# Merton Safeguarding Children Board

## Constitution

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Author</th>
<th>Date of the Next Review</th>
<th>Lead officer</th>
</tr>
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<tr>
<td>March 2015</td>
<td>Paul Bailey</td>
<td>March 2019</td>
<td>MSCB Chair</td>
</tr>
<tr>
<td>Version 2</td>
<td>MSCB Board Manager</td>
<td></td>
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<tr>
<td>Revised June 2017</td>
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Merton Safeguarding Children Board

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1. **Statutory Context**

The Children and Social Work Act 2017 received royal assent on 27th April 2017. This Act reframed the approach to local safeguarding by giving three key partners – the local authority health services, and the Police – greater autonomy to define the approach to be taken locally. We are awaiting Regulations. The arrangements outlined in this refresh of the Merton Safeguarding Children Board are therefore provisional until the statutory regulations and guidance for partnership arrangements are published.

1.1 Merton Safeguarding Children Board (MSCB) is the Local Safeguarding Children Board for Merton.

1.2 Local Safeguarding Children Boards (LSCB) have a range of roles and statutory functions.

1.3 Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board for their area and specifies the organisations and individuals (other than the local authority) that the Secretary of State may prescribe in regulations that should be represented on LSCBs.

1.4 Children Act 2004 Section 14 sets out the objectives of LSCBs, which are:

   (a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

   (b) to ensure the effectiveness of what is done by each such person or body for those purposes.

1.5 The LSCB is not an operational body and has no direct responsibility for the provision of services to children, families or adults. Its responsibilities are strategic planning, coordination, advisory, policy, guidance, setting of standards and monitoring. It can commission multi-agency training but is not required to do so.

1.6 The delivery of services to children, families and adults is the responsibility of the commissioning and provider agencies, the **Partners**, not the LSCB itself.

1.7 Regulation 5 of the **Local Safeguarding Children Boards Regulations 2006** sets out LSCB duties as:

5.1 (a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

   (i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

   (ii) training of persons who work with children or in services affecting the safety and welfare of children;

   (iii) recruitment and supervision of persons who work with children;

   (iv) investigation of allegations concerning persons who work with children;

   (v) safety and welfare of children who are privately fostered;
5.1 (b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

5.1 (c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve (See Appendix 1)

5.1 (d) participating in the planning of services for children

1.8 Regulation 5 (2) relates to the LSCB Serious Case Reviews function and regulation 6 relates to the LSCB Child Death functions.

1.9 Regulation 5 (3) offers that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

1.10 These duties are further clarified in the statutory guidance: *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, 2015* (WT 2015)

1.11 LSCB duties are specified in WT 2015, Chapters 3, 4 and 5, with a responsibility to have oversight of single agency and multi-agency safeguarding and promotion of children’s welfare (under Children Act 2004, section 11) as set out in WT chapters 1 and 2. See appendix for clarification for Agency responsibilities under section 11)

2. **Key Principles**

The key principles of the MSCB and its Sub Groups are:

2.1 To promote up-to-date knowledge of safeguarding and high standards of practice in responding to need for children and young people in Merton; focusing on good and safe outcomes.

2.2 To co-ordinate and monitor the effectiveness of agency, multi-agency and the Board’s own work to safeguard and promote the welfare of children.

2.3 To seek to communicate with and listen to children and young people and ensure that in monitoring agency and the Board’s work to ensure that the voices of children and young people are considered. Where possible and appropriate to involve young people in the work of the Board.

2.4 To seek to consult front-line practitioners and their line-managers in the work of the Board through providing information regularly and seeking feedback.

2.5 To seek to understand and respect the local community and its diversity, and to share information and seek views, where possible.

2.6 To work with the ethics, behaviour and values of public services (The Nolan Principles) https://www.gov.uk/government/organisations/the-committee-on-standards-in-public-life
3. **MSCB - Structure and Governance**

The Structure is set out in Appendix 2

3.1 To meet these statutory requirements the MSCB has agreed the following structure and governance arrangements.

3.2 The MSCB will have an **Independent Chair** who has significant experience at a senior level in the strategic co-ordination of multi-agency services to safeguard and promote the welfare of children. The Chair will be accountable to the Local Authority Chief Executive and will work closely with the Director of Children, Schools and Families who holds statutory responsibilities for the co-ordination of multi-agency working to support and safeguard children.

3.3 A **Vice Chair** will be agreed from within the MSCB Statutory Membership and confirmed at the Annual Business Planning Meeting. The Vice Chair role should not be taken by Children, Schools and families or the CCG, or the Council Lead Member.

3.4 Business will be conducted through the MSCB (‘Main Board’) which holds the statutory responsibilities & duties; the MSCB will have ultimate accountability for ensuring that the responsibilities are achieved. Business will be conducted through MSCB meetings, Sub Groups, correspondence and exchange of information between meetings.

3.5 The MSCB will prioritise and organise its work through the Annual Business Plan; and regular monitoring of the Plan and Risk and Challenge Registers.

3.6 The MSCB will agree Sub Group Terms of Reference and Sub Group Annual Work Plans and monitor their progress by receiving reports from the Sub Group Chairs on an agreed cycle of reporting; with exception reporting as required. (See Annual Planning Cycle)

3.7 The MSCB will hold the overall responsibility for the overview of the quality of multi-agency safeguarding work and agency performance.

3.8 On behalf of the Main Board the **Business Implementation Group** will co-ordinate, prioritise actions and ensure the coverage of statutory functions & business plan by ensuring governance and connectivity across the Sub Groups and task groups.

3.9 The Business Implementation Group will enable commissioning agencies to secure and plan delivery of the total work programme. It will contribute to Board and agency self-evaluation and to challenge and improvement priorities.

3.10 The Business Implementation Group will report to and be accountable to the MSCB.

3.11 **Sub Groups** and Short Term **Task and Finish Groups** will be commissioned by the MSCB with agreed Terms of Reference and Work Plans and will be given delegated responsibility to act on the MSCB’s behalf to progress the agreed Business objectives. There should be multi-agency leadership and chairing of such working groups. (See Appendix Two - Structure)
3.12 The MSCB will liaise with and receive relevant reports from other local Strategic Partnerships, such as the Health and Well-Being Board. At times it will be appropriate to agree joint work with such partnerships.

4. Accountabilities

4.1 The Chief Executive is responsible for appointing (or dismissing) the MSCB Chair, with advice of a panel of MSCB members (including lay members). The Chief Executive will meet with the MSCB Chair at last three times per year to review the MSCB’s work.

4.2 The Chair will have executive authority to make decisions on behalf of the MSCB between meetings, consulting key Partners as appropriate. The Chair will report on any such decisions to the Board no later than the next meeting of the Board or in writing.

