**Local Safeguarding Children Group (LSCG) – Norwich**

**Date: 6th March 2024**

**Time: 10:00 – 12:00**

**County Hall, Cranworth Room, Ground Floor**

**Present:**

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| **Name** | **Title** | **Organisation** |
| Letasha Reeve | Head of service | NCC |
| Mandy Marriott-Sims | Team Manager Community & Partnerships | NCC |
| Mark Osborn | Safeguarding Intelligence & Performance Co-ordinator (SIPCo) | NCC |
| Abby Whittaker | Administration Assistant (Level 2) | NCC |
| Trudy Sargeant | Safeguarding attendance lead | Lionwood Federation schools |
| Tina Chuma | Interim clinical lead |  |
| Luke Stebbing | Senior probation officer |  |
| Cathie Mcleod | Deputy Head & DSL | Harford Manor School |
| Carol Jacques | Head teacher | Earlham nursery school |
| Sandy Lovelock | Case Co-Ordinator | Leeway services |
| Paul Farmer | Family group conference and family networking advisor |  |

**Apologies:**

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| **Name** | **Title** | **Organisation** |
| Kath Griffiths | Locality manager | NCC |
| Nicola Arnup | Safeguarding Children Lead South Locality | HCP |
| Alice Stevenson | Young Carers Development Manager | The Benjamin Foundation |
| Rachel Omori | Independent Living Manager | Norwich City Council |
| Clare Harrison |  | Action for Children |
| Annalisa Puricelli | Border Officer | Border Force, Central Region |
| Charlotte Reed | Designated Safeguarding Lead & Attendance Officer | Norwich High School for Girls |
| Rob Mckenzie | Service Manager | Shaw Trust |

