MANCHESTER CITY COUNCIL

GREATER MANCHESTER POLICE

NHS

Manchester's Multi-Agency Safeguarding Arrangements (MMASA)

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Our Manchester

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Executive summary

Joanne Roney OBE
Chief Executive of
Manchester City Council

Umer Khan
Chief Superintendent,
Greater Manchester Police

Ian Williamson
Chief Accountable Officer,
Manchester Clinical Commissioning Group

We are proud to publish our new Manchester Multi-Agency Safeguarding Arrangements (MMASA) to strengthen our work with vulnerable children, young people and adults across Manchester. As a partnership, we are clear about our responsibility to provide leadership that will make a real difference to the most vulnerable members of our community. These guidelines are published in accordance with the revised statutory guidance, Working Together (DfE 2018), which requires all local areas to publish their new multi-agency safeguarding arrangements by 29 June 2019.

This guidance will build upon our strong foundation as an effective partnership. There have been many strengths in our previous safeguarding board arrangements and the work to join up children and adult safeguarding. From the recent external scrutiny by our statutory regulators, we take confidence in the strengths in our partnership arrangements as part of our journey of continuous improvement.

Our safeguarding arrangements will be led at Chief Officer level within Manchester City Council, Greater Manchester Police and the Manchester Clinical Commissioning Group. This will further strengthen our collective approach to safeguarding across Manchester. Alongside working within and across Greater Manchester, it is our aim to provide leadership that sets clear and rigorous priorities. We will follow them through and ensure the arrangements reduce harm wherever possible to improve the lives of Manchester's residents.

Manchester's Multi-Agency Safeguarding Arrangements will be regularly monitored and quality-assured to maintain effectiveness in all our work, and they will be reviewed as necessary. We will be more thoughtful about our learning and improvement activities to ensure that we listen and learn from our service users and that the improvements we make are delivered in a measured, impactful and sustainable manner.

These arrangements will be governed by the leaders in our organisation who will meet on a quarterly basis to review and consider the quality and impact of our services and ensure that we maintain the highest levels of safeguarding across the whole of the city.

If any new and emerging safeguarding issues are identified, they will be addressed and acted upon. We are committed to ensuring there is wide representation from across the sector to deliver our safeguarding priorities and that all relevant partners fully contribute to these arrangements.

We recognise that the voice of children, young people, parents and adult citizens should be at the heart of our work and we will maintain effective engagement processes to ensure we hear and respond to their experiences/voices as the new arrangements develop and mature.

We also acknowledge that the involvement and support of schools, colleges and other education providers are key to the success of our local arrangements. These arrangements will include all frontline services through our locality model and through our citywide services and Integrated Hubs (Manchester Local Care Organisation). We will continue to take a lead role in ensuring that our information-sharing arrangements are clear and accessible to all and that our arrangements for dispute resolution are transparent and open in line with good practice.

In this way we are committed to providing the best services for the most vulnerable children, young people and adults in our city.

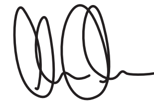
Manchester City Council

Joanne Roney OBE
Chief Executive

Manchester CCG

Ian Williamson
Chief Accountable Officer

Greater Manchester Police



Umer Khan
Chief Superintendent

Definition of safeguarding

Children

Safeguarding is the action that is taken to promote the welfare of children and protect them from harm. Safeguarding means: protecting children from abuse and maltreatment; preventing harm to children's health or development; ensuring children grow up with the provision of safe and effective care. (NSPCC definition)

Adults

Safeguarding means protecting an adult's right to live in safety, free from harm and abuse. (Care Act 2014 Statutory Guidance)

The Care Act requires a significant shift in culture and practice in response to the views of people who have experienced the safeguarding process. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control, and that improves quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them.

Manchester Safeguarding Standard

Manchester's Multi-Agency Safeguarding Arrangements partnership expect all providers and commissioners of services for children and adults at risk in Manchester to adhere to this agreed minimum safeguarding standard. Details of this standard can be found on the current safeguarding website.

The MMASA will quality-assure against this standard using a number of tools, including annual self-assessment for all MMASA member agencies and other key stakeholders:

- Single-agency audit information
- Quality review of the Multi-Agency Risk Assessment Conference (MARAC)
- MMASA multi-agency audit information (Section 11 and Adults' quality-assurance statement)
- Individual organisation's inspections/ declarations and audits
- Safeguarding Adults Review recommendations – evidence of practice improvement
- Serious Case Review recommendations – evidence of practice improvement
- Domestic Homicide Review recommendations – evidence of practice improvement
- Child Death Overview Panel recommendations – Annual Report.

Section 1:
Multi-Agency Arrangements

1.1 Our vision and priorities

Through these arrangements we will deliver against the partnership visions for vulnerable children and vulnerable adults and they will be underpinned by the 'Our Manchester Behaviours':

- We work together and trust each other
- We take time to listen and understand
- We 'own it' and aren't afraid to try new things
- We're proud and passionate about Manchester.

Our visions

Children and young people

"Every child in Manchester to be safe, happy, healthy and successful. To achieve this, we will be child-centred; we will listen to and respond to children and young people, focus on strengths, resilience and take early action."

Vulnerable adults

"Living a life that is free from harm and abuse is a fundamental human right of every person. When abuse does take place, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the issues. In addition, the person at risk, at the centre of any safeguarding concern, must stay as much in control of decision-making as possible. The right of the individual to be central throughout the process is a critical element in the drive to ensuring personalised care and support."

Manchester's Multi-Agency Safeguarding Partnership will develop a shared vision that will articulate our collective ambitions and ensure effective safeguarding arrangements through the delivery of three distinct pillars of activity:

1. **Strategic and System Leadership** – working in partnership with other key strategic boards to follow through on clear priorities that improve the safeguarding of children, young people and adults in Manchester.
2. **Effective Assurance** – understanding clearly the strengths and weaknesses of safeguarding practice across all partner agencies. Learning from emerging issues through analysis. Learning from the voices of children and service users, quality audit findings, case review findings and performance data. Using this evidence to hold each partner agency to account for their performance and to improve service delivery.
3. **A Learning System** – systematically engaging frontline practitioners and managers in the effective improvement of practice through learning from quality assurance and case reviews.