4.3 The Chair has the personal responsibility to decide whether a Serious Case Review (SCR) is required (WT 2015 Chapter 4) and in so doing will consult with the key agencies and professionals involved, including the Designated Doctor, the Designated Nurse and the Principal Social Worker. The Chair will agree if any other form of Learning and Improvement Review (LIR) is required instead of a SCR. For any such SCR or LIR the MSCB Chair will endorse the agreed terms of reference, the use of any independent reviewer/author and whether a Case Review Group will be established to manage the review process. The MSCB Chairs hold accountability for communication with the National Panel of Independent Experts in SCRs about decision-making in relation to SCRs and LIRs. (See Appendix Six – Critical Incidents, SCRs and Learning Improvement Reviews)

4.4 The Vice Chair may take executive action in an emergency or in the longer term absence of the MSCB Chair in consultation with the Director of Children, Schools and Families and at least one other Commissioning Partner, excluding their own agency.

4.5 The MSCB is accountable to its member agencies and to the local community for its work. This accountability will be demonstrated through the MSCB Annual Report, through which the MSCB will evaluate the effectiveness of its own work, as well as that of the local multi-agency partnership. The Annual Report will be shared with the Chief Executive of Merton Council and with the Health and Well-Being Board. It will also be published on the MSCB website. (See Appendix 7 Measuring effectiveness)

4.6 The MSCB is accountable to the Children and Young People of Merton. We will work with the CSF Participation Manager and the LAC and Permanency Manager to ensure meaningful participation, consultation and accountability with young people

4.7 The MSCB will work within and will comply with statutory guidance and limitations.

4.8 Partners will be accountable to the MSCB by ensuring appropriate representation and attendance on the MSCB, the Business Implementation Group or Sub Groups, as agreed.

4.9 Partners will respond to information requests from the MSCB in relation to data, commentary, evaluation, planning, performance and resources in order to assist the MSCB in the completion of its objectives. Such data will be governed by any limitations of the Data Protection Act. An LSCB can require a person or body to comply with a request for information under section 14A of the Children Act 2004 (Amended 2010).

4.10 Where Partner Agencies are asked for information or consulted on MSCB business or draft documents between meetings it is expected that agencies will make a definite
response and not assume that no response means agreement. Where an agency does not respond to such a request this will be raised at the following MSCB meeting. The MSCB needs confirmation of agreement and sign up to MSCB Business.

4.11 Where consensus cannot be achieved and there is a requirement for a vote, only one Member per agency may vote. The Lead Member, Advisors and Business Support Officers may not vote. Sub Group Chairs should not vote unless they are also representing their Agency or Sector. (See Membership section for clarification of roles)

4.12 The MSCB will be quorate if at least five separate statutory agencies are present, split between commissioners and providers.

4.13 The Business Implementation Group will be quorate if CSF, CCG, Police and one other agency representative are present.

5. Membership

5.1 The MSCB will comprise statutory members as set out in WT2015 (p68) and co-opted members. (See Appendix Three – Membership)

5.2 Members from Partner agencies must be sufficiently senior and delegated to speak, make decisions and commit resources on their agencies’ behalf.

5.3 Members who represent their sector rather than a single agency, e.g. Head Teachers and Voluntary Sector representatives, cannot speak on behalf of any other single agency apart from their own. They are expected to give a generic view for their sector. They are not expected to canvass the views of their sector. It is expected that they will link with their counterparts through relevant forums, etc.

5.4 For the MSCB to work effectively there must be commitment, consistency and continuity in membership. The role of the Member must be to contribute actively to the work of the MSCB, provide constructive support and challenge, and act as a ‘critical friend’ to partner agencies in the monitoring of their safeguarding responsibilities.

5.5 Members will be expected to attend the meetings and are required to respond to communications between meetings.

5.6 Each Partner Agency should nominate a standing deputy to represent the Member in her/his absence. The deputy will hold the same authority on their Agency’s behalf. A deputy should be briefed in advance on the Agency’s perspective concerning issues on the Agenda and should not overturn an agency view expressed by the substantive Member in a previous meeting, without confirmation from the substantive Member in writing that there has been such a change of Agency perspective.

5.7 Members who represent a sector will be covered in their absence by other members from that sector and so do not require a deputy – e.g. head teachers, voluntary sector.

5.8 Where a Member does not attend two consecutive meetings this absence will be reviewed with them on behalf of the MSCB Chair, by the MSCB Manager, and after this may be added to the MSCB Risk Register.

5.9 Partner Agencies are expected to ensure appropriate membership and commitment to the Sub Groups and Task and Finish Groups, according to the membership agreed in their terms of reference.
6. **Business Planning and Meetings Annual Cycle**   (See Appendix Four)

6.1 The Board will have a rolling 24-month Business Plan, to be refreshed each March for the business year starting April. Priority items can be added within the year.

6.2 The MSCB will meet three times per year in half-day business meetings; and in a Business Planning Away Day once per year, in March.

6.3 The Business Implementation Group will meet four times per year.

6.4 The progress of the actions agreed in the Business Plan will be reviewed at each meeting.

6.5 A series of Agency Quality Assurance and Challenge Peer Review Meetings (Section 11) will be held each May/June to scrutinise Agency Safeguarding. Evaluations from these meetings will be fed into the Annual Report.

6.6 Each Sub Group will have an agreed Work Plan. An annual reporting schedule will be agreed for Sub Group reporting to the MSCB.

7. **Resources**

7.1 The MSCB will have a shared budget to further its objectives. Partner agencies will agree contributions each autumn for the following business year.

7.2 The cost of any serious case review will be borne by additional subscription from the key lead commissioning agencies who have been involved in the case (mainly Children, Schools and Families and the CCG as the lead service commissioners). The outline costs of the commissioning of the review, independent author/s, legal advice, media work will be estimated as part of the planning of the SCR and apportioned according to agency/sector involvement in the case. The cost of dissemination of lessons will be borne as part of the MSCB Training Budget.

7.3 Partner agencies will bear the costs of the attendance and contribution of their representatives and will ensure that sufficient time is given to Members to attend meetings and undertake the work of the Board.

7.4 Partner agencies will take responsibility for chairing the range of Sub Groups to ensure that there is leadership across several disciplines.

7.5 The MSCB will be supported by a Business Manager, Administrator/s and part-time Training Officer.

7.6 Merton Council will host the MSCB Business Support Team and MSCB meetings. Partners will be encouraged to host appropriate meetings or training, where possible and appropriate at no expense to the MSCB Budget.

7.7 The MSCB will not routinely seek legal advice on all its work but only when it is needed.

8. **Delegation of key responsibilities**

8.1 To further its objectives the MSCB will delegate its responsibilities and activities by theme and through its Business Plan and the Sub Group Annual Work Plans. However, the MSCB (Main Board) will remain accountable for the work undertaken even where it
has been delegated.

