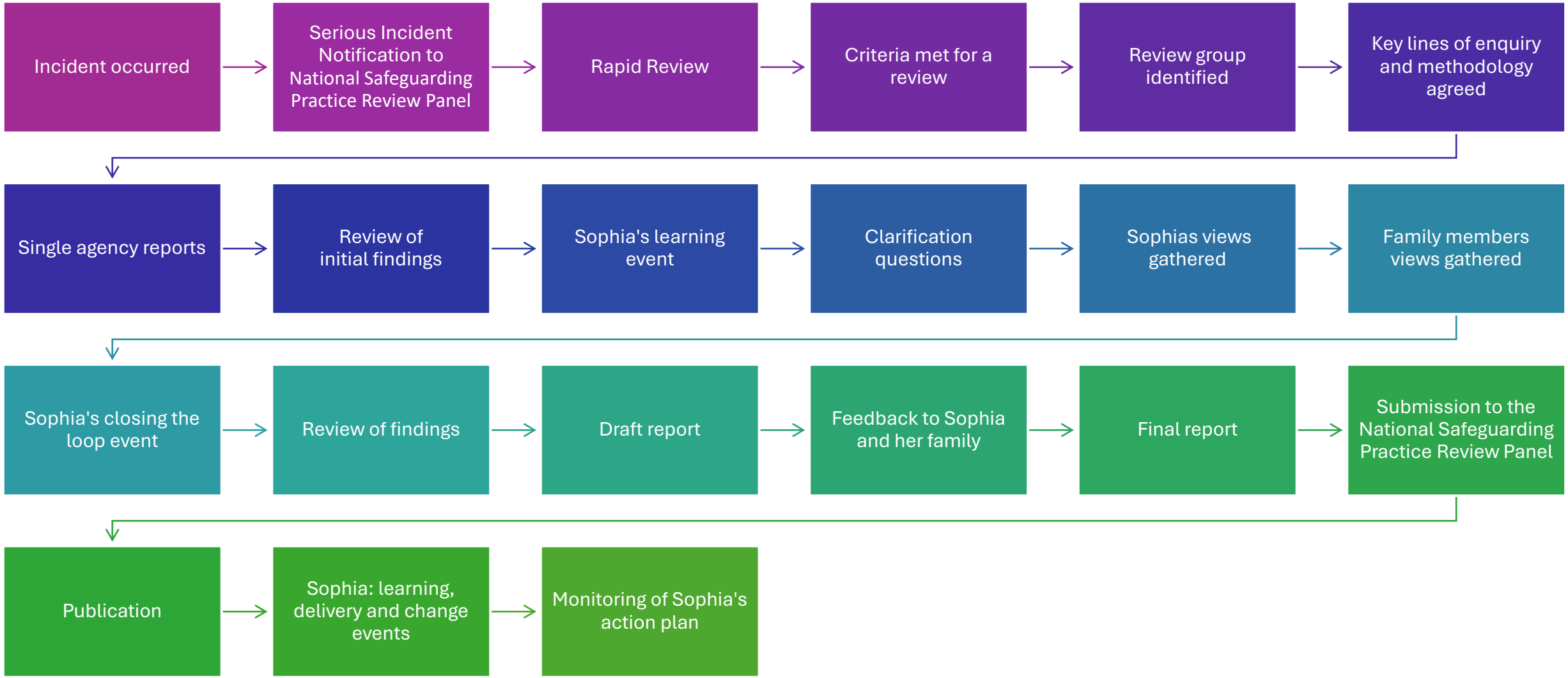
- ❑ *Chapter 5: Learning from serious child safeguarding incidents (WT23)*
- ❑ *Child Safeguarding Practice Review Panel's Guidance*
- ❑ *NCASP's LCSPR Framework & Rapid Review Process*

# Sophia: My safeguarding review

**Links:**

- ❑ Storyboard (summary)
- ❑ Sophia's Safeguarding Review

# Sophia's safeguarding review process..



# Future practice..


## Possibility statements

1. **Understanding a child's day to day life.**
2. **Recording information.**
3. **Information seeking and sharing.**
4. **Having a co-ordinated plan and review.**
5. **Understanding healthy growth and development.**
6. **Access to quality supervision.**

# What practice will look like..

## Understanding a child's day to day experiences

- People who work with children will know how to build trusting relationships with us and how to understand who we have in our life, who helps and loves us.
- They will speak to us alone and somewhere we feel comfortable and safe.
- They will understand that sometimes what we say might be different to what we do and that should help them understand our worries and our feelings.
- If they are not able to see us they will speak to our family and the other people who work with us to see how they can make sure we are ok, and to plan the next steps.
- When someone tells them about us they will make sure they check this information out, making sure that it is not just one person's view.
- **They will not assume that is what we think or feel.**
- People will think about what the best questions are and how to ask us, our families or other people that know us.
- We will then know that our views, thoughts and feelings are important and understood, because these will be being used when decisions are made about our life.