1.2 The legislative requirement for change

The Children and Social Work Act 2017 mandates Local Safeguarding Children Boards (LSCBs) to replace their current arrangements with new flexible local safeguarding arrangements. The revised statutory guidance underpinning the Act, Working Together 2018, came into effect on 29 June 2018 and can be read here.

In addition to this, The Care Act 2014 says:

- Each local authority must establish a Safeguarding Adults Board (SAB) for its area.
- The objective of an SAB is to help and protect adults in its area in cases of the kind described in section 42(1).
- The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does.
- An SAB may do anything that appears to be necessary or desirable for the purpose of achieving its objective.

In Manchester we want to use this opportunity to further bring together the children and adult safeguarding arrangements into a single guidance document to ensure a more comprehensive set of arrangements for vulnerable people in our community. A definition of safeguarding is included on page 7 of this document. The Act establishes collective responsibility and accountability of these arrangements across the three chief officers in the Council, the clinical commissioning group (health), and the police.

For Manchester the safeguarding partners are:

- Chief Executive of Manchester City Council
- Chief Superintendent, Greater Manchester Police
- Chief Accountable Officer of Manchester Health and Care Commissioning (Clinical Commissioning Group).

The three safeguarding partners have made arrangements to work together as the Accountability Group with overall responsibility for safeguarding and promoting the welfare of children in the city as well as undertaking their duties under the Care Act 2014. The Accountability Group have agreed to co-ordinate their safeguarding services; they act as a strategic leadership group in supporting and engaging others, and implement local and national learning, including from serious child-safeguarding incidents.

The Manchester Multi-Agency Safeguarding Arrangements (MMASA) will be overseen and implemented through the delegated decision making for the three statutory agencies to represent their organisation. This group will be called the Leadership Board. This group will take decisions, and make commitments on policy, resourcing and practice matters, holding their respective organisation to account on how effectively they participate in and implement the local arrangements. The proposed members of the Leadership Board are:

- Director of Children's Services, Manchester City Council
- Director of Adult Services, Manchester City Council
- Superintendent, Greater Manchester Police
- Medical Director of Manchester Health Care and Commissioning.

1.3 The purpose of these arrangements

The purpose of these local arrangements is to support and enable local organisations and agencies to work together in a system where:

- Vulnerable young people and adults are safeguarded, and their welfare is promoted
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable people in our city
- Organisations and agencies challenge appropriately and hold one another to account
- There is early identification and analysis of any new safeguarding issues and emerging threats
- Learning is promoted and embedded in a way that local services for children, families and vulnerable adults can become more reflective and improve practice
- Information is shared to facilitate more accurate and timely decision-making for children, families and vulnerable adults.

1.4 Strategic partnerships

The Accountability Group will convene an annual meeting with the chair of the Health and Wellbeing Board and the Safer Manchester Partnership Committee to ensure new and emerging safeguarding issues are identified and addressed and to ensure there is no duplication across the system. The Manchester Inter Board Protocol will be used to facilitate good multi-agency working.

1.5 Accountability and leadership

The Leadership Board will meet on a quarterly basis with the delegated senior officers as detailed in section 1.2 above. The Leadership Board have equal and joint responsibility for local safeguarding arrangements. The focus of the Board and constituent members is to identify, challenge, support and resolve cross-cutting themes and issues, thus providing a comprehensive understanding of the safeguarding risks and needs of Manchester's citizens.

In situations that require a clear, single point of leadership, they will decide who will take the lead on issues that arise. If the lead representatives delegate their functions, they remain accountable for any actions or decisions taken on behalf of their agency. The representative or those with delegated authority are expected to:

- Speak with authority for the safeguarding partner they represent
- Take decisions on behalf of their organisation or agency and commit them on policy, resourcing and practice matters
- Hold their own organisation or agency to account on how effectively they participate and implement the local arrangements
- Ensure these arrangements are in alignment with and complements the Greater Manchester arrangements.

Performance management and accountability for adults' and children's safeguarding systems will be through the Children's MMASA and Safeguarding Adult Executive Groups. The objectives of the Executive Groups will be to:

- Lead the implementation of the new Multi-Agency Arrangements – September 2019
- Ensure that Manchester City Council and the Manchester Clinical Commissioning Group implement the new CDOP arrangements – September 2019
- Work with the Youth Council, Children's Board and Corporate Parenting Panel and adult participation groups to provide a robust mechanism to effectively listen to and respond to citizens' needs within the new arrangements
- Identify an independent Scrutiny Partner to develop a Scrutiny Framework and ensure reciprocal independent scrutiny of Manchester and the other areas' arrangements
- Ensure good communication and engagement with key stakeholders around the development and implementation of the new arrangements to other partners
- Deliver on the priorities for scrutiny and focus set by the statutory partners – review on an annual basis
- Ensure production and effective sharing of a business plan and annual report
- Undertake immediate changes to ensure performance-reporting across the city aligns with and complements the Greater Manchester arrangements, and maintain a regular review of performance
- Review these arrangements to maintain ongoing alignment with Greater Manchester protocols.