8.2 The table in Appendix Five shows the main areas of delegation/responsibility. This will be reviewed annually at the Business Planning Away Day in March.

*Revised Constitution Agreed to be agreed at the MSCB on 27th June 2017*
Appendix One:

Agency/service statutory objectives and functions

A key responsibility of an LSCB is to monitor the local compliance by agencies with these responsibilities to safeguard children.

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Section 11 places a duty on the following organisations:

- local authorities and district councils that provide children's and other types of services, including children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services;
- NHS organisations, including the NHS Commissioning Board and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts;
- the police, including police and crime commissioners and the chief officer of each police force in England and the Mayor's Office for Policing and Crime in London;
- the British Transport Police;
- the Probation Service;
- Governors/Directors of Prisons and Young Offender Institutions;
- Directors of Secure Training Centres; and
- Youth Offending Teams/Services.

These organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- a senior Board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- appropriate supervision and support for staff, including undertaking safeguarding training;
- employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;
• staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and
• all professionals should have regular reviews of their own practice to ensure they improve over time.
• clear policies in line with those from the LSCB for dealing with allegations against people who work with children. An allegation may relate to a person who works with children who has:
  o behaved in a way that has harmed a child, or may have harmed a child;
  o possibly committed a criminal offence against or related to a child; or
  o behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Section 175 Education Act 2002 places a duty on local authorities (in relation to their education functions and governing bodies of maintained schools and further education institutions, which include sixth form colleges) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school, or who are students under 18 years of age attending further education colleges. The same duty applies to independent schools (which include Academies and free schools) by virtue of regulations made under section 157 of the same Act.

In order to fulfil their duty under section 157 and 175 of the Education Act 2002, all educational settings to whom the duty applies should have in place the arrangements set out in chapter 2 Working Together 2015. These are the section 11 duties as listed above at paragraph 2.4 of this document.

In addition schools and colleges should have regard to the specific guidance in Keeping children safe in education: Statutory guidance for schools and colleges, September 2016.
Appendix Two  MSCB Structure

** MASE Multi-Agency Sexual Exploitation Group

In addition there is the Child Death Overview Panel (CDOP) and

the Human Resources Sub Group.

Youth Crime Executive Board (YCEB)

Violence Against Women and Girls (VAWG) Sub-Group

MASH Strategic Board

The MSCB will commission Task and Finish Groups as required.

The MSCB Chair may commission a Panel to undertake SCRs or LIRs.  (See Appendix Eight)

** Reporting**

Sub Groups will routinely report to the MSCB on their work plans as follows; and where required by exception:

**Quality Assurance**
- Multi-Agency data – quarterly in arrears
- Lessons from quality assurance at each MSCB meeting

**Learning and Development** – twice per year

**Policy** – twice per year

**Promote and Protect Young People** - twice per year
- Quality and aggregated lessons arising from case monitoring in Promote & Protect/MASE meetings will be reported via QA and to the MSCB
**HR Sub Group** – once per year

**CDOP** – once per year, usually through the draft CDOP Annual Report

The Sub Groups will work together to ensure that Policy Development and Learning and Development reflect lessons being learned through QA and PPYP
Appendix Three Membership

See statutory guidance WT 2015 Chapter 3 page 68

P Statutory Partner  S Statutory Sector Partner  C Co-opted  V Voting
PO Participant Observer  SA Statutory Advisor  A Advisor  B Board support

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>Independent Chair</td>
<td>Casting vote</td>
</tr>
<tr>
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<td>Vice Chair to be drawn from the Statutory Members</td>
</tr>
<tr>
<td>P V</td>
<td>Chief Officer, Merton Clinical Commissioning Group</td>
</tr>
<tr>
<td>P V</td>
<td>NHS England (London)</td>
</tr>
<tr>
<td>P V</td>
<td>Head of Safeguarding, Community Health Services</td>
</tr>
<tr>
<td>P V</td>
<td>SW London &amp; St George’s Mental Health Trust</td>
</tr>
<tr>
<td>P V</td>
<td>Consultant Child and Adolescent Psychiatrist, SW London &amp; St Georges</td>
</tr>
<tr>
<td>P V</td>
<td>St George’s Healthcare NHS Trust</td>
</tr>
<tr>
<td>P V</td>
<td>Director of Nursing, Epsom &amp; St. Helier NHS Trust</td>
</tr>
<tr>
<td>P V</td>
<td>Borough Commander, Met Police</td>
</tr>
<tr>
<td>P V</td>
<td>DCI, Child Abuse Investigation Team, Met Police</td>
</tr>
<tr>
<td>P V</td>
<td>Assistant Chief Officer, London Probation</td>
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<tr>
<td>P V</td>
<td>Asst Chief Officer The London Community Rehabilitation Company Limited</td>
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<tr>
<td>S V</td>
<td>Lay Members (Two)</td>
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<td>S V</td>
<td>Voluntary Sector Agency (Two)</td>
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<tr>
<td>P V</td>
<td>Director, Children Schools &amp; Families</td>
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<tr>
<td>P V</td>
<td>Head of CSC &amp; YI, CSF</td>
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<tr>
<td>P V</td>
<td>Head of Education, CSF</td>
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</tr>
<tr>
<td>C V</td>
<td>Director of Public Health Merton, Community &amp; Housing</td>
</tr>
<tr>
<td>C V</td>
<td>Safeguarding Adults Manager, Community &amp; Housing</td>
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<tr>
<td>C V</td>
<td>Housing Needs Manager, Community &amp; Housing</td>
</tr>
<tr>
<td>P V</td>
<td>Senior Service Manager, CAFCASS</td>
</tr>
<tr>
<td>S V</td>
<td>Head Teacher Primary School ‘Rep of Governing Body of a Maintained School</td>
</tr>
<tr>
<td>S V</td>
<td>Special School</td>
</tr>
<tr>
<td>S V</td>
<td>Maintained secondary school</td>
</tr>
<tr>
<td>S V</td>
<td>Representative of the proprietor of a city technology college, a city college for technology or the arts, or an Academy</td>
</tr>
<tr>
<td>S V</td>
<td>Independent Sector School – vacant at Jan 2017</td>
</tr>
<tr>
<td>C V</td>
<td>CP Officer, Merton Priory Homes</td>
</tr>
<tr>
<td>P O</td>
<td>Merton Council Lead Member Children’s Services <strong>Non-voting</strong></td>
</tr>
<tr>
<td>S A</td>
<td>Designated Doctor for Child Protection, Merton CCG <strong>Non-voting</strong></td>
</tr>
<tr>
<td>S A</td>
<td>Designated Nurse Safeguarding, Merton Clinical Commissioning Group <strong>Non-voting</strong></td>
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<tr>
<td>S A</td>
<td>Principal Social Worker <strong>Non-voting</strong></td>
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<tr>
<td>P V</td>
<td>Consultant Child and Adolescent Psychiatrist, SW London &amp; St Georges</td>
</tr>
<tr>
<td>A</td>
<td>Joint Head of HR Business Partnerships <strong>Non-voting</strong></td>
</tr>
<tr>
<td>A</td>
<td>Service Manager, Policy, Planning and Performance <strong>Non-voting</strong></td>
</tr>
<tr>
<td>B S</td>
<td>MSCB Board Development Manager <strong>Non-voting</strong></td>
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<tr>
<td>B S</td>
<td>MSCB Administrator/s <strong>Non-voting</strong></td>
</tr>
<tr>
<td>A</td>
<td>MSCB Training Officer <strong>Non-voting</strong></td>
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</table>
Statutory Partners will nominate an agreed senior Agency Deputy who is able to speak and take decisions on their Agency’s behalf.