# What practice will look like..

## Recording Information

- People who work with children will make sure that when they write things down they will use words that are respectful and clear.
- It is important that not everything in our lives is a problem, we have strengths and hopes for the future too.
- People will be clear about what difference their work is making to us and their responsibilities towards us.
- They will say whether what they are writing is fact or opinion, who told them and use the words of the person that said it.
- They will keep in mind that this is our lives they are writing about and how it would feel to read what they are writing if it was them.
- By keeping accurate and clear records themes or continuing issues will be identified which will mean our story does not have to be told over and over again.

# What practice will look like..

Links:

- ❑ Information Sharing Protocol *(children and adults)*
- ❑ Info Sharing Flowchart

## Information seeking and sharing

- People who work with children will think about what has happened to us in the past but they will also know how important it is to consider what our lives are like now and what that means to us.
- They will ask questions not only of our families but of other workers too.
- They will not make complicated decisions without listening to what others say.
- They will feel confident to share information about us and our families which is relevant.
- This will mean that everybody has the right information so they can be part of discussions about how best to help us.
- People who work with children will feel able to have difficult conversations about their concerns and say who else they may need to speak to or what they are going to do about it.
- It is important they are honest with us and our family, especially if people think we, or someone else, may not be safe.
- If someone thinks we might not be safe and they decide not to speak to other people about this, they will write down why and what they did do to make sure that other people can understand what risks and safety they could see.
- This will mean that the people who need to be involved with our families are the right people and that we have the right help.
- It also means that the decisions being made will be supported by clear information from all the people who work with us.

# What practice will look like..

## Co-ordinated plan and review

- When there is more than one person working with our families and there are lots of things happening that make people worried, the important people in a family like the child and their parents or carers and the relevant workers will come together to talk about what is happening.
- People will understand that for us and our families to work with a plan it should be our plan not theirs and that we should be fully involved in making the plan and agreeing the actions, unless it would make us unsafe to do so.
- There will be a **lead professional** that helps everyone to explore and understand what everyone is worried about but also the things that are going well.
- Everyone will help to create a multi-agency plan that includes all the tasks that need to be done and why, who will do them and how, by what date and what it will look like to know the plan is working.
- This will mean everybody will understand what is expected from them and what they can expect from others.
- There will be an agreement about how often the multi-agency plan needs to be reviewed.
- At the review meetings everyone will talk about the progress that is being made using behavioural examples.
- If the plan needs to change, everybody will share their best ideas about what needs to be different to make it work to keep us safe and well, and how.
- If nothing changes, then everyone will know what the next steps will be to make sure we are happy and safe.

# What practice will look like..

## Healthy child growth and development

- People working with children will have the knowledge they need about healthy child growth and development, and they will understand how our day to day lives might influence our behaviours.
- They will feel confident to recognise our physical health needs, know when things are going well or when to worry and what to do about it.
- They will understand that this may change so it will need to be considered often.
- If they feel that they do not have enough knowledge they will know who to speak to and how to involve others who may be specialists.

## Quality supervision

- People who work with children will be able to talk about us and our families with someone who is knowledgeable and experienced and who will help them reflect and think about our day to day lives, how our plan is working, and what needs to happen if it is not.
- When there are lots of people involved with us and our families it can be complicated so having a network of support from other workers helps people remain clear about what they are doing.
- People should have the opportunity to reflect on these things as a group to help them keep us safe.
- These conversations might be difficult for people as they will be encouraged to think differently about our situations and their responsibilities, but it will make sure that we remain at the centre of their thinking and planning.

# 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 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 SOPHIA LCSPR (some already implemented).