1.6 Geographical area

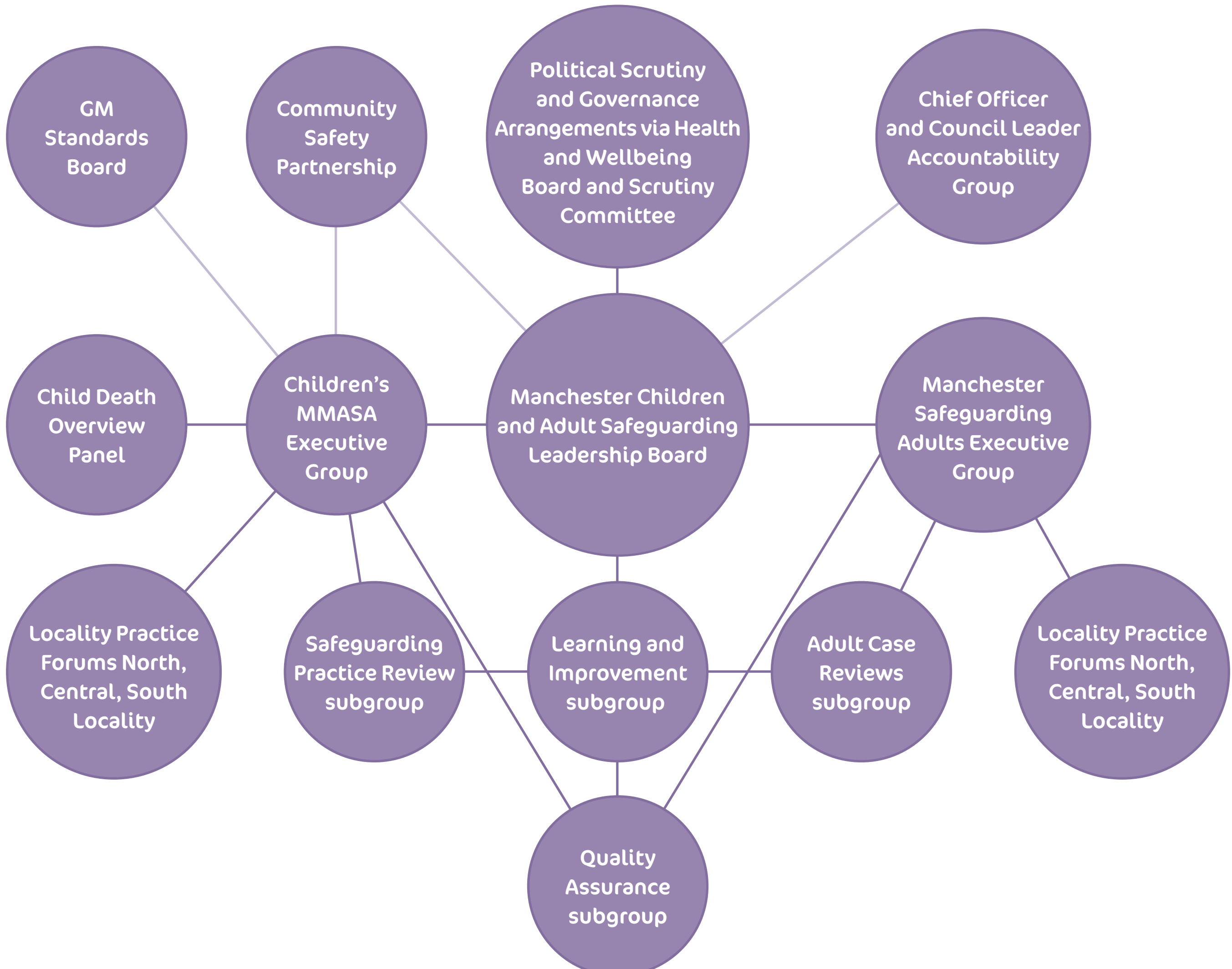
The geographical area covered by the city of Manchester, these arrangements are reflective of and in accordance with the statutory guidance Working Together 2018. It is based on the local authority boundary in accordance with the current arrangements.

1.7 Governance arrangements

The governance arrangements will be built upon the existing safeguarding board arrangements which, while complex, remain fit for purpose. Those arrangements will be subject to an ongoing review to simplify, while allowing for regular reporting to the lead representatives for each of the statutory safeguarding partners as follows:

- The Accountabilities Meeting of the local authority convened by the Chief Executive and Leader of Manchester City Council
- Annual Reporting of MSCA/MSCB/MSAB (Multi-Agency Safeguarding Arrangements) business to the Health and Wellbeing Board and Political Scrutiny Committees
- Manchester Health and Care Commission (CCG) Board
- GMP – Vulnerability Board.

Diagram 1: Structure chart – Manchester's Multi-Agency Safeguarding Arrangements (Children's and Adults')



1.8 Building on strong foundations – Manchester Children and Adult Safeguarding Leadership Board

In order to strengthen partnership working and for strategic leadership to be effective, it is important that we maintain a joined-up approach to safeguarding. Therefore, the Manchester Children and Adult Safeguarding Leadership Board will provide the forum for this integration and 'systems' thinking which will be supported through the MMASA/MSAB support team.

The chair of the group will be the Executive Safeguarding Lead in Manchester CCG, who will be supported by their counter-part in Manchester City Council and Greater Manchester Police.

There is already a strong partnership and co-ordination of strategic boards in Manchester. The new MMASA will ensure that these arrangements will be maintained and will seek to further improve and strengthen the partnership and board co-ordination. It will therefore work to the already established inter-board protocol, which will be amended to reflect the changes in arrangements and for the Manchester Children and Adult Safeguarding Leadership Board to represent the MMASA for both children and adults in Manchester.

Terms of reference for the respective boards, subgroups and forums will be reviewed annually alongside the arrangements; in the interests of continuity it is expected that the chair will be held for a minimum of 12 months. An analysis of the current safeguarding arrangements for children and vulnerable adults has been completed and this has identified some significant strengths that we intend to build on within the new MMASA.

The key strengths in the current arrangements:

- A journey of continuous improvement – recognising the significant improvements that have been achieved in Manchester in recent years
- Serious Case Reviewing – has also been significantly improved and arrangements are now timely and effective
- Safeguarding Adults Reviews – provide the opportunity for learning and improvement of practice; we have an effective Safeguarding Adults Review subgroup that seeks to further develop the response to Safeguarding Adults Review referrals
- CDOP – well managed and effective
- Strategic Join-up – to further develop a strong commitment to a joint safeguarding agenda between children and adults
- There is a clear and strong consensus for change among partners that needs to deliver:
  - A streamlined structure
  - A lower volume of activity that delivers more impact
  - Locality working developing as the means to engage frontline practice effectively
  - Continued partnership between children and adult safeguarding arrangements.