Sector Partners will cover each other and do not require a deputy for their own agency.

Advisers will not have deputies.

Where a Sub Group Chair is appointed who is not a Board Member they will be co-opted to the Board but will not be a voting member, unless they are deputising for an Agency Member.

Sub Group Chairs may be asked to attend the Business Implementation Group if the business of their sub group is on the agenda.

<table>
<thead>
<tr>
<th>Business Implementation Group Membership</th>
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<tbody>
<tr>
<td>Independent Chair</td>
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<tr>
<td><strong>P</strong> Vice Chair to be drawn from the Statutory Members</td>
</tr>
<tr>
<td><strong>P</strong> Chief Officer, Merton Clinical Commissioning Group</td>
</tr>
<tr>
<td><strong>P</strong> Borough Commander, Met Police</td>
</tr>
<tr>
<td><strong>P</strong> Assistant Chief Officer, London Probation</td>
</tr>
<tr>
<td><strong>S</strong> A Voluntary Sector Agency</td>
</tr>
<tr>
<td><strong>S</strong> Lay Member for a year at a time between the two Lay Members</td>
</tr>
<tr>
<td><strong>P</strong> Director, Children Schools &amp; Families</td>
</tr>
<tr>
<td><strong>P</strong> Head of CSC &amp; YI, CSF</td>
</tr>
<tr>
<td><strong>P</strong> Head of Education, CSF</td>
</tr>
<tr>
<td><strong>P</strong> Director of Public Health, Merton Council</td>
</tr>
<tr>
<td><strong>P</strong> Senior Service Manager, CAFCASS</td>
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Appendix Four – Business Planning and Meetings - Annual Planning Cycle

**March**
MSCB – Away Day to review year & agree revised Business Plan & start Annual Report

**April**
Start of the Business Year

**May**
BIG

**June/July**
Annual Agency Peer Reviews - QA & Challenge Meetings

**July**
BIG

**September**
MSCB Annual Report

**Sept (late)**
MSCB

**Nov**
BIG MSCB Budget review / forward planning of priorities for referral to other partnerships & agencies for next year’s planning cycle

**Jan (mid)**
MSCB

**Feb**
BIG – to plan March Away Day

Meetings will be scheduled to avoid school holidays where possible and to prevent clashes with other Strategic Partnerships
## Appendix Five  Delegation of key responsibilities

<table>
<thead>
<tr>
<th>Responsibility / Action</th>
<th>Leadership</th>
<th>Comment</th>
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<tbody>
<tr>
<td>To ensure the effectiveness of what is done by each body …</td>
<td>MSCB Chair, Business Implementation Group</td>
<td>Annual Agency QA &amp; Peer Reviews (section 11)</td>
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<tr>
<td>Assess whether LSCB partners are fulfilling their statutory duties as set out in Chapter 2 of Working Together 2015 (section 11 Children Act 2004)</td>
<td>Quality Assurance Sub Group for the monitoring of agency and multi-agency service delivery</td>
<td>Multi-Agency Data Set</td>
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<td></td>
<td>Policy Sub Group except where delegated to other Sub Groups</td>
<td>MSCB subscribes to the London Child Protection Procedures (LCPP); it should be exceptional for the MSCB to have its own Policy or Protocols, except where it is necessary to localise the LCPP or that there is particular need Domestic abuse Parental Mental ill-health Drug and substance abuse</td>
</tr>
<tr>
<td>Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures…</td>
<td>Policy Sub Group except where delegated to other Sub Groups</td>
<td>Young people identified as at risk of CSE will be monitored through the MASE</td>
</tr>
<tr>
<td></td>
<td>Promote and Protect Young People Strategy Sub Group</td>
<td></td>
</tr>
<tr>
<td>Monitoring of children who are particularly vulnerable</td>
<td>Promote and Protect Young People Strategy Sub Group</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Learning and Development Sub Group</td>
<td>Training Strategy Annual Training Needs Analyses Commissioning the annual MSCB multi-agency training programme</td>
</tr>
<tr>
<td>Monitor and evaluate the effectiveness of training, including multi-agency training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake training needs analyses and commission multi-agency training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment and supervision</td>
<td>HR Sub Group</td>
<td>Partner Agencies are responsible for the implementation of the policies</td>
</tr>
<tr>
<td>Allegations concerning persons who work with children</td>
<td>Children, Schools &amp; Families – will provide the LADO</td>
<td>Quarterly data to QA Sub Group Annual LADO Report to MSCB</td>
</tr>
<tr>
<td>Responsibility / Action</td>
<td>Leadership</td>
<td>Comment</td>
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<tr>
<td>-------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Private fostering</td>
<td>Children, Schools &amp; Families – will assess referrals from Partners</td>
<td>Annual Private Fostering Report to MSCB</td>
</tr>
</tbody>
</table>
| Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children | MSCB Chair  
MSCB Business Manager/Support Group  
Training and Development Sub Group | Governed by the agreed Communications Strategy which will be reviewed each year as part of the Annual Business Review |
| Serious Case Reviews & Learning Improvement Reviews          | MSCB Chair  
advised by Business Implementation Group  
Quality Assurance Sub Group will be responsible for Actions arising from SCRs | Designated Doctor, Designated Nurse and Principal Social Worker will have role in advising |
| Child Death Reviews                                         | Joint Child Death Overview Panel                                           | With Sutton LSCB                                                                                                                      |
| Learning and Improving System                               | MSCB All Sub Groups and All Partners                                       | Learning and Improvement System approved July 2014                                                                                   |
| Learning and Improving - monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve | Quality Assurance Sub Group  
Learning and Development Sub Group will promote the lessons from SCRs, audits and other learning processes. | The Quality Assurance Sub Group will commission multi-agency audits and monitor single agency audits  
Termlly Practitioners Safeguarding Briefings on local and national learning  
Lessons posted to the MSCB website |
| Monitoring the effectiveness of Initial Child Protection Conferences ICPCs (WT 2015 Chapter 1 page 44) | Quality Assurance Sub Group                                                | Each multi-agency audit will include at least one ICPC and once per year there will be an audit of ICPCs.  
Data on ICPCs will also be included in the MSCB Data Set |
<p>| Participating in the planning of services for children       | MSCB Business Implementation Group                                          | The MSCB will receive feedback from the Health and Well Being Board and expects to be consulted on any planning which includes the safeguarding of children or promotion of their welfare; e.g. Domestic Abuse Strategy |</p>
<table>
<thead>
<tr>
<th>Responsibility / Action</th>
<th>Leadership</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Report</td>
<td>MSCB Chair and all agencies with support of the Sub Group Chairs and the Business Manager</td>
<td>Rigorous and transparent assessment of the effectiveness of local services To include any identified weaknesses and any lessons from reviews (WT 2015 page 70)</td>
</tr>
<tr>
<td>Participation and Consultation with young people</td>
<td>Participation Strategy</td>
<td>MSCB</td>
</tr>
</tbody>
</table>
Appendix Six