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

# Policies and Procedures..

Over-arching *multi-agency* policies and procedures

Children Safeguarding Procedures

Safeguarding Adults Procedures

Children's Services Procedures

*Single-agency* policies and procedures

**See:** ***How to navigate the online procedures manuals***

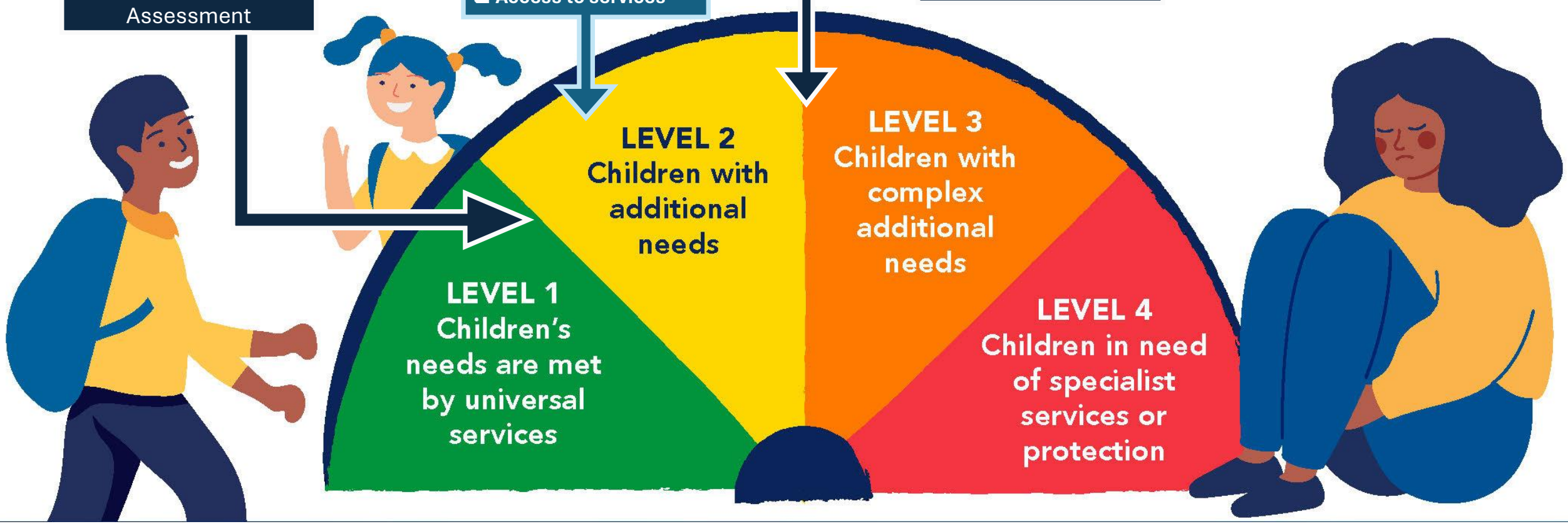
# Thresholds of needs..

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

- ❑ Parenting
- ❑ Home conditions
- ❑ Children's behaviour
- ❑ Family relationships
- ❑ Managing income
- ❑ Health and wellbeing
- ❑ Access to services

Early Help Assessment

Threshold for children's social care




| Examples: Schools, Early Years, school nurse, GPs, midwives, health visitors | Early Help – EHA / TAF / Group parenting offer family hubs, EH Team | Children in need First Contact, Locality SW teams, DCT | Child protection plans Safeguarding Children Unit |
|---|---|---|---|

LINKS

- Thresholds of need
- Information about thresholds

# Allegations against staff and volunteers

See:
- LADO - Information Sheet and Flowchart
- LADO Referral Form

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 *WT2023* - The NCASP has *procedures* 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: *Learning Together – Safeguarding Adults and Children*
- 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 ncc.learningpool.com.
- 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

- Children's Social Care Procedures (single agency) & resource library (forms etc)
- Children Safeguarding Procedures (multi-agency) & resource library (including briefings)
- Thresholds of need - DOCUMENT & Information about thresholds (SWAY)
- Local Child Safeguarding Practice Review (LCSPR) - FRAMEWORK AND PRACTICE GUIDANCE & FLOWCHART

## Adults

- Northumberland Safeguarding Adults Board Procedures
- Safeguarding Adult Reviews
- Mental Capacity Act 2005 Resource and Practice Toolkit
- Contacts and Practice Resources

# Contacts..

NCASP
NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP

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