We will also improve our arrangements by:

- Promoting good practice through learning from our reviews and performance management
- Ensuring that our strategic priorities are supported by SMART planning
- Streamlining the governance structure
- Developing our business unit to support evidence impact and improvements in service delivery
- Reviewing our funding arrangements to ensure they are shared evenly by key partners.

1.9 Co-ordination of services and relevant agencies, and designated health roles

The oversight of the co-ordination of services will be through the MMASA structure (see page 17); this comprises key relevant agencies that will work together to safeguard and promote the welfare of children and adults with regard to local need. Relevant partners are listed in Appendix 1; they have been chosen because of their key role in safeguarding children locally. The list of relevant agencies will be reviewed annually.

All relevant agencies are aware of the purpose of these arrangements and expectations; they have been consulted with in their development to make sure they consider each agency's structure and statutory obligations. This includes the obligations for children's services as set out in Working Together 2018 and the obligations for adult services as set out in the Care Act 2014. Consultation has been managed through a number of board workshops and in accordance with the timetable outlined in Appendix 2.

The Safeguarding in the NHS – Accountability and Assurance Framework describes the roles and responsibilities of NHS England, Clinical Commissioning Groups (CCGs), NHS providers and various other bodies in the health system. The framework describes how responsibilities for safeguarding are enshrined in legislation. Some duties apply only to children, some apply only to adults and some apply to both. There are fundamental differences between the legislative framework for safeguarding children and that for adults which stem from who can make certain decisions.

CCGs need to demonstrate that their Designated Clinical Experts (children and adults), are embedded in the clinical decision-making of the organisation, with the authority to work within local health economies to influence local thinking and practice. It is the duty of CCGs as strategic commissioners of local health services to assure that the organisations from which they commission have effective safeguarding arrangements in place.

Therefore, CCGs are responsible for securing the expertise of Designated Professionals on behalf of the whole health economy and this includes seeking overarching assurance of safeguarding and LAC functions. In Manchester this translates as the Safeguarding team within MHCC.

The Designated Professional's role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. Designated Professionals are clinical experts and strategic leaders for safeguarding and as such are a vital source of advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups (QSG), regulators, the MMASA and the Health and Wellbeing Board. For example, they:

- Support CCG representatives to ensure that their professional expertise effectively contributes to the local safeguarding arrangements
- Undertake serious case reviews/case management reviews/significant case reviews on behalf of health commissioners, and quality-assure the health content
- Must be consulted on and able to influence at all points in the commissioning cycle to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children
- Are responsible for providing expert advice for HEE and Local Education and Training Boards to ensure that the principles of safeguarding are integral to education and training curricula for health professionals
- Are expected to give clinical advice, for example in complex cases or where there is dispute between practitioners
- Must have direct access to the Executive (board level) Lead to ensure that there is the right level of influence of safeguarding on the commissioning process
- Provide guidance on identifying adults at risk from different sources and in different situations
- Understand and embed the routes of referral for adults at risk across the health system
- Provide a health advisory role for the Safeguarding Adults Board (SAB), supporting the CCG SAB member
- Take a lead for health in working with the SAB to undertake safeguarding adult reviews and take forward any learning for the health economy
- Support and advise commissioners, including CCGs, NHS England and Population Health and Wellbeing, on adult safeguarding within contracts and commissioned services
- Secure assurance from providers that they have effective safeguarding arrangements in place
- Provide advice for commissioned services on how to improve systems for safeguarding adults.

The CCG Accountable Officer (or other executive level nominee) should meet regularly with the Designated Professional to review child safeguarding.

The designated doctor and designated nurse for Manchester will be members of the safeguarding leadership board to ensure that clinical expertise of designated health professionals is secured.

- **Children – MMASA Executive Group**
  Strategic Leadership for the safeguarding arrangements will be provided by a Children's Safeguarding Executive Group, with the three executive members being the statutory safeguarding partners (see page 17). It is being considered that the chair of the group will be the Statutory Director of Children's Services, who will be supported by their counterparts in GMP and Manchester CCG.
- **Manchester Safeguarding Adults Executive Group**
  Strategic Leadership for the safeguarding arrangements will be provided by the Safeguarding Adults Executive Group (see page 17). It is being considered that the chair of the group will be the Statutory Director of Adult Services, who will be supported by their counterparts in GMP and Manchester CCG.

The terms of reference are reviewed annually alongside the arrangements, and will reflect the core statutory agencies and stakeholders in the safeguarding and promotion of children's and vulnerable adults' welfare; in the interests of continuity it is expected that the chair will be held for a minimum of 12 months.

1.10 Subgroups' general terms of reference

Quality Assurance subgroup

This subgroup will be led by Greater Manchester Police and is responsible for the effectiveness of Multi-Agency Safeguarding Arrangements, as it has the role of providing strategic leaders with a clear line of sight to understand the ways in which vulnerable children and adults are being effectively protected. It will also report on any single agency or partnership practice and actions that are not sufficiently effective.

The subgroup will assimilate information from the full range of sources, supported by the safeguarding team to ensure the best possible analytical product for strategic leads. The key sources of information will include:

- Key Performance Indicators from all agencies
- Quality Assurance/Audit findings – both single agency and multi-agency
- Feedback from children, young people and families
- Feedback from other strategic boards (Community Safety, Health and Wellbeing and Children's Board)
- Annual s156/s11 Audit activity/review process
- Adult services Annual Assurance Statement.

Children's Safeguarding Practice Review Panel subgroup

Manchester's safeguarding partners must learn and improve from the evidence presented from serious child safeguarding incidents. This group will be led by the CCG.