Merton Children Safeguarding Board Performance Management Framework

Chapter 3 of Working Together 2015 specifically outlines that in order to fulfil its statutory function under Regulation 5 an LSCB should use data and, as a minimum, should:

1. assess the effectiveness of the help being provided to children and families, including early help;
2. assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of Working Together 2015;
3. quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
4. monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Local authorities and Board partners should provide the LSCB with data to enable it to fulfil its statutory functions effectively.

Merton’s Performance Management Framework has therefore been developed to present a systematic approach to ensuring that statutory responsibilities are delivered and objectives are achieved, within a learning and improvement culture where all agencies within the MSCB align their own priorities and actions to accomplish the objectives.

The following table represents the MSCB Performance Management approach to delivering its statutory functions.

<table>
<thead>
<tr>
<th>LSCB functions</th>
<th>MSCB Performance Management approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess the effectiveness of the help being provided to children and families, including early help</td>
<td>• Performance monitoring reports</td>
</tr>
<tr>
<td></td>
<td>• Single and multi-agency audits</td>
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<td>• Thematic reports from agencies to MSCB</td>
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<td></td>
<td>• Annual Report</td>
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<tr>
<td>2. Assess whether LSCB partners are fulfilling their statutory obligations</td>
<td>• Annual report and business plan</td>
</tr>
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<td></td>
<td>• Section 11 self-assessments</td>
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<td></td>
<td>• Chair’s Annual Agency QA &amp; performance meetings</td>
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<td></td>
<td>• Subgroup work plans and monitoring</td>
</tr>
<tr>
<td>3. Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned</td>
<td>• Single agency audits</td>
</tr>
<tr>
<td></td>
<td>• Multi agency audits</td>
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<td></td>
<td>• SCRs/ IMRs and LIRs</td>
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<td></td>
<td>• Case reviews</td>
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<td></td>
<td>• Annual Private Fostering report</td>
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<tr>
<td></td>
<td>• Annual LADO report</td>
</tr>
<tr>
<td>4. Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.</td>
<td>• MSCB training strategy</td>
</tr>
<tr>
<td></td>
<td>• MSCB training plan</td>
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<td></td>
<td>• MSCB training attendance</td>
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<td></td>
<td>• MSCB training programme evaluation</td>
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<td></td>
<td>• Training sub group progress reports</td>
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</tbody>
</table>

Table 1: Summary table Merton’s LSCB Performance Management approach
The MSCB has a comprehensive performance monitoring data set. All statutory agencies contribute data and commentary. The indicators to be monitored are agreed annually. Contributing agencies include: London Borough of Merton Children Schools and Families department, Police (local and regional), Merton CCG, Sutton and Merton Community Health, South West London Mental Health Trust, Epsom and St Helier Hospital Trust, St Georges NHS Trust and London Probation. The MSCB data set builds on the understanding that each agency has their own quality assurance and performance framework that will include key indicators of performance, outline of governance and structure, workforce and training data.

From 2014/15 the performance oversight has been developed into a twofold approach including a full and comprehensive “Quality Assurance subgroup performance data set” and a “Main Board summary performance report”. All partner agencies contribute data and commentary to the data set quarterly. This data set is discussed at the QA subgroup where agencies are able to challenge performance and consider links with single and multi-agency case audits, ‘voice of the child’ findings and other intelligence gathered. From 2014/15 the Main Board will receive a summary report which will draw together an analysis of performance monitoring conducted by the QA sub group.

Single and multi-agency audits; The QA sub group sets an annual programme of multi-agency audits. Summaries of the audit findings are presented to MSCB Main Board. Agencies are responsible for their own single agency audit programmes and for sharing key relevant findings with the QA sub group. These are governed under the Learning and Improving System.

Section 11 reports are completed by all statutory agencies, including commissioning agencies bi-annually and contribute to Chair’s annual Agency QA and Performance Monitoring Meetings and to the annual report.

An annual Private Fostering report is presented to the Board in line with Regulation 5 relating to the LSCBs function to ensure correct policies and procedures are in place in relation to the safety and welfare of children who are privately fostered.

A Local Authority Delegated Officer (LADO) report is programmed to the Board annually.

There is a separate Learning and Improvement System (Framework) which dovetails with this Performance Management Framework.

In summary:

This Performance Management Framework is underpinned by;

- Children Acts 1989 and 2004 and accompanying regulations
- Working Together 2015
- DfE The Children’s Safeguarding Performance Information Framework (all so known as the Munro indicators)
Appendix Seven  Learning and Improvement System

The MSCB Agreed this Learning and Improvement System in July 2014 – it is updated here to reflect Working Together 2015

Working Together 2015, Chapter 4 states:

1. Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

2. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.

3. Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

4. Each local framework should support the work of the LSCB and their partners so that:
   - reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and that this learning is actively shared with relevant agencies;
   - reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
   - action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
   - there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.

5. The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children. Some of these reviews (i.e. SCRs and child death reviews) are required under legislation. It is important that LSCBs understand the criteria for determining whether a statutory review is required and always conduct those reviews when necessary.

Ensuring the quality and continuing improvement of frontline practice is a key statutory task of LSCBs. As well as being set out in the statutory guidance above it is also the Section 11 standards:
Section 11 Standards
(The list which follows is not the full list of section 11 standards but only those which interrelate to Learning and Improvement).

- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;

- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);

- a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;

- appropriate supervision and support for staff, including undertaking safeguarding training;

- employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;

- staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child’s safety or welfare; and

- all professionals should have regular reviews of their own practice to ensure they improve over time

Each statutory agency, including all schools and colleges, and agencies 'commissioned' to provide services on behalf of statutory agencies must meet these standards.

The MSCB will ask each statutory partner agency to report annually on its own effectiveness in delivering its Learning and Improvement responsibilities, as part of the annual Agency QA and Performance Challenge Meetings. This task is core to the MSCB’s responsibility in holding agencies to account for the quality of safeguarding service delivery to children and young people.

Learning and Improvement & Quality Assurance
The delivery of quality safeguarding practice requires informed, competent and well-supported practitioners in a context of clear agency and inter-agency standards and policy.

Safeguarding learning draws on agency intelligence, performance indicators, auditing of the quality of service delivery (single agency and multi-agency), commissioned case reviews, the child death reviews, SCRs and research. We also need to be capturing examples of good practice, both within the Borough and from other places, disseminating them across the partner agencies.
Learning and disseminating lessons may be easier than ensuring implementation and improvement across large and diverse workforces who work with children and their families. It is about ensuring knowledgeable, skilled, competent and confident practitioners, well-supported by their knowledgeable supervisors/managers or clinical advisers.

Key questions for the Board will be:

- What is the quality of the work?
- What is our evidence?
- What works well and what needs to improve?
- What do the MSCB and Agencies need to do to maintain good practice or improve practice?
- How will we test that there has been improvement over time and that improvement is being sustained?
- How can we ensure that the voices of children and young people are being heard and incorporated into our learning?

**Learning and Improvement Reviews – see Appendix Eight** Critical Incident Reporting, SCRs and LIRs

**The MSCB Multi-Agency Audit Process and Programme has been agreed**

The Quality Assurance Sub Group will both commission multi-agency audits and monitor the lessons from single agency safeguarding audits in an annual programme.

Lessons will be disseminated back to the case practitioners. They will then be disseminated as widely as possible to all local practitioners/services and their first line managers/supervisors in a timely way through a MSCB-led series of termly *multi-agency briefing seminars* to provide short summaries of the lessons from audits, case reviews, including child death reviews, SCRs (including wider than Merton) and research in order to influence practitioners’ knowledge and skills. This will be promoted through the MSCB Training Programme and website. Materials from the seminars will be available for agencies to use within their services for in-house briefings and training.

The Communication task and Finish Group will also have a role in developing other ways that the lessons can be promoted to practitioners and managers and prioritised within the overall bombardment of messages which practitioners receive.

Agencies will be asked to account for how they have implemented lessons promoted by the MSCB throughout the year, and asked for the numbers of agency staff who have been briefed as part of their agency returns for the MSCB Annual Report and through future Agency challenge meetings – i.e. agencies will be asked to describe and evaluate their safeguarding training, dissemination and implementation of the agreed MSCB lessons, including workforce data and commissioners will be asked to monitor this in their commissioning roles.

MSCB Audit and Training Programmes and the MSCB Annual Conference will be planned to reflect the agreed annual priorities for the MSCB.
It will be necessary to draw from lessons learned from single-agency audits. We will establish a register of single-Agency audits and lessons learned which can also be fed into the multi-agency briefings. Agencies will be asked to set out their annual audit programme with the MSCB and share the findings.

Our Learning and Improvement Framework will draw on the work of several sub-groups as well as feedback from agencies. Each SubGroup will have a standing item on its agenda to note the Learning and Improvement actions within the meeting and to refer them to the Training and Development Sub Group.

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**Learning and Improvement System**

This is not a cycle but a dynamic system; any one part influencing the others but not in a linear way.

The MSCB needs to have an overview of the whole and also the ability to sample the detail, especially for trends and habits.

Overseeing the system is a core task for the MSCB, Partner Agencies and all sub groups.

- **Policy, Guidance & Clear Expectation**
  - Agency and Multi-Agency

- **Case reviews, SCRs, child death reviews & research**
  - inc views of practitioners

- **Testing implementation**
  - re-testing that specific practice lessons have been improved and are embedded; inc barriers to implementation,

- **Maintenance**
  - training & retention of historic lessons – refreshers and inductions for new staff, ease of access for stored lessons, manageable summaries, accessible archived briefings

- **Competent reflective ‘supervision’, management or clinical advice**

- **Reflective Practitioner Competence**
  - up-to-date safeguarding children knowledge & skill – appropriate for level of contact with children or risky adults & professional role

- **Supervisor - up-to-date safeguarding children knowledge & skill – appropriate for level of contact with children or risky adults & professional role**

- **Dissemination of lessons from reviews & audits**
  - Agency and multi-agency briefings to the relevant workforce - MSCB & Agency awareness of the size of the task and the number of workforce to be informed

- **QA of competence**
  - by agency management & single & multi-agency audit inc views of the practitioners & service users

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Unexpected Child Death

Rapid Response meeting – Multi agency – led by Designated Doctor Child Deaths

Child Death Overview Panel

Serious Safeguarding Incident
(Incident, LADO, Homicide, Gang incident, Terrorism, Honour violence, FGM, Systems issue, etc.)

Can be referred by any agency

Children’s Social Care QA Manager and/or MSCB Manager take co-ordination lead
Liaison with MSCB Chair

Initial Enquiry & Information Gathering about whether the case requires a review and if so what kind of review
Liaison with MSCB Chair

Notification to OFSTED of Critical Incident and within one month notification to National SCR Panel of decision to do or not do SCR (or within 5 days of MSCB Chair’s decision)
(Keep National SCR Panel informed of progress if SCR agreed – see notes in addendum. Advise OFSTED, DfE & National Panel, if SCR not agreed following advice from National SCR Panel)

Case Group – Multi-Agency
[Ad hoc]
Advised by Designated Dr, Designated Nurse & Principal Social Worker
If no review is required the process stops.

Serious Case Review
Must be published-unless exceptional issues

Commission
Independent Reviewer/s,
SCR Panel, agree ToR,
methodology & keep National SCR Panel informed of progress

MSCB Main Board
For final amendment and sign off
Agreement to Multi-Agency Action Plan
Tracking of Action Plans by SCR Sub Group
Regular reporting on progress to the MSCB
Reporting lessons in Annual Report

Learning & Improvement Review
Multi Agency or Joint Agency
MSCB Commissioned Case Panel and Independence

Individual Agency Management Review / Learning & Improvement Review

Case Audits
Single or Multi-Agency
Commissioned by QA Sub Group

Quality Assurance Sub Group
To commission and endorse such reviews or Audits, receive the reports and agree any Multi-Agency Action Plan
Tracking of Action Plans by QA Sub Group
Regular reporting on progress to the MSCB
And commissioning of learning events by Learning & Development Sub Group

Parallel Reviews
Youth Justice Board
Domestic Violence Homicide reviews
NHS England SI Reviews
Where there are parallel reviews the LSCB should seek to ensure congruence between the ToRs & methodologies - Coroner
Note High Court Judgement & WT 2015 guidance for SCRs and CDRs on disclosure to Coroners

MSCB Serious incidents, SCRs and Learning & Improvement Reviews - 2015

Statutory Guidance for SCRs, other reviews and Child Death reviews is contained in Working Together 2015 Chapters 4 and 5  www.workingtogetheronline.co.uk/index.html

The 2015 Working Together Guidance revises and adds to that which was used up to March 2015.

