Minutes

Meeting Name:	Suffolk Safeguarding Partnership Board (Children's)
Meeting Date & Time:	Wednesday 20 September 2023 13.00h-15.00h
Meeting Venue:	MS Teams Meeting

Attendees

Role	Organisation
Independent Chair	Suffolk Safeguarding Partnership
Designated Doctor	ICB
Head of Safeguarding	Suffolk County Council
Designated Nurse	Suffolk & Northeast Essex ICB
Professional Advisor	Suffolk Safeguarding Partnership
Detective Superintendent	Suffolk Constabulary
Partnership Co-Ordinator	Suffolk Safeguarding Partnership
Interim Director of Childrens Services	Suffolk County Council
Assistant Director for Childrens Services	Suffolk County Council
Director - Children, Young People and Maternity	Norfolk and Waveney ICB and Norfolk Children's Services
Detective Superintendent	Suffolk Constabulary
Training, Safeguarding and Quality Standards Development Officer	Community Action Suffolk
Prevention and Safeguarding	Suffolk Fire and Rescue Service
Education Officer	Education Services
Head of Service	Suffolk probation
Deputy Chief Executive	Babergh & Mid Suffolk Councils
Consultant	Public Health
Service Manager	Cafcass
Designated Nurse	Norfolk & Waveney ICB
Designated Nurse	SNEE ICB

Role	Organisation
Head of Safeguarding	West Suffolk Foundation Trust
CEO	Healthwatch Suffolk

In Attendance

Role	Organisation
Communication & Engagement Officer	Suffolk Safeguarding Partnership
Head of Intelligence	Suffolk County Council
Named Nurse for Safeguarding	West Suffolk Hospital
	Volunteering Matters

Apologies

Role	Organisation
Chief Executive	Community Action Suffolk
Director of Nursing	Suffolk & Northeast Essex and Norfolk & Waveney ICBs
Deputy Chief Executive	Babergh & Mid Suffolk Councils
Partnership Manager	Suffolk Safeguarding Partnership
Deputy Designated Nurse Safeguarding Children	Norfolk and Waveney ICB

Item No.	Item Description
1.	**Minutes and actions from the last meeting held on 23 June 2023.** The minutes from the last meeting were agreed and the actions were updated as below: **SSP Practitioners Conference-** The conference went well with a high attendance virtually, feedback has been requested from attendees and will be reviewed to inform the planning for next year's conference.
2.	**Live Updates:** • **CYP Leadership Challenges-** The challenges facing CYP currently were explained and highlighted SEND as a key area to focus on as well as education issues like school attendance levels. • **Update from all partners on upcoming winter pressures-** The inevitable winter pressures were discussed amongst partners. • The ongoing industrial action is also causing pressure on the ICB system. • The 30% reduction in running costs that the ICB is facing is also causing some challenges including being unable to recruit to the MASH health posts, this will be discussed offline and brought back to the December meeting.

Item No.	Item Description
Agenda Items for Discussion	
3.	**Lived Experience of BAME Children who need safeguarding in Suffolk** Every child death is reviewed in Suffolk and ECDOP holds all the data from these deaths. It was reported that 30% of all deaths in Suffolk are BAME children and this had raised concerns within the Child Death team due to this disproportionate number, even though the sample was small
4.	**Lucy Letby- Health Assurances** This was added to the agenda following the conviction of Child Nurse Lucy Letby. Assurances had been given on the work that is happening following on from this learning: Below are all the things that have come into place since 2017. Medical examiners https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/ Statutory guidance https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1120062/child-death-review-statutory-and-operational-guidance-england.pdf PMRT https://www.npeu.ox.ac.uk/pmrt/programme HSIB https://www.hsib.org.uk/who-we-are/about-hsib/ PSIRF https://www.england.nhs.uk/patient-safety/incident-response-framework/ PSIRF incident response plans all reference national priorities for Patient Safety Incident Investigation (PSII). Two of the national priorities are pertinent here: Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII) Child deaths referred for Child Death Overview Panel review. A Locally-led PSII (or other response) may be required alongside the panel review – organisations should consult with the panel. The plans are signed off by the ICB and mean each child death must be considered for PSII investigation. If deemed more likely than not the child death has been caused by problems in care, then a PSII must be commenced alongside the CDOP process. Each PSII must be raised on the national database and the final report should be shared widely across the system by the organisations. As part of PSIRF assurance we attend the following meetings. Agendas and papers are shared: • WSFT and ESNEFT learning from deaths meetings. • ESNEFT patient safety group, which includes periodic updates from maternity and paediatrics. • WSFT Emerging Incident Review Meeting. All significant incidents (including Paediatrics and Maternity) are discussed here, and the most proportionate incident response is agreed. • LMNS Maternity Patient Safety Group. Both WSFT and ESNEFT present their monthly incident data covering significant harm and near misses. Freedom to Speak Up