The duty to notify the National Safeguarding Practice Review Panel sits with the local authority and must be completed within five days of the incident. However, through Manchester's Safeguarding Practice Review subgroup, consideration will be given to all serious child-safeguarding incidents. They will make recommendations to the safeguarding partners, initiating Serious Incident/ Safeguarding reviews, and overseeing the commissioning and quality of local child safeguarding practice/learning reviews.

This subgroup will progress the decisions, recommendations and notifications to the National Panel and act upon decisions on whether to carry out a local child-safeguarding practice review. They will also consider any learning that is identified within adult safeguarding and Domestic Homicide Reviews.

It is important to note the shift in the statutory guidance that gives more discretion for local decisions on when a review should be carried out. [Working Together 4.17: "Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice."

The core purpose of carrying out child safeguarding practice is to determine lessons for improvement and to ensure that those lessons are then effectively learned and acted upon by frontline practitioners.

Safeguarding Case Review subgroup (Adults)

The Safeguarding Case Review subgroup (Adults) will be led by the CCG and will undertake the review of Safeguarding Adults Review referrals and make a decision in regard to whether a formal review or other learning exercise is required. The aim is to ensure that lessons are learned, and practice is developed in the multi-agency partnership. Practice lessons and strategic themes that are learnt from the review of adult cases will be reported through the Manchester Safeguarding Adult Executive Group and Leadership and Improvement Subgroup.

Leadership and Improvement subgroup

This subgroup will take the learning from the Quality Assurance and Case Review subgroups for both the Children's and Adults' services, determining the plans and arrangements for effective action to deliver learning and improvement, whether in respect of events/courses, policies, processes and procedures or practice issues.

The work of the subgroup will be enhanced by the development of a Learning Hub approach. This is an innovation seen in some of the 'Early Adopters', which brings the resources of the safeguarding team and core partners together in a shared and systematic programme of work to clarify and simplify the key areas for improvement. It also directly links this to a programme of learning that genuinely engages and changes the behaviour of frontline practitioners and managers. The Leadership and Improvement subgroup will also be responsible for determining what multi-agency training is needed for partner agencies in Manchester, and for monitoring and evaluating the effectiveness of all commissioned training.

Children's Locality Forum/ Adult Safeguarding Practice Forums – North, Central and South

The Locality Children/Adult Safeguarding Practice Forums will be the principal place in which core operational services and partners are engaged in the safeguarding children agenda and work programme. Together they will deliver the learning from serious incidents and reviews.

The MMASA Executive Group will set the priorities and focus for these groups in order to make a difference for children, young people and vulnerable adults in Manchester. They will consider how the learning and improvement is put into practice. They will also ensure new issues or trends are systematically identified and communicated to strategic leaders. The Locality Children/Adult Safeguarding Practice Forums will also provide the means to engage the wider community in safeguarding activity, including through awareness raising campaigns and more targeted strategies to protect children and adults.

Chairs of the associated subgroups and locality forums will be contributors to the core membership to ensure a clear line of sight and engagement between strategic leaders and frontline practitioners. In addition, it is envisaged this arrangement will support the work of the MMASA for children through joint accountability for the work of each subgroup and forum. Subgroups and task and finish groups will be required and these may include the use of independent facilitators to encourage open and objective discussion, debate and embed learning/working together.

1.11 How schools, colleges and other education providers will be included

Schools, colleges and other education providers have a pivotal role to play in safeguarding children and promoting their welfare. These include academies, independent and private schools, as well as those that remain the responsibility of the local authority.

Representatives from the primary, secondary and special school sectors will be invited to be members of the Children's MMASA Executive Group. In addition, a termly newsletter will be sent to all schools, colleges and other education providers to promote good safeguarding practice and ensure engagement and inclusion in the new safeguarding arrangements.

All schools and settings complete an annual S156 or S175 self-assessment, which is reported to the MMASA to ensure that good safeguarding arrangements are in place within all education settings in the city.

1.12 Information-sharing and information requests

All relevant agencies have signed up to the multi-agency Information Sharing Protocol. All agencies will provide information that enables and assists the Executive Group to perform its functions to safeguard and promote the welfare of children in Manchester, including that related to local and national child-safeguarding reviews and child death reviews.

In accordance with Working Together (DfE 2018) the safeguarding partners may take legal action against an organisation or person that does not comply with such a request and will act in accordance with the guidance provided by the Information Commissioner's Office when issuing and responding to requests for information.

1.13 Independent scrutiny

Working Together (DfE 2018) states the MMASA must have independent scrutiny of its arrangements and functions. This is to provide assurance in judging the effectiveness of Multi-Agency Arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child-safeguarding cases.

Therefore, safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend, and promotes reflection to drive continual improvement. The independent scrutineer should consider how effectively the arrangements are working for children, families and practitioners, how well the safeguarding partners are providing strong leadership, and agree with the safeguarding partners how this will be reported.

The newly forming Greater Manchester Safeguarding Standards Board will offer independent peer challenge/review as part of the terms of reference approved by the Greater Manchester Children's Board.

Manchester Children and Adult Safeguarding Leadership Board – the reporting/scrutiny arrangements will be aligned with the current arrangements for the MSAB.

In addition, an independent scrutineer will be commissioned to provide an annual scrutiny role and production of an annual report. This will be achieved over a determined number of days each year and scrutinise the arrangements with a strong emphasis upon reporting on the difference that the MMASA are making to children, young people and vulnerable adults. This report will be shared and presented in accordance with the existing chief officer and political scrutiny arrangements.

An evaluation of these independent scrutiny arrangements will be included in the MMASA annual report, and any changes to the plans will be recommended on at least an annual basis.

1.14 Funding

Resource and funding contributions from relevant agencies are included in Appendix 3 and will be overseen by the Accountability Group and the Executive Groups to ensure they are equitable and proportionate. Costs incurred by the MMASA include training and development, administration of board business, and local safeguarding practice reviews. They do not include the commissioning or delivery of services, which is outside the remit of these arrangements.

1.15 Dispute resolution

The Executive Group and relevant agencies will work together to resolve any disputes locally and will follow the guidance as outlined in the Manchester Inter Board Protocol. Public bodies that fail to comply with their obligations under law are held to account through a variety of regulatory and inspection activities.