Changes are:

Chapter 4 Para 13

Additional guidance on incidents that are notifiable to OFSTED:
- a child has died (including cases of suspected suicide), and abuse of neglect is known or suspected;
- a child has been seriously harmed and abuse or neglect is known or suspected;
- a looked after child has died (including cases where abuse or neglect is not known or suspected); or
- a child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

LSCBs with secure units within their area should annually review the use of restraint and report their findings to the YJB – Merton SCB may wish to require commissioners to review such annual reports when placing children in such secure units

Para 19 Criteria for an SCR – amended

... even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children’s home...

Para 24 (Checklist)

New: In cases where an LSCB is challenged by the national panel to change its original decision, the LSCB should inform OFSTED, DfE and the national panel of the final outcome

Agreeing Actions from SCRs

(The SCR Checklist page 78/79) has introduced a new requirement to establish timescales for actions arising from lessons from SCRs, the need to agree success criteria and assess the impact of the actions taken.

Disclosure of Information to the Coroner

The Worcestershire Case and Working Together 2015 require professionals and LSCBs to provide information to Coroners with evidence about deaths to assist the Coroner to carry out his or her statutory duty.

www.judiciary.gov.uk/publications/law-sheet-no-3-the-worcestershire-case
Timescales

Once an Incident has been agreed as a **Critical Incident** OFSTED should be notified using the online Critical Incident Notification Form (Keep a copy before it is submitted! At the end of the process **before submission** there is a chance to save the form as a pdf – which is essential.) *Agreement is needed as to whether this will be done by the LSCB or within Children’s Social Care.* It is recommended that the MSCB Team takes lead responsibility.


Within one month of notifying a critical incident a decision must be made as to whether the case meets the criteria for a SCR or not; and the **National Panel of Independent Experts in SCRs** (‘National SCR Panel’) must be notified of the decision of the Chair of the LSCB (within 5 days of the Chair's decision). National SCR Panel may query this. The LSCB Chair usually communicates through the LSCB Manager.

[https://www.gov.uk/government/groups/serious-case-review-panel](https://www.gov.uk/government/groups/serious-case-review-panel)

From the date of decision to undertake an SCR the review should usually be completed within 6 months.

If there is a risk of delay in completing an SCR the National SCR Panel must be advised.

An SCR must be submitted to the National SCR Panel at least one week in advance of publication.

It is best practice to ensure that the practitioners involved in the case and the family members are advised and informed of the findings of an SCR before it is published and that they be advised of the publication date as soon as it is known.

**Publication of SCR**

An SCR cannot be published until criminal or coronial investigations/hearings have been completed. Publication can be withheld in exceptional circumstances, normally as agreed following discussion with the DfE, the National SCR Panel and legal advice. It would still be expected that lessons would be disseminated confidentially.

**Parallel Reviews**

**NHS Serious Incident Framework: Supporting learning to prevent recurrence 2016**

**Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews**
August 2013; Home Office

**Youth Justice Board:**  Community Safeguarding and Public Protection Incidents (CSPPI) – Notification and Learning Standard operating procedures for youth offending teams Version 3 March 2017
The commissioning of SCRs and Learning and Improvement Reviews should consider:

- **Independent Reviewer/s / Author/s.**
  For an SCR it is a requirement to have at least one Independent reviewer, some methodologies require more than one. This is good practice for L&I reviews, but not mandatory.

- **Terms of reference / scope** – including the period of the case history that the review will cover up to the critical incident – bearing in mind proportionality and need to influence current practice; and any specific questions that the review should be asked to address. Involvement of other LSCBs, joint-commissioning, which LSCB will take the lead – involvement of agencies outside the LSCB area and how lessons will be shared with relevant commissioners and LSCBs for such agencies.

- **Methodology** – there is no prescribed methodology for SCRs – however SCRs must use a systems approach, including the wider systems context in which the work took place, SCRs must also take into account the views of the involved practitioners (and their managers) and family members. Police/CPS have issued guidance on involving family members (suspects, victims and witnesses) where there are on-going criminal investigations or trial).
  
  The main methodologies promoted by the DfE are described in the Addendum to this guidance. Other methodologies and hybrid methodologies are being developed.

- **Information Sharing for SCRs** - An LSCB has the statutory authority to require an agency or person to provide information. Agencies supplying reports to the SCR or Learning and Improvement Review Process should ensure that information (chronologies, commentary and analysis) are signed off at an appropriately senior level.

- **Budget** - In commissioning an SCR or a Multi-Agency Learning and Improvement Review the LSCB will consider the implications for the LSCB joint budget and whether it will be necessary to seek additional subscriptions from Commissioning Agencies on a pro-rata basis to meet the cost of engaging independent reviewer/s, legal advice (if needed), facilitating the review and meetings and communications advice.

  Partner Agencies required to provide reports or information to the Review Process or invited to provide a representative for an SCR Panel will meet their own costs for this.

- **Formulating, Agreeing and Monitoring Actions** - As learning emerges during the review process it must be agreed what actions should be taken to mitigate any knowledge or quality issues in the delivery of agency or multi-agency services to safeguard children and young people.

  Actions should be planned and carried out confidentially where it is not possible to
‘publish’ a review pending a trial, inquest or any other enquiry.

See also research on effectiveness of recommendations and actions from SCRs summarised within the Addendum to this guidance.

Agreed Agency and Multi-Agency Actions will be monitored at least quarterly and reported to the Business Implementation Group.

- **Publication – SCRS** It is expected that an SCR will be published on the LSCB’s website and remain there for at least a year for openness and transparency.

Review reports must be fully anonymised. It is expected that the Author/s will do this.

There may be exceptional circumstances where the LSCB, the LSCB Chair, the SCR Panel or individual agencies assess that it is not appropriate to publish a review (or part of a review) even when it is anonymised.

Such a decision will require legal advice and must be discussed with the National SCR Panel.

Reasons for not publishing may include risk to subjects or family members, or confidentiality of the subject/s or family members, etc. – this list is not exhaustive. Risk of adverse publicity is not a reason not to publish.