Item No.	Item Description
	https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf ESNEFT Freedom to Speak Up report. https://www.esneft.nhs.uk/wp-content/uploads/2023/02/020323-Item-5.3-Freedom-to-Speak-Up-Report-March-2023-Final.pdf WSHFT Freedom to Speak Up Policy https://www.wsh.nhs.uk/CMS-Documents/Trust-Policies/Freedom-to-Speak-Up-Policy.pdf It was noted that families are filming work on neonatal units as they have raised levels of anxiety . This will be taken up offline and a code of practice for this will be considered. **Actions/Decisions** • The SSP will consult with the ICB to look at the filming of clinical practice including surgery and to consider developing practice guidance.
5.	**Summary of headline findings and any arising concerns – S157/175** It was explained that the Safeguarding Self Assessments for schools are now ending. The presentation was circulated with the notes, and asked if the partnership can be assured that where there is a school with a safeguarding concern that there is joint work to tackle the issues? It was reported that schools are visited when intelligence is reviewed, and concerns are raised.
6.	**Safer Sleeping, in the light of recent cases** Following a spate of deaths from unsafe sleeping the SSP are holding a Webinar in November on Safer Sleeping. There are already 400 people signed up to this webinar. Resources will be available to share with families alongside this.
7.	**Introduction and promotion of the Involvement Checker** The involvement checker that has been developed within CYP to help identify services that are sitting around the child or young person being worked with was shared. The presentation will be shared with the notes. This is currently only available to Suffolk County Council staff but it is hoped this will be expanded more widely in the future.
8.	**Strategic Business Plan 23/25** Colleagues were reminded of the priorities within the SSP business plan and that partners are able to request any help towards these priorities as required.
9.	**A personal story - Lived experiences** Volunteering Matters attended the meeting with some young people. The young people were thanked for attending the meeting and asked to return to each Board meeting for the next year to raise the issues highlighted below that affect them: • Youth Homelessness • Isolation and a lack of diversity in schools • Being supported after leaving care • Support for asylum seeking young people The SSP will link with Volunteering matters to arrange these slots on forthcoming Board agendas. **Actions/Decisions** • The SSP will link with Volunteering matters to arrange these slots on forthcoming Board agendas.

Item No.	Item Description
10.	**Update on case reviews** There are currently 8 cases open to the Case Review Panel, the main themes coming out from these are overlay, neglect and lack of engagement with professionals. She explained the case of [redacted] is currently being finalised.
11.	**Sharing Good Practice** Board members were asked to share any areas of good practice they would like highlighting with the SSP. **Actions/Decisions** • Board members are asked to share any areas of good practice with the SSP.
12.	**Working Together Consultation** This is a national consultation and all the papers have been distributed with the agenda. An update will be given when the government response is received. **Actions/Decisions** • An update will be given once a response is received from the government on these processes.
Any Other Business	
9.	**Any Other Business** • **MARF Webinar-** The SSP are hosting a webinar looking at the MARF Process, this webinar will be held on Thursday 12th October- 2pm to 3.30pm This webinar is open to all professionals. It will be delivered by MASH colleagues and is an opportunity to learn more about and review how the MARF process works in the MASH. To book a space please follow this link to the Eventbrite booking page: https://www.eventbrite.co.uk/e/713764969237?aff=oddtdtcreator • **POLICY PAPER:** Suicide prevention in England: 5-year cross-sector strategy- See attached paper for information.