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| **No.** | **Item** |
| **1** | **Welcome - Minutes from the last meeting including updates from actions –**   * Welcomed the attendees to the meeting and asked them to introduce themselves. * Minutes from previous meeting were discussed and approved – No issues |
| **2** | **Presentations from LSCG members**  ***Trudy Sargeant – Safeguarding and attendance Lead for Lionwood Federation Schools*** – Trudy takes the lead at her school as the safeguarding and attendance officer which she took on as her lead role 4 years ago. This was initially just across the junior school but has now been implemented across to the infants too. This does have its benefits as the children who come up to the junior school benefit from having 1 consistent DSL. Trudy is often already working with a family at the junior school, so it made sense for her to take the lead with the siblings at the Infant school.  Trudy is the lead for the attendance which is something which Trudy has always felt sat within the safeguarding arena. Her hope is that if attendance can be improved within the infant school, then it will have a positive effect on the children when they go up to the junior school. Trudy reports that there are often children who go up to the junior school in year 3 who already have poor attendance.  Both schools use CPOMS (electronic safeguarding reporting system) which is important for both schools to be using in the same way to ensure continuity of good safeguarding practice. So, Trudy has trained the infant staff within the updates and expectations. Trudy is generally the duty designated safeguarding lead, unless she is offsite but will be alerted to any significant concerns which are raised within the schools. Anything more serious they go to Trudy straight away.  Every September Trudy delivers ‘Keeping Children Safe In Education’ (KCSIE) across both the schools and the information she shares she try to keep relevant to both schools. Trudy receives a presentation to deliver from the NCC but she will add in slides to include some of the families the school work with.  During the training she does activities. This year she set a task ‘How as a school can we provide Early Help’. She then shared that a new service which is has been rolled out across Norfolk which would allow professionals and parents to seek support and be sign posted to the most appropriate help. This new service being the Early Childhood and Family Service (ECFS), they can be accessed at the new Family hubs which have been set up.  Trudy also raised awareness to the staff that the Neglect Strategy that was published in 2020 is also being rewritten as it is clear from safeguarding practice reviews that neglect is at the centre of these reviews. The review is to ensure that the neglect strategy recognises progress to date, and more actions planned to focus resources so that the partnership becomes more effective in tackling and preventing neglect to help ensure all children and young people in Norfolk Flourish.  Trudy also made the staff aware that the NSCP had amended the threshold guidance and now being described as risk assessment and decision making in terms of the continuum of need.  The NSCP has a strong alliance with its sister board Children and Young People’s Strategic Alliance (CYPSA) which is delivering FLOURISH in the Children and Young People Partnership Strategy. The work between these two boards is to ensure a shared ambition to make Norfolk a place where all children and young people can flourish.  Trudy also provides both schools with safeguarding updates, especially if she has been aware of a safeguarding risk in the area. Last year there was an incident with a year 6 boy who was carrying a knife in his school bag. There is now a weapons policy for the school.  ***Tina Chuma – Clinical Lead for the Complex Health Hub– NNUH, Acute hospital***  Tina’s role enables the collaborative working of 6 specialities: Safeguarding, Substance misuse, Dementia, Mental Health, Learning Disabilities and Mental Capacity Act. Complex health hub also holds the lead role within the organisation for adopting trauma informed approaches, prison healthcare, homelessness, reducing restrictive interventions and smoking cessation. Our role mainly is developing polices and within that is Domestic Abuse and Preventing serious violence. We provide a full day level 3 safeguarding training and decided everyone needs to have level 3 and moving away from isolated working.  The mission of the Complex Health Hub is to increase parity of esteem for our service users and patients by raising awareness of health inequalities and to influence better health outcomes by our specialist services working together to provide an integrated care system. Safeguarding is uniquely encompassed within all these specialties and it's about ensuring that we are delivering and assessing individual needs whilst thinking family. If it's not obvious, it can be challenging at times to identify safeguarding because we are an acute hospital so essentially treat medically and everything else comes within that, but also, as a service there is very little time spent with service users.  Working together and partnership working underpins safeguarding and we all have different priorities but ultimately, we are all one big puzzle and need to work together. Our focus isn’t always safeguarding but sometimes it’s the other things such as ‘this is the 6th time a child has come to hospital with tummy pain so are we going to look at reasoning behind this’. Sometimes this is about what has been said. Through our trauma informed work, what is it that the child is saying.  An example of working partnership was mock JTAI, which is a joint targeted area inspection which is an Ofsted inspection. This one was on serious violence. The idea of this was to look at all our processes. For example, there was a 17yr old with a minor injury who did not want parents to know at all and the police were informed but due to the child not wanting anyone involved this took 3 hours to convince him otherwise.  There was an unfortunate incident about three years ago where there was an abduction of a baby from our hospital, who thankfully was found safe in an hour. The impact of this was tremendous, however, when the family presented again about a year later, it did lead to better communication between partners and better and earlier planning. There was openness, honesty and transparency with the family, and they were more engaging and felt better supported. It's not to say they weren't supported last time but sometimes when managing high risk cases, professionals tend to get too risk averse and are possibly clouded by the fear of what could happen as opposed to transparency and assessing what's needed now.  Are there any themes which you can recognise?  TC - We are seeing a rise in substance misuse; we aren’t seeing the children but this does have an impact on the child. The parent is coming in to report this. |

