



	<b>NEL Safeguarding Children Partnership Full Board</b>
	<b>Venue: Microsoft Teams</b> <b>Date:</b> Friday 20 <sup>th</sup> August 2021 <b>Time:</b> 09:30 – 12:30
1.	<b>Attendees:</b> D Wildbore (Chair) – Chief Superintendent, Humberside Police J Haxby – Director of Quality & Nursing Services, CCG S Hunt – Assistant Director Safer NEL, NELC H Willis – NEL SCP Manager A Rawlings – SCP PSO & Designated Nurse for CLA & Deputy Designated Nurse for Safeguarding Adults & children CCG P Booker-SCP PSO & DCI PVP South Bank, Humberside Police J Wilburn – Designated Nurse for Safeguarding Adults & Children A Harty – CP and Court Services Manager, Assessment and Safeguarding, NELC Yvonne Shearwood – Assistant Director, Early Help and Safeguarding, NELC Councillor Ian Lindley – Portfolio Holder for Children, Education and Young People, NELC P Pankova- Strategic Lead for Safeguarding, Reviewing and Partnership, NELC  <b>Presentations made by:</b> D Alaszewski – Head of Safeguarding, NELC Carolyn Beck – Health & Wellbeing Commissioning Lead, Public Health, NELC  <b>Guest for Agenda Item 7:</b> Christine Jackson – Adult Principal Social Worker, Focus  <b>Apologies</b> L Arthey –Director of Children and Family Services , NELC S Mills - Head of Learning Service, Grimsby Institute of Further Education R Moody, Eastfield Primary Academy J Swinburn – SCP PSO & Specialist Lead – Performance & Quality, NELC P Hutchinson – Executive Principal, Wellspring Academy Trust L Kosciwicz – Head of PVP, Humberside Police Dr M Pathak – Named GP for Safeguarding, NELC A Harty – CP and Court Services Manager, Assessment and Safeguarding, NELC Dr Z Haider – Designated Doctor, NLaG
	<b>Note Taker</b> – Sally Greetham, Business Support Specialist, SCP
1.	<b>Minutes from Previous Meeting &amp; Matters Arising</b>
	The Minutes of the SCP Full Board held on the 13 <sup>th</sup> May 2021 were agreed as a true and accurate record.
2.	<b>Action Tracker</b>
	<b>Action 78:</b> P Pankova to arrange a meeting with P Booker to discuss the issue around Police not falling under the LADO framework <b>Update:</b> P Pankova advised this needs to be a decision by the SCP. Benchmarking has been undertaken with other areas including Hull, where the role impacts on children all

allegations go through the LADO. P Booker advised he was not aware of any agreement with Hull and understood the police were not part of the process as were not in a position of trust. Agreement that the Polices inclusion in the LADO process needs to be explored by L Kosciwicz at the Assistant Director meeting across Hull, Scunthorpe, East Riding and NEL on a cross boundary basis. J Haxby confirmed that the DASM process also needs to be considered.

ACTION	LEAD	DEADLINE
To set up meeting with the four CSC strategic Assistant Director leads across North Lincs, Hull East Riding and Grimsby to discuss if the police should be subject to the allegation management process based on Working Together Guidance 2018	L Kosciwicz	12.11.2021

**Action 77:** C White to investigate if there are any accreditations available around the work that has been undertaken in respect of the Voice of the Child.

**Update:** Details of any available accreditations to be included in the Voice and Influence report presented at the next SCP Full Board.

**Action 76:** P Pankova to develop a Task and Finish Group of representative agencies in respect of children subject to CP Plans including effectiveness of core groups and report back to the SCP Full Board in 3 months

**Update:** P Pankova advised that the action did not reflect the discussion around the work required and requested that this was re worded. Individual conversations have taken place with Children’s Health Provision and Navigo around the process of invites to CP Conferences. The Child Safeguarding and Reviewing Service team are mapping and considering invites to conference, reports provided by agencies, partner participation and the development of the right dataset to analyse performance and quoracy at the meetings. A draft Terms of Reference has been developed for the Task and Finish Group to review representation of agencies at CP Conferences. An update report will be available for the next SCP Full Board. P Booker and J Wilburn asked that the be part of the Task and Finish Group