Although not anticipated, issues of difference/ concern cannot be resolved by the Executive Group; issues/challenges will be shared with and considered by the Accountable Group. In the event a resolution is not achieved, the independent scrutineer would be invited to discuss and resolve the issue. Ultimately, should a dispute still not be resolved, the statutory guidance should be followed; this makes provision for any non-compliance to be referred to the Secretary of State.

1.16 Reporting and implementing local and national learning

The Executive Group will publish an annual report on the MMASA website outlining what they have done as a result of the arrangements, including child safeguarding practice reviews and how effective Manchester's arrangements have been in practice.

The report will also include:

- A summary of safeguarding activity undertaken by the partners within the MMASA
- A summary of key learning, training and service improvement over the previous 12 months
- Evidence of the impact of the work to improve the outcomes for vulnerable children, young people and vulnerable adults
- An analysis of any areas where there has been little or no evidence of progress on agreed priorities
- A record of decisions and actions taken by partners in the report period to implement the recommendations of any local and national child-safeguarding practice reviews, including any resulting improvements
- Ways in which partners have sought and utilised feedback from service users to inform their work and influence service provision
- Any updates to the published arrangements, including reviewing the list of relevant partners and the proposed timescale for implementation
- The effectiveness of the arrangements for independent scrutiny.

The report will also be sent to the Child Safeguarding Practice Review Panel and What Works Centre for Children's Social Care within seven days of being published. An Annual Business Plan will also be produced outlining key priorities and actions for the next year.

The Executive Group will hold an annual safeguarding conference and two learning events per year to promote key local and national themes and emerging issues in relation to safeguarding. They will also ensure that multi-agency training is delivered across the children's workforce in Manchester.

Section 2:
Arrangements for commissioning and publishing child-safeguarding practice reviews

2.1 Purpose

The purpose of child-safeguarding practice reviews at both local and national level is to identify improvements to be made to safeguard and promote the welfare of children.

2.2 Responsibility

Responsibility for learning lessons from serious incidents lies at a national level with the Child Safeguarding Practice Review Panel (National Panel) and with the Executive Group in Manchester implemented through the key statutory partners within the MMASA. The National Panel will maintain oversight of the system of national and local reviews and judge how effectively it is operating.

2.3 Serious harm and notifications

Section 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

'Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

1. The child dies or is seriously harmed in the local authority's care, or
2. While normally resident in the local authority's area, the child dies or is seriously harmed outside England.'

The notification must be made by the local authority within five days of becoming aware of the incident. The local authority should also report this to the Children's Safeguarding Practice Review Panel subgroup. The local authority must also notify the Secretary of State and Ofsted when a looked-after child dies, whether or not abuse or neglect is suspected.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgement should be exercised in cases where impairment is likely to be long term, even if this is not immediately certain.

Any notification of an incident referred to the Panel will also be referred to the Learning and Improvement subgroup for a local decision on whether the case:

- Meets the criteria for a Child Safeguarding Practice Review
- May raise issues that are complex or of national importance.

2.4 Decisions regarding local child-safeguarding practice reviews

The criteria below will be used by the Children's Safeguarding Practice Review Panel subgroup to determine whether a local child safeguarding practice review needs to be carried out.

The criteria will consider whether the case:

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- Is one in which the Children's Safeguarding Practice Review Panel Subgroup and concluded a local review may be more appropriate.

Further criteria cover concern about the actions of one agency, the lack of any agency information, cases that involve a number of authorities where families have moved around, and concern about the welfare of children in institutional settings.

Recommendations on whether to undertake reviews will be made by the Children's Safeguarding Practice Review Panel subgroup and the final decision rests with the Executive Group.

Child safeguarding practice reviews will be a standing item at the Executive Group's quarterly meetings. If it is considered that the case raises issues that are of national importance, then the Executive Group will be informed in between the quarterly meetings. Decisions will be made transparently, and the rationale communicated appropriately, including to families.

2.5 The rapid review

When a serious incident becomes known to the MMASA, the Children's Safeguarding Practice Review Panel Subgroup will promptly undertake a rapid review of the case (see Appendix 4 for our definition of serious incident). According to the guidance, the MMASA should report the outcome to the National Panel within 15 working days.

The aim of the review is to enable the MMASA to:

- Gather the facts about the case, as far as they can be readily established at the time
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- Consider the potential for identifying improvements to safeguard and promote the welfare of children
- Decide what steps we should take next, including whether to commission a child-safeguarding practice review.

As soon as the rapid review is complete, the MMASA will:

- Send a copy to the Learning and Improvement subgroup setting out the case for the decision made
- Share with the Learning and Improvement subgroup any thoughts we have had on whether the case may raise issues that are complex or of national importance such that a national review may be appropriate, and on whether we plan to carry out a child-safeguarding practice review
- Make sure that the Executive Group, the Department for Education and Ofsted are aware of the decision to initiate/publish child-safeguarding practice reviews.

If the Panel does decide to undertake a national child-safeguarding practice review, the MMASA will take this into account when making a final decision on whether to undertake a local child-safeguarding practice review of any case covered by a national review.

2.6 National Panel responsibilities for national reviews

The National Panel is responsible for identifying and overseeing the review of serious child-safeguarding cases that, in its view, raise issues that are complex or of national importance. The National Panel will consider if the case could highlight improvements, lead to legislative changes, or highlight recurrent themes; consideration will also be given to children not educated in school. Due regard will be given to children who die while in local authority care, subject to a Child Protection Plan, and for cases that involve a range of types of abuse or cover issues relating to the welfare of children in institutional settings.

The National Panel will consider evidence from inspection reports (Ofsted, Her Majesty's Inspection of the Constabulary, Care Quality Commission, Joint Targeted Inspections, Ofsted thematic reviews).

If the Panel does determine to do a national review, the MMASA and families will be contacted promptly.