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| **3** | **Family Networking – Paul Farmer (Family group conference and family networking advisor)**    We have a team of 13 staff members and have 2 pathways and have a core offer where we meet families of children who are at risk. Network meetings are used to gather information to be able to support the family, this isn’t just for Norfolk. Norfolk have decided that all the learning we have should be pulled down from when we first start to work with families. We have now done this for a few years with some good success stories. We also have advisory roles and offer development practice sessions and case discussions to figure out where best to support that family.  There are 3 main stages for how family networking works. Firstly, we need to engage with families using appreciative enquiry. This is how we turn our worries and concerns into questions to the families about who they are and what they do. The next thing we do is to identify who the natural supporting network is around them and then we mobilise. Having spoken to the family we ring those families and bring them together into a family networking meeting which can help the children and families.  We have loads of tools which we use *(Slide 3-6)* – Genograms   * **Genogram** - this is generally a clinical tool which tends to scare a lot of people. These are predominantly for biological families and each line makes up a generation which then links people together. So, for instance, yellow for maternal family members and light blue for paternal family members. For some families we can use pictures or drawings to add a sense of fun to the genogram rather than using plain objects. * **Community genograms** – These are used for going beyond the biological family and can include anything to do with the child/ family which are important to them, such as football, animals, their house, friends etc. * **Cultural genograms** – These can be helpful when there is something unique about a family and is a way of exploring things such as gender identity, geography, race, religion, class, culture, education, sexual orientation etc *(See slide 6)*. * The simplest form of a genogram is a family tree.   **Ecomaps** – These are a much more graphic way of identifying how relationships are. In the centre there would be ‘me’ and then the outside there are lots of different things which are important to that person. For example, yellow squiggly lines show a wobbly relationship, green solid lines with an arrow show a strong relationship with the arrow signifying which way the relationship is strongest, red zig zag lines show a stressful relationship and dotted lines meaning a distant/ tenuous relationship. You can also include circles around key people which can help identify who is significant to the person.  **Safety circles** – This is a really gentle way of showing information. They don’t need to be circles but can be columns etc. There are 5 template circles.   * Blue is for who you work for   + Inner circle – People CS think can be useful.   + Middle circle – People CS think might be useful.   + Outer circle – People CS think won’t be helpful. * Yellow is you   + Inner circle - People who already know everything.   + Middle circle – People who know some things.   + Outer circle – People who don’t know anything. * Purple is who need to know everything.   + Inner circle – People who need to know everything.   + Middle circle – People who need to know something.   + Outer circle – People who don’t need to know anything. * Green is for who doesn’t need to know anything.   + Inner circle – people your child would want involved.   + Middle circle – People your child would be ok with   + Outer circle – People your child would not want to be involved. * Red is who does the child want to be involved.   + Inner circle – people we can easily involve.   + Middle circle – people we can involve if we must.   + Outer circle – people there is no way we would involve.   The reason we have the blue circle about us is because we have gentle approaches to families about why we are involved. This is a really safe way of explaining why this is the case.  **Supporter circles** – These are used to help family members identify where the support is sitting. We have emotional and practical supporter, (its ok for people to be in more than one of these circles). Fairweather are people who would like to be able to help but tend to have a lot on their own plate so may not be able to give that additional regular support to another family member. Fake supporters are for example parents who will ask another parent to pick their child up from school but when they are asked for a favour for school pick up then they are no where to be seen.  **Tree of life -** This is a much more reflective piece of work.   * **Roots** - Where you’re from * **Ground** - Where you live now and everyday activities. * **Trunk** - What you do, so skills and abilities. * **Branches** - Hopes and dreams and what it looks like * **Leaves** - Significant people within their lives (this could also be someone they don’t know, for example if someone says Martin Luther King is their hero) * **Fruits** - Something we are given, so playing cards given by nanny and grandad, guitar lessons from a father. * **Seeds -** What can you give out and what can you do to support someone else.   **Mobility mapping** – This is done by visual memory, they are asked to draw the first house they lived in with family, so mum and dad. First school etc.  We see better outcomes when all their family is involved. We are more likely to place children in kinship care rather than in foster care if this is done properly. From a professional point of view, if there is an EHAP pending then we can focus on who is actually involved rather than second guessing and constantly worrying about those children who may not have family network.  Family and community is a priority, and we need to get better at family networking and we need to show that we are getting better at documenting this. |
| **4** | **LSCG members experience of using the CoNG toolkit**  We talked about this at the last meeting. What we have under the continuum needs guidance is a toolbox and whole range of resources. [Norfolk Guidance to Understanding Continuum of Needs | NSCP | PWWC (norfolklscp.org.uk)](https://norfolklscp.org.uk/people-working-with-children/norfolk-continuum-of-needs-guidance)  The whole idea of this is to see who is using what and are you using this at all?     * Using the document with parents to help us phrase our worries and concerns. And to help the parents not to feel so overwhelmed. * Not having to have the need to use the consent form currently as parents don’t seem to have an issue with consent. * We have a really strong relationship with parents as we see them everyday and have formal relationships. The Continuum needs for us is very useful.   Tina – we have shared the guide and explained what its for and how to use it but because we are an acute hospital we don’t have a need to use them. We haven’t had any reports from CADs to say they are getting lots of unneeded calls from our setting.  Action - We will need to have a review about how the tool is being used etc. |
| **8** | A.O.B.  Next presentations to be done by Carol Jacques – Head Teacher and Sandy Lovelock– Leeway |
| **9** | Next meeting  Wednesday 29th May 2024  MS Teams |