ACTION	LEAD	DEADLINE
Action 76 “P Pankova to develop a Task and Finish Group of representative agencies in respect of children subject to CP Plans including effectiveness of core groups and report back to the SCP Full Board in 3 months” to be revised	S Greetham	03.09.2021

ACTION	LEAD	DEADLINE
The draft Terms of Reference for Representative Agencies at CP Conferences to be shared with the SCP Full Board ahead of the first meeting of the group	P Pankova	12.11.2021

**Action 75:** M Thompson, CCG to explore the local mental health services for children and young people with eating disorders and provide a report for the next SCP Full Board.

**Update:** Deferred to SCP Full Board in November. Members have asked that M Thompson provide assurance around the wider mental health agenda in addition to information on eating disorders.

	<p><b>Action 72:</b> J Haxby to include an agenda item for the Safeguarding Adults Board around Adults Services involvement in the MACE process</p> <p><b>Update:</b> J Haxby confirmed t this work has been picked up. D Alaszewski advised that Focus are not attending MACE. Emily Scott is working with Adult Mental Health Services around the consideration of a pilot linked to the child in need offer, around a possible mental health hub with clear lines of communication around adults and children and what we would like it to look like. Arrangements have been made to discuss this in detail with the Mental Health Commissioner. A proposal should be in place over the next couple of weeks.</p> <p><b>Action to be discharged</b></p> <p><b>Action 62:</b> The CCG to explore with Young Minds Matter information governance team the issues in respect of the young inspectors sending an anonymous survey to children and parents as part of the inspection.</p> <p><b>Update:</b> It was confirmed that Young Minds Matter have agreed for the Young Inspectors to undertake an external survey to capture the experiences of children/young people using the service. <b>Action to be discharged</b></p> <p><b>Action 53:</b> P Booker to liaise with J Wilburn in including health within the police review of MASH.</p> <p><b>Update:</b> P Booker advised a meeting was held on Wednesday 18<sup>th</sup> August 2021. Working groups have now been scheduled on a 6 weekly basis. <b>Action to be discharged</b></p>
	<p><b>ITEMS FOR DECISION/DISCUSSION</b></p>
<p><b>4.</b></p>	<p><b>Performance</b></p>
	<p><b><u>MACE Report Update</u></b></p> <p>D Alaszweski presented the latest MACE Report highlights included:</p> <ul style="list-style-type: none"> <li>• Clear Progression is being made with child exploitation.</li> <li>• The Adolescent Risk Strategy groups are now in place and clear plans.</li> <li>• Level 2 training on exploitation is being delivered to all partners.</li> <li>• The Devolved decision making pilot went live on 14<sup>th</sup> June 2021. One panel has taken place. All children have been discussed in the timescales set by the home office and 2 reasonable grounds decisions have been made. There is clear confidence in the decision making.</li> <li>• Working with supermarkets, hotels taxi companies around raising awareness</li> <li>• A toolkit covering a number of areas around adolescent risk, which will also include substance misuse and knife crime is to be developed to provide a holistic overview to schools of resources that can be delivered in their schools.</li> <li>• Graft continues to provide high levels of success. 92% of children who have received support have had their risk reduced.</li> <li>• A key issue is that the Graft Project funding will cease end March 2022. A proposal is being drawn up for a NELC exploitation service, utilising staff to model what has worked within the Graft Project. We do not want to lose what we have gained.</li> <li>• Returned interviews have improved.</li> <li>• 68% reduction in risk as a result of the Operational Vulnerability Meeting.</li> <li>• Ryan’s story has been launched with over11,000 views, young people are the actors, and it is based on true stories and is for children over age of 16.</li> </ul>

### Discussion

- P. Caswell has been exploring if any funding is available to extend the GRAFT project. A Conversation is being undertaken to see if the staff can be retained in a similar role with funding from YOS and CSC in order to continue the work .
- S Hunt confirmed an Adolescent Strategic group will be established, this group will oversee the legacy of Graft and the development of options for its continuation after the funding runs out on 31<sup>st</sup> March. A meeting with D Blackwood is to take place on the 1<sup>st</sup> September to in respect of exploitation and adolescent risk..
- Good decision making by MACE identified by the Home Office
- Consideration of an extraordinary meeting of the SCP executive is required in respect of the proposed GRAFT options

<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
Provide an update on plans to reshape the GRAFT offer as a result of end of the funding	D Alaszewski	12.11.2021

### SCP Performance Report

P Booker present the SCP Performance report, highlights included: Progress in Quarter 1 (Q1)

- The number of referrals received which were within 12 months of the start date of a previous referral has decreased again over Q1.
- We are performing better than average in terms of assessment timeliness. Our Q4 performance was 87% which is higher than the regional average of 83%.
- Timeliness of ICPC's was 88.6% which is an increase, bring us above the regional average.
- The number of children open to CP plans in June was 249, a reduction of 3 since May.
- Children looked after numbers continue to safely reduce.
- The percentage of statutory cases for youth offending has remained the same
- Consideration will be given to which Health data would be valuable to the SCP i.e sexual abuse medicals in Q2.
- Performance around dental checks for children looked after has improved from 14% in Q4 to 42% at the end of Q1.

### Exceptions Analysis

- Easing of lockdown has seen a significant increase in children missing reports, 2 children responsible for 39 of these reports.
- Number of Child Criminal Exploitation investigations and Child Sexual Exploitations investigations do not reflect the level of this activity in the area.
- Increase in referral to CSC for reasons of sexual harm of April (43) and June (52)
- Number of children on a child protection plans for the reason of neglect or emotional harm remains the highest categories. In June there were 108 children at risk of emotional harm and 87 children at risk of neglect.
- Number of children becoming looked after notified to the health team within timescales continues to be low. 87.9% of notifications were late.
- There have been 3 child deaths as a result of extreme prematurity which is an increase from 1 in Quarter 4.
- Number of children electively home educated continued to increase with 268 children compared to 179 Children in September.

### Recommendations

PSOs are proposing the following themes (based on performance analysis and LOS themes) are the priority areas of focus and are endorsed by the SCP

- The basics of working together 2018 (Expectations agencies)
- Response to sexual harm
- Response to neglect
- Response to presenting injuries

In addition there would be a focus on key themes,

- Voice, and lived experience child
- Supervision
- Challenge and escalation
- Communication/ information sharing

J Haxby raised the poor performance in respect of the timeliness of initial health assessment of CLA and a there being a lack of progress in this area. Y Shearwood confirmed that work was being undertaken, agreement for J Haxby and Y Shearwood to have a discussion outside of the meeting. D Wildbore advised the Quarter 2 performance report now needs to include an exception report and narrative on this.

<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
Have a discussion outside of the SCP board in respect of the work on the timeliness of initial health assessments and impact	J Haxby Y Shearwood	12.11.2021

<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
Narrative around work undertaken to improve performance in respect of timeliness of initial health assessments to be included in the Quarter 2 performance report	PSOs	12.11.2021

#### Discussion

- P Pankova advised that assurance in respect of missing children should be provided by the PSOs as part of their work. J Haxby felt it is important that the data and intelligence identify where the child is and assurance is provided about identified themes by the worker, however felt it was not the role of the PSOs to get involved with individual cases.
- D Wildbore confirmed there will be a missing person dedicated team in place by the end of the month, the Locate team, which will have a positive impact. There will be an inspector, 8 constables and 2 sergeants on the south bank. The Governance is yet to be finalised however, all safe and well checks will be done with 24 hours Assurance will be provided by this team and will inform the performance report rather than the PSOs doing the work
- S Hunt advised the PSO recommendations within the performance report on the proposed areas of focus within the work plan cannot be looked at in isolation. They need to be part of the review of the function of the SAIG based on the findings of the risk capacity report . P Pankova will lead on the review with L Arthey acting as the Board sponsor for the progress of this work.
- J Haxby acknowledged the work the PSOs have done and would not disagree with the recommendations. The response to sexual harm has been raised by the designated doctor in respect of concerns around pathways which needs to be included in the work. J Haxby confirmed there needs to be consultation with the Board in respect of the proposals from the review of the SAIG and SCP workplan
- Discussion regarding any gaps in performance. In process of having discussions in health around sexual abuse medicals, A&E, self-harm etc. P Booker advised when they go live with the vulnerability tracker this will provide additional information and ensure we are considering new trends etc.

5.	<b>Risk Register</b>												
	<p>S Hunt provided an update against the key risks</p> <p><u>Engagement with third sector.</u> It was agreed a workplan needs to include awareness raising events for voluntary community sector, making explicit roles and responsibilities, feedback following any concerns being raised, good communication, training and case studies by voluntary and community agencies in respect of safeguarding process and practice. The Early Help Strategic Forum would be the best place to interact and share information with the voluntary sector as around 20-30 organisations attend the meeting.</p> <p><u>Capacity Risk work.</u> The review has been completed and recommendations made to the SCP executive. The next step is for P Pankova to lead the review of the SAIG, its functions, the SAF and SCP workplan and develop a proposal to the November SCP executive.</p> <p><u>Practitioner voice.</u> There has been slippage related to capacity, it was agreed we need to get practitioner events scheduled in on the calendar. J Haxby confirmed we haven't done enough and it is about listening. H Willis confirmed that there was agreement the next session would focus on learning from line of sight and feedback from practitioners.</p> <p><u>Thresholds.</u> An audit of thresholds was part of the PSO workplan however this has been on hold due to the risk capacity work. P Booker advised the police are undertaking work on thresholds across the four areas and will be having accountability meetings and two day training. They are looking at aligning the four areas child concern/ threshold models. P Pankova confirmed the SCP needs to understand the local application of thresholds and the quality of referrals, are we risk adverse. D Wildbore confirmed the SCP needs assurance that we are getting it right. Agreement thresholds should be next focus group at SRMG</p> <p><u>Training.</u> The training review evidenced the current SCP offer does not meet assessed need and is greatly under resourced, and that resource and buy in is required across a partnership level. A proposed offer was presented to the SCP Executive. Further clarity was requested by the SCP Executive, and agreement for L Arthey to work with S Impey, E Wragg and members of the SAIG in developing further the Core Safeguarding Training Offer and report back to the SCP</p> <table border="1" data-bbox="280 1368 1445 1518"> <thead> <tr> <th data-bbox="280 1368 1046 1402">ACTION</th> <th data-bbox="1046 1368 1238 1402">LEAD</th> <th data-bbox="1238 1368 1445 1402">DEADLINE</th> </tr> </thead> <tbody> <tr> <td data-bbox="280 1402 1046 1518">Schedule in two practitioner events around November/ December time and second one April/ May time (half day events)</td> <td data-bbox="1046 1402 1238 1518">H Willis</td> <td data-bbox="1238 1402 1445 1518">12.11.2021</td> </tr> </tbody> </table> <table border="1" data-bbox="280 1585 1445 1704"> <thead> <tr> <th data-bbox="280 1585 1046 1619">ACTION</th> <th data-bbox="1046 1585 1238 1619">LEAD</th> <th data-bbox="1238 1585 1445 1619">DEADLINE</th> </tr> </thead> <tbody> <tr> <td data-bbox="280 1619 1046 1704">Thresholds to be the focus of the October Strategic Risk Management Group</td> <td data-bbox="1046 1619 1238 1704">S Hunt</td> <td data-bbox="1238 1619 1445 1704">12.11.2021</td> </tr> </tbody> </table>	ACTION	LEAD	DEADLINE	Schedule in two practitioner events around November/ December time and second one April/ May time (half day events)	H Willis	12.11.2021	ACTION	LEAD	DEADLINE	Thresholds to be the focus of the October Strategic Risk Management Group	S Hunt	12.11.2021
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6.	<b>Highlight Reports</b>												
	<p><u>Safeguarding assurance and improvement group</u>  H Willis spoke to the headlines of the report</p> <ul style="list-style-type: none"> <li>• The SAIG is a large group that does not function well as well as it could</li> <li>• Current function to oversee assurance work and drive practice improvement</li> <li>• Member survey undertaken and members clear on the role and remit but not full buy in</li> </ul>												

- The work of the SAIG is aligned and reliant on the findings of the assurance activity within the SAF. The fact that the SAF activity has not been fully implemented has impacted on the work of the SAIG.
- Has overseen the training review .
- Overseen the Line of Sight action plans and progress and development 7 minute briefings.
- PSOs triage Line of Sight referrals, and develop performance report
- Lots of work being undertaken but not seeing the impact.
- Review of neglect strategy and graded care profile as recommended by SCP is on hold due to capacity work.
- Function of the SAIG to be reviewed by the Strategic Lead for Safeguarding, Reviewing and Partnerships, this will include further review of the scrutiny and assurance framework and identification of required assurance activity and on areas of focus based on performance data and findings from line of sight.
- This will make explicit the expectations of agencies and what additional support and resources are required and whether the PSO model is the best approach. A proposal will be made to the October SCP Executive.
- The development of the safeguarding practice standards will support this work.
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#### Discussion

J Haxby requested that as part of the review and revised arrangements a process is built in so that we can demonstrate the so what question and difference made. Suggestion around a multi-agency audit programme, which is clearly linked to the two key outcomes. H Willis advised that the reform bid work on the development of what good looks like statements under the 2 outcomes will support this work.

#### Safeguarding Review Group

J Wilburn spoke to the headlines of the report

- 2 Serious incident notifications (SIN) made by CSC to SCP and the National Review Panel in July
- First regarding TP aged 9 months old, Romanian parents, in receipt of universal services, not known to CSC ,received life threatening head injury assessed as non-accidental injury. Rapid review undertaken and recommendation of no practice review required as sufficient learning. Report submitted to the National Review Panel and action plan being developed.
- Key learning included, routine enquiry regarding domestic abuse, importance of medical history of families moving from other countries, interpreting support, lack professional curiosity, issues in respect of information sharing between GP and CPHP.
- The second SIN was in respect of the B family, 7 children aged between 18 months and 12 years. The case was due to come to Line of Sight , issues long term neglect and domestic abuse. It was escalated to SIN after 4 of the children sustained significant burns due to being in the sun.
- Due to the complexity of the case and having 2 SINs an extension to complete the rapid review was requested and granted. The rapid review takes place on the 02.10.21 and the report will be submitted to the National Review Panel after endorsement by the SCP Executive on the 13<sup>th</sup> of September 2021.
- Regarding the V Sibling practice review, the report was submitted to the National Review Panel on the 30<sup>th</sup> April 2021, the police enquiry is continuing and no outcome as yet. A learning summary has been developed and disseminated to partner agencies. An action plan has been developed and is being implemented, impact is being assessed
- The rapid review process is to be developed further to ensure the right level of agency information and analysis is received and the impact on the child/ren is explicit

	<p><u>Discussion:</u> Y Shearwood advised professional curiosity underlines all practice issues, the LA are re-invigorating the signs of safety model. Professional curiosity is aligned to the signs partnership safety practice model. H Willis confirmed that a professional curiosity guidance tool and practice workshop is being developed by the SCP in partnership with CafCass</p> <p>J Haxby asked if the work included the SAB too as professional curiosity is a key finding in all reviews and the work needs to be joined up. H Willis advised the tool is in its early stages and the intention is to consult with the SAB manager</p>
<b>7.</b>	<b>PIT Stop and Vulnerabilities Hub (including consent report)</b>
	<p>P Booker presented the pitstop paper, highlights included,</p> <ul style="list-style-type: none"> <li>• Co-opting 4 Multi Agency Safeguarding Hubs from 4 local authorities into one Pitstop (Partnership Integrated Triage).</li> <li>• Information to front door as statutory requirement</li> <li>• Pitstop to do assessment of police information using threshold windscreen if open case</li> <li>• 80% of police referrals to the front door sit at early help, Pitstop will identify level of risk and whether needs escalating or if should be at early help</li> <li>• Improvement to assessing managing risk outside of the home</li> <li>• Evidence from the pilot in North Lincs that domestic abuse is triaged more effectively as decision making is better</li> <li>• Also top ward areas identified including level of need and understanding of vulnerability in the community</li> <li>• P Booker is working with D Alaszewski on the NEL vulnerability tracker. Information will be factored into PowerBI which will allow a drill down on the data that can inform future SCP Board meetings</li> </ul> <p><u>Discussion</u></p> <ul style="list-style-type: none"> <li>• D Wildbore advised Pitstop is a multi-agency approach. He asked if the right consultation taken place. Communications have gone out to all boards and has been signed off by the Directors of Childrens Services for the four local areas. Work is being undertaken with the SAB, to ensure a joined-up approach and the finer details. Pitstop will have a big impact and domestic abuse will be part of it.</li> <li>• Y Shearwood advised it was her understanding that Pitstop would be up and running in NEL by the end of August and was not aware it had been delayed and asked for confirmation of the start date. P Booker confirmed it cannot start until resources are available, it is a priority to release staff. D Wildbore welcomed Y Spearwoods challenge and confirmed it was complex and involved transferring people. It is the number one priority for the force and will be weeks not months.</li> <li>• J Haxby felt the paper really helpful, the CCG raised concerns a few weeks ago as health had not been included in the discussion and it was not clear what was happening. This has been resolved as a result however a learning point is to ensure everyone is engaged at the start. There are particular pressures for health in getting the right people engaged.</li> <li>• About learning about the learning within each of the neighbourhoods was interesting which will be helpful for the ICS to understand as they are commissioning the services to respond .</li> </ul> <p>P Booker confirmed that demands have changed as a result of the pilot of the PITstop in North Lincolnshire which has had a significant impact.</p>
<b>8.</b>	<b>Suicide Report - issues relevant to children and families</b>
	<p>C Beck Health Lead for Suicide Prevention and Health delivered a presentation and highlighted the following:</p>



- Real Time Surveillance (RTS) is a process where the Police (Humberside and British Transport Police share sudden death forms where suicide is suspected with Public Health.
- CCG Safeguarding and Public health have developed a follow-up process the aim of which is to learn from suspected suicides and to prevent suicides in the future and to identify any cluster or contagion (where death could cause other people to consider suicide). Wrap around support is provided to prevent further suicide.
- The follow up process asks organisations to complete a Discovery form, this information is then added to an individual's timeline.
- Suicide Learning Panels view these timelines and actions are developed.
- Humberside Police directly refer people affected by the suspected suicides into the NEL Mind Together Bereaved by Suicide Service.
- Between January 2020 and February 2021 there has been a significant increase in female deaths by suspected suicide.
- Children taken into care was mentioned as a factor in ending their life.
- 63% of the females had been victims of domestic abuse, for many this related to multiple perpetrators and staying in the women's refuge.
- The most common cause of death was by hanging.
- 43% were unemployed, 40% lived in the most deprived quintile of NEL
- Between 2014 and 2018 there were 67 deaths recorded as suicide or undetermined intent.
- RTS between January 2020 and end of July 2021 identified there have been 33 suspected suicides (24 males and 10 females).
- Of the 33 deaths 12 were parents who had children under the age of 18 and 3 of parents who had recently been bereaved by children.
- Impact on the children have included being in the house at the time of death, being directly linked to the death, potential witness of death in public place and teachers.
- Experiences of the parents included parents being separated, high number were unemployed, mental health diagnoses, previous suicide attempts, alcohol misuse, children removed into care Domestic.
- The SCP need to Understand the picture of children bereavement by suicide and Give suggestions of how we can support children and young people following the suspected suicide of a parent.
- Important to identify any potential clusters or contagion and put work into place immediately to prevent further suicides.
- No official way of identifying the bereaved children – unless they are involved in Children's Services.

#### Next steps

C Beck is currently leading on the development of a Suicide Prevention Action Plan update, the vulnerability of children and young people and the bereavement of children and young people are both included in this plan. Once it is completed the Public Health Lead will monitor and support the plan.

#### Discussion

- D Wildbore advised the agenda is also important to the SAB
- In terms of those adults who have children taken from them – is the support fit for purpose
- When a sudden death form is received children are not identified on the form so are not able to provide support for these children.
- Must ensure barriers are unblocked. This reinforces the need for a Safeguarding Adults person to be in the front door.
- Consideration of a referral process through the vulnerability hub.

- Children’s services can only provide information in respect of children know to children’s social care.
- P Booker to have further discussions with C Beck around provision of police information.
- Lack of support for children through the mental health service. Aware of a female suicide with a number of children, support had to be purchased from Barnardo’s. Mental health services are not meeting this need and consideration needs to be included around this when the service is recommissioned.
- Available support for adults including emotional support is ineffective at the moment. Bereavement support services are available through Cruse and MacMillan.
- J Haxby agree that this is something that needs commissioning but it is not a mental illness so not appropriate to be part of the mental health commissioning. Advised that conversations should be undertaken with St Andrew’s Hospice as they are the ones who the work is usually requested.
- The Suicide Prevention Action Plan, which sits under Public Health needs to be a partnership approach. This plan does link to the Safeguarding Adults Board.
- Resilience is a key factor, death effects people all the time, and effect a child’s confidence and emotional well-being and do not always have strong family unit for support. It was noted a lot of the parents had a number of adverse childhood experiences.
- H Willis advised there are a number of issues raised and asked how they will be addressed going forward and is there a local suicide preventions strategy
- C Beck advised everything is intertwined with the local action plan. CSC have got public health but NEL is part of the Humber coast and Vale strategy and work closely with other areas where suspect suicide of under 18s.
- The action plan to be shared with the SCP in order identify where support could be provided by existing SCP Groups
- C Beck highlighted that there have been 4 female suicides were domestic abuse was involved and 2 cases were domestic abuse was identified but not a direct issue. Details of these females to be shared with D Wildbore for checking around domestic homicide reviews.

<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
C Beck to share the details of the four females who committed suicide where the was domestic abuse with H Willis for forwarding to D Wildbore	C Beck	26.8.21 <b>Complete</b>

<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
Share the suicide prevention action plan to the SCP Board to enable the board to identify which groups could support with the plan	C Beck	When revised

**9. Modern Slavery**

S Hunt highlighted the following:

- The MDS strategy has been refreshed.
- Group work around online communications facebook, twitter.
- Modern Slavery Training & Awareness Training Sessions have been delivered
- A Modern Slavery Resources document has been developed.
- An Operational Enforcement Group has been established.
- A pilot has been established around NRM decision making.
- Statistics were shared for 2020 .

	<p><u>Next steps</u></p> <ul style="list-style-type: none"> <li>• Humberside wide MDS partnership would like to commission a peer review</li> <li>• A refresh of the problem profile.</li> <li>• The performance Dashboard needs developing further to include joint operation.</li> <li>• Community awareness raising via campaigns and communications.</li> <li>• Businesses – covid has impact on getting into business to raise awareness.</li> <li>• To have an agreed housing protocol across the Humber, starting in Hull, to provide accommodation for victims whilst they are going through the NRM process.</li> <li>• Developing Champions within agencies.</li> </ul> <p><u>Discussion</u></p> <p>D Wildbore noted the progress however this does not answer the so what question in terms of impact. View the next steps are prudent. There is potentially MDS that we don't know about which is about awareness raising, we are effective dealing with intelligence</p> <p>The Police and Council driving the work, there is a need to check that people know why they are attending the meeting and for assurance to be sought and evidenced</p> <p>J Haxby advised it is absolutely clear what we want others to do, now we need to be explicit what is required in terms of expectations of agencies. A Rawlings advised that in MACE they rotated the Chair which has helped to engage people to engage. There is a need to see the impact of the enforcement work.</p>
<b>10.</b>	<b>Prevent/Channel</b>
	<p>S Hunt highlighted the following:</p> <ul style="list-style-type: none"> <li>• Prevent strategy has been refreshed.</li> <li>• Compliant with government CONTEST.</li> <li>• A wide range of online communications and campaigns have been developed.</li> <li>• Strong network of prevent champions in place and strong channel arrangements.</li> <li>• Undertaken a self-assessment and strengthen local channel arrangements.</li> <li>• It is an issue that there have been no referrals to channel in 2021, awareness raising has continues.</li> </ul> <p><u>Next steps:</u></p> <p>Planning consultation with all colleges and FE providers to undertake a survey around online extremism. To prepare for “Protect and prepare” as more requirements are coming, the prevent group has been reframed group to look at protect and public spaces</p> <p><u>Discussion</u></p> <ul style="list-style-type: none"> <li>• J Wilburn advised that there is further homework to check these awareness sessions are reaching all services i.e. GP practice, emergency services.</li> <li>• S Hunt advised agencies who had a duty under prevent will highlight what they are doing in the action plan at meetings, the focus will be in training, the CSP are to seek assurance.</li> <li>• J Wilburn advised from health perspective they are mandated to undertake training 85% and above. There is an anxiety around lack of referrals and it is important messages continue to go out. In the cell case – would we be see this as part of the prevent remit . It was confirmed this is seen as a potential threat as form parts of the new training which is now much broader.</li> <li>• In-between training there is the need to ensure awareness is still getting out there which is where the prevent champions come in.</li> </ul>
<b>11.</b>	<b>Development of the Integrated Care System (ICS) and the Integrated Care Partnerships (ICPs)</b>

	Due to time restraints it was agreed that the presentation would be circulated and the item deferred to the next SCP Full Board.		
	<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
	The revised presentation in respect of the Development of the Integrated Care System and the Integrated Care partnership (ICPs) be circulated with the Minutes for information	H Willis	12.11.2021
	<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
	Agenda Item: Development of the Integrated Care System (ICS) and the Integrated Care Partnership be deferred next SCP Full Board	H Willis	12.11.2021
<b>12.</b>	<b>Young Inspectors Interim Report – Young Minds Matter</b>		
	<p>H Willis presented the interim report from the Young Inspectors in respect of their inspection of Young Minds Matter, which included:</p> <ul style="list-style-type: none"> <li>• Challenge faced around not being able to gather the views of children and young people about the service has not been resolved, supported by J Haxby.</li> <li>• It has been agreed that the Young Inspectors themselves will undertake an open survey with the support of the CCG engagement team. This will not be supported by Young Minds Matter.</li> <li>• The next step is for the survey to go live and be shared across appropriate networks.</li> <li>• A Rawlings commented that the young inspectors should be praised for the tenacity around completing this inspection due to the challenges they have faced.</li> <li>• The results of the survey and recommendations will be reported to the next SCP Board.</li> </ul> <p>Discussion:</p> <ul style="list-style-type: none"> <li>• H Willis advised the Safeguarding Lead at LPFT was not aware of the Young Inspectors inspection of Young Minds Matter.</li> <li>• A letter to be written, from the Board to the Young Inspectors to commend them for the tenacity and the great work they have done.</li> <li>• The draft letter to future agencies around Young Inspector inspections to be signed off by D Wildbore and shared with SCP Board.</li> </ul>		
	<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
	Send the letter that will be sent to agencies explaining the purpose of the young people’s inspection to the SCP board for final agreement	H Willis	12.11.2021
<b>13.</b>	<b>Any other business</b>		
	An item in respect of Inter Agency Audit to be carry forward to the next SCP Full Board.		
	<b>ACTION</b>	<b>LEAD</b>	<b>DEADLINE</b>
	Advise L Arthey that the item in respect of Inter Agency Audits has been deferred to the next SCP Board meeting and ask if there is anything that needs to be addressed prior to this meeting	H Willis	12.11.2021

	<b>ITEMS FOR INFORMATION - Noted</b>
<b>14.</b>	<b>Forward Plan</b>
<b>15.</b>	<b>Corporate Parenting Board Minutes</b>
<b>16.</b>	<b>Finance Report</b>
<b>17.</b>	<b>Modern Slavery Additional documents</b>
<b>18.</b>	<b>Prevent additional documents</b>
	<p><b>Next Full Board Meeting:</b></p> <p>Date: Friday 12<sup>th</sup> November 2021  Time: 10:00 – 13:00  Venue: to be confirmed</p>