2.7 Local reviews

On behalf of the Executive Group, the Children's Safeguarding Practice Review Panel subgroup will take responsibility for commissioning and supervising reviewers for local reviews. In each case the Children's Safeguarding Practice Review Panel subgroup will take into account whether the reviewer has the appropriate:

- Professional knowledge
- Understanding of relevant research
- Recognition of the complex circumstance in which practitioners work together
- Understanding of practice at the time rather than using hindsight
- Effective communication skills.

The subgroup will also take into account any conflict of interest.

The Children's Safeguarding Practice Review Panel subgroup will determine the methodology and ensure that the review is proportionate and focuses on learning. The subgroup will also take responsibility for overseeing the quality of the review, ensuring that practitioners are fully involved and that families have the opportunity to contribute. The President of the Family Division's guidance (May 2017) covering the role of the judiciary in serious case reviews will also be noted. https://www.judiciary.uk/publications/presidents-guidance-judicial-cooperation-with-serious-case-reviews/

The final report will include a summary of recommended improvements and an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report. In addition, for surviving children a 'later-life' letter explaining the review and its findings and learning will be produced by the reviewer on behalf of the Executive Group. This will be put in the safe care of the child's non-abusive parent/carer, for all children who are subject to a review.

Published reports will be available on the MMASA website for at least one year. In preparation for publication the MMASA will carefully consider how best to manage the impact of publication on children, family members, practitioners and those closely affected by the case. A copy of the full report will be sent to the National Panel, Ofsted and the Secretary of State for Education no later than seven working days before the date of publication. Where the safeguarding partners decide only to publish information relating to improvements to be made these will also be submitted within seven working days.

The report should be completed and published no later than six months from the date of the decision to initiate the review. Where other proceedings may have an impact on or delay publication, the Independent Chair will inform the National Panel and the Secretary of State of the reasons for the delay. The justification for any decision not to publish the full report will be communicated to the Panel and the Secretary of State. Learning will be disseminated, and corrective action will be taken at the earliest point, and not wait until publication or completion of the review.

2.8 National reviews

There is further guidance about how the National Panel should approach, complete and publish national reviews on page 87 of Working Together (DfE 2018).

Section 3:
Arrangements for Child Death and Safeguarding Adult Reviews

3.1 Context and statutory information

Child death review partners consist of local authorities and clinical commissioning groups.

The child death review partners will be:

- Chief Executive for Manchester City Council
- Accountable Officer, Clinical Commissioning Group for Manchester.

The designated doctors for child deaths are:

- Designated Doctor for Child Death, Manchester University Hospitals.

The purpose of the review and analysis is to identify any matters relating to the death that are relevant to the welfare of children in the area or to public health and safety and to consider what action should be taken. There is also a requirement to ensure that co-ordinated care and support of the family and community is prioritised.

3.2 Responsibilities of child death review partners

In line with statutory requirements the child death review partners for the city of Manchester have agreed the following:

- A structure and process to review all child deaths of children normally resident in the area and if appropriate and agreed by the partners, the deaths of children not normally resident in the area but who have died here (see 3.4 below)
- The arrangements will include analysis of information from all deaths reviewed
- We will prepare and publish reports on what we have done as a result of the child death review arrangements in our area and how effective these arrangements have been in practice
- Funding will be through the Clinical Commissioning Group (see Appendix 3)
- The core representation of the panel structures will include public health, Sudden Unexpected Death in Childhood Lead for Greater Manchester, children's social care, Greater Manchester Police, the designated doctor/nurse for safeguarding, GP/health visitor, nursing/midwifery, lay representative, and any others relevant to the local area
- The geographical area will be Manchester City Council boundaries. This takes into account networks of NHS care and organisational boundaries, and reflects the integrated care and social networks in the area. Manchester has an average number of child death notifications of 61.4 per year, which exceeds the required minimum of 60 deaths in an area covering the child death review arrangements
- The designated doctor for child deaths is notified of each child death and is sent relevant information by the Child Death Overview Panel (CDOP)
- The child death review arrangements will be reviewed after a year in operation.

3.3 Responsibilities of other organisations and agencies

All local organisations or individual practitioners that have had involvement in the case will co-operate in the child death review process and will have regard for the guidance issued. Specific responsibilities for registrars and coroners, including timescales for notifications, are outlined in the statutory guidance.

3.4 Responding to the death of a child: the child death review

Immediate decision-making and notifications, and investigation and information-gathering

Practitioners will work together to respond in a thorough, sensitive and supportive manner.

The aims of the response are to:

- Establish, as far as possible, the cause of the child's death
- Identify any modifiable contributory factors
- Improve ongoing support to the family by identifying a key worker who would be the single, named point of contact and provide a leaflet to help understand the child death review process (see Appendix 5)
- Learn lessons to reduce risks to other children
- Ensure that all statutory obligations are met
- Identify whether the death meets the criteria for a Joint Agency Response (page 100 of Working Together (DfE 2018))
- Identify whether a Medical Certificate of Cause of Death can be issued, or whether a referral to the coroner is required
- Identify whether the death meets the criteria for a serious incident investigation from any agency.

As an immediate response, relevant practitioners in all agencies will notify the Manchester CDOP administrator of the death of a child using 'the child death notification form' (formerly Form A). Child Health notify the CDOP of all the deaths of children normally resident in Manchester.

Allied to the child death review process, if there is a criminal investigation, the police are responsible for collecting and collating all relevant information and practitioners should consult the lead police investigator and Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings.

If the results of any investigations suggest evidence of abuse or neglect as a possible cause of death, the paediatrician will inform the CDOP, the MMASA Business Manager and the National Panel immediately.

Child death review meeting

Every child's death should be discussed at a hospital child death review meeting (CDRM). This is a multi-agency professional meeting that takes place prior to the CDOP and involves practitioners who were directly involved in the care of the child and the investigation into their death and should not be limited to medical staff. A draft child death analysis form will be completed by the CDRM and forwarded to the CDOP.