Before publishing good practice will be to share the final report with family members and involved practitioners to allow them to make any final representation about what will go into the public domain. They should also be advised of the proposed publication date and signposted to support as required. For non-English speakers it may be necessary to translate the Report.

**Learning & Improvement Reviews** – There is not a requirement to publish L&I reviews but the spirit of the guidance is that they should be open for learning and sharing. It will be usual to provide an anonymised Executive Summary of the key learning points as part of the dissemination to practitioners. The same principles of sharing the findings with the practitioners and managers who were involved and the family apply, as appropriate, before disseminating more widely.

- **Media Response** - Where a critical incident or trial is likely to attract media attention the MSCB multi-agency Media response will be planned by the MSCB Chair with the MSCB Lead Members and relevant agencies and with the advice of the Merton Council Communications Department or other similar communications expertise. **No agency should respond to media requests without the agreement of the MSCB Chair, the Director of Children, Schools and Families and the Merton Council Communications Team.**

It would be exceptional to respond to the Media before the outcome of a trial or inquest.
The need to co-ordinate a response will be agreed in accordance with requests and in planning the publication of any SCR.

June 2015, revised June 2017
Addendum

Agreeing SCRs or other Learning and Improvement Reviews & Consideration of methodologies and terms of reference

The statutory guidance for deciding whether a case requires a SCR is set out in Chapter 4 Working Together 2015. The decision rests with the LSCB Chair.

The Working Together 2015 guidance does not prescribe any one methodology.

In the Government sponsored training for independent authors and chairs of SCRs five possible methodologies were promoted equally, as meeting the terms of Working Together. Other methodologies, including hybrid methodologies are also being developed. NHS England has piloted a methodology for health overview reports in line with the guidance drawing on the Root Cause Analysis methodology.

In its First Annual Report (31 July 2014) the national panel of independent experts in serious case reviews stated that good SCRs:

“(Para) 28. The panel has reflected on the features it would expect to see in an effective SCR, and has concluded that these would include:
• A sharp focus on what caused something to happen and how it can be prevented from happening again.
• A concise account of critical points in the management of a case (rather than a lengthy chronology of undifferentiated events).
• A detailed analysis of what went wrong and why, including individual errors and system failures.
• Clear learning points and recommendations that are addressed to named people or organisations locally and nationally, including adult services where appropriate. Measures should be included to follow up and see whether these recommendations have been accepted and implemented.
• A focus on what the lessons should be for the services concerned, rather than giving a blow-by-blow account of what happened to a child.
• Proportionate to the case being considered when applying the points above. This is far more important than a blind adherence to a specific methodology. LSCBs should be looking at a ‘sliding scale’ of SCRs, from those which result in very quick outcomes and a short report, to those which by the nature of the incident require a greater level of investigation.
• Prepared to highlight relevant failings and good practice and policy at all levels, not just those at the lower levels.”

The Five Models for Reviews promoted by the Government in 2013 – 14 are summarised here:

1. Learning Together (‘The SCIE Model’) – a flexible systems model for all learning and improvement activities

History of Learning Together
• Designed in collaboration with Professor Eileen Munro in 2008-2010
Merton Safeguarding Children Board

- Tested and refined in collaboration with the sector including the North West, West Midlands and South West regional improvement and efficiency partnerships and London Safeguarding Children Board
- Used since in over 50 case reviews
- DfE grant supported establishment of pool of accredited reviewers 2011-2013
- Ministerial dispensation to Devon, Lancashire and Coventry LSCBs to use Learning Together in SCRs
- A sliding scale of applications being developed and tested
- New pilots underway, in Scotland, Germany and the Netherlands and in adult safeguarding

**A systems approach for a high risk sector**

SCIE’s Learning Together model is a tried and tested systems approach for improving child safety and welfare. In both these respects it is unique.

A systems approach is the established methodology for improving safety in fields marked by ‘low probability, high impact’ incidents and accidents e.g. aviation, nuclear power as well as health. SCIE has adapted the systems approach specifically for the field of multi-agency safeguarding and child protection.

With extensive testing and refinement it is the model of choice for a growing network of Safeguarding Boards, across both adult services and the children's sector, as well as in Europe.

**More than a just a method**

SCIE Learning Together offers:

- a core set of principles and analytic tools to unify all learning and improvement activities including audits, case reviews and serious case reviews (SCRs)
- a range of possible applications including ‘reflective audits’; ‘focused’ and ‘speed’ versions
- opportunities to build internal capacity by having staff trained and accredited in the approach
- access to a pool of independent reviewers who are trained and accredited in the model
- availability of methodological supervision to assure rigour and reliability of analyses and foster expertise over time
- access to an archive of systemic findings produced through Learning Together audits, case
  - review and SCRs
- membership to a methodological network providing forums for critical reflection and on-going development of the model and its application

**Working Together; Learning Together**

Boards are now required to maintain a local learning and improvement framework that supports the regular conduct of reviews and audits beyond those meeting the statutory SCR criteria. “Learning Together” is based on methodological principles that are not negotiable but is otherwise flexible in how it can be applied. So it lends itself to underpinning a wide range of learning activities. Working Together (2013) also gives a new freedom of process and proportionality for SCRs. So, for the first time, Boards can use a systems methodology.
as recommended by the Munro Review3 for all learning and improvement activities - including SCRs.

**Principles for learning and improvement**

Working Together specifies five principles (page 67) according to which SCRs and other case reviews should be conducted:

1. Recognising the complex circumstances in which professionals work
2. Seeking to understand the underlying reasons why people acted as they did
3. Seeking to avoid hindsight bias
4. Being transparent about research methods
5. Making use of research as well as case evidence to inform findings

These echo the essential ingredients that Professor Munro explained must be present in an investigation, for it to justify the name a ‘systems approach.’ They are central to the core of Learning Together, which we refer to as the ‘methodological heart’.

**Use in Serious Case Reviews**
The new requirement to involve staff in SCRs can raises challenges when there are criminal proceedings and staff are witnesses. This is particularly so for models, like Learning Together, which involve bringing the multi-agency staff group together as standard. Devon LSCB’s experience demonstrates this is possible nonetheless. However, decisions about necessary adaptations will need to be made on a case by case basis.


2. **Child Practice Reviews** (‘The Welsh Assembly Model’)

Child Practice reviews replace the Serious Case Review system in Wales and came into effect on 1st January 2013. They are underpinned by a clear set of principles and bring together agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability and not culpability. It is about learning and not about blame.

If a situation meets the criteria for a review then a Review Panel is established to both guide and steer the process but also to be integral to the learning. The tasks of the Review Panel are to:

- Agree the time frame of the review.