For unexpected deaths, current arrangements will continue with some minor adjustments to the process. For expected deaths, existing relevant health-led meetings will be expanded to ensure wider information is available and to include other agencies who may have had an involvement. Responsibility for convening the meetings will not change.

Child Death Overview Panel (CDOP)

This multi-agency panel at a senior level is the final, independent scrutiny of a child's death by professionals with no responsibility for the child during their life. The panel will meet on a quarterly basis. At this meeting the consolidated child death review form will be considered, and the child death analysis form will be finalised and signed off. Manchester City Council will continue to convene the CDOP for the area to review the death of all children normally resident in their area and also where appropriate, the deaths of non-resident children. The panel will also identify modifiable factors that could be altered to prevent future deaths.

Thematic child death review panel

The thematic panel will meet three times a year. These meetings involve professionals who have had no involvement in the cases under discussion and who can identify thematic system changes in order to learn lessons for the prevention of future child deaths. This panel will be chaired by Population Health and Wellbeing.

Safeguarding Adult Review

The Care Act 2014 requires that a Safeguarding Adult Review (SAR) is carried out when the following criteria are met:

- There is reasonable cause for concern about how MSAB members or other agencies providing services, worked together to safeguard an adult.
- The adult has died, and the MSAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); or, the adult is still alive, and the MSAB knows or suspects that the adult has experienced serious abuse or neglect.

In these cases the review will be overseen by the Manchester Safeguarding Adult Executive Group, which will ensure that the review meets the statutory and practice standards.

3.5 Publishing a report

Child and adult death review partners will publish an annual report that will form part of the MMASA Annual Report. In addition, an annual CDOP report will be produced as an appendix, providing an analysis and learning. The report will include:

- Local patterns and trends in child and adult deaths
- Any lessons learnt and actions taken
- The effectiveness of the wider child death review process and safeguarding adult death review process and any revisions to be made to the process.

Appendix 1: **Relevant agencies**

Manchester City Council

- Chief Executive
- Director of Children's Services
- Deputy Director Children's Social Care
- Deputy Director Safeguarding
- Deputy Director for Education
- Director Adult Social Care
- Deputy Director Adult Social Care
- Director for Neighbourhoods
- Principal Solicitor
- Executive Member for Children and Schools
- Executive Member for Adults, Health and Wellbeing
- Director of Population Health.

Greater Manchester Fire and Rescue Service

- Assistant Chief Fire and Rescue Service.

Greater Manchester Police

- Nominated Local Police Area Commander
- Detective Chief Inspector, Protecting Vulnerable People/Community Safety.

Manchester Health and Care Commissioning (Clinical Commissioning Group)

- Chief Accountable Officer
- Medical Director
- Deputy Director – Nursing and Safeguarding
- Designated Doctors and Nurses.

Manchester University NHS Foundation Trust

- Chief Executive
- Chief Nurse
- Safeguarding Leads.

Pennine Acute Hospitals NHS Trust

- Chief Executive
- Chief Nurse
- Safeguarding Leads.

Greater Manchester Mental Health NHS Foundation Trust

- Chief Executive
- Director of Nursing and Governance
- Safeguarding Leads.

National Probation Service

- Senior Operational Support Manager.

School representatives

- Head teacher representatives from:
  - Secondary school sector
  - Primary school sector
  - Special school sector
  - Further education sector.

Cafcass

- Senior Service Manager.

Housing representative

- Two voluntary sector representatives
- Two lay members.

Please note: Other agencies, community groups, professional experts and specific stakeholders may be invited to join various working groups as determined by the Leadership Board and Executive Groups.

Co-operative relationships between all boards are supported by the Manchester Inter Board Protocol

Appendix 2:
Timetable for agreement of the arrangements

December 2018

- Executive Board: review of proposals.

January 2019

- Joint Children and Adults Safeguarding Board and Executive subgroup workshop to consider Manchester's MMASA arrangements.

February 2019

- Children and Young Peoples Scrutiny Committee.

June 2019

- Elected Member consultation – review detailed proposals for child and adult safeguarding arrangements
- Manchester Health and Care Commissioning (Clinical Commissioning Group) Board
- Manchester Child Death Overview Panel: review detailed proposals for child death review processes
- Communications cascade to confirm Manchester MMASA
- Publish and launch new arrangements.

Appendix 3: **Current funding arrangements for review – funding streams**

Contributions

Manchester City Council Dedicated Schools grant	–£71,000
Manchester CCG	–£105,000
Greater Manchester Police	–£63,732
National Probation Service	–£4,000
Manchester City Council	–£421,279
Cafcass	–£550
Manchester City Council – Housing	–£9,450
Total income	**–£675,011**

Expenditure

Independent Chair	£40,000
Business unit	£423,386
Communications	£86,625
Training and learning	£2,000
Subgroups	£30,000
All case reviews	£93,000
Total	**£675,011**

Appendix 4: **Definition of serious incident**

Child Safeguarding Incident Notification System

A notification to the Child Safeguarding Practice Review Panel (National Panel) should be made if it's known or suspected that a child has been abused or neglected.

Manchester City Council and/or MMASA board should do this, in certain circumstances, if:

- A looked-after child dies, including where abuse or neglect is not known or suspected
- A child dies or is seriously harmed in the local authority's area
- A child dies or is seriously harmed outside England while normally resident in the local authority's area.

The notification must be made within five working days of becoming aware of the incident.

The Panel will share all notifications with:

- The Department for Education
- Ofsted.

Appendix 5: **Key worker role for child death reviews**

Supporting and engaging a family that has lost a child is of prime importance throughout the whole child death review process. Recognising the complexity of the process, and the state of total shock that bereavement can bring, families should be given a single named point of contact (key worker) they can turn to for information on the processes following their child's death, and who can signpost them to sources of support. In addition, families should be provided with a leaflet for parents, families and carers to help understand and navigate the child death review process. The introduction of the role of key worker will involve additional resources from a range of services. In the majority of cases this will be from a health team.

The arrangements within this document will be subject to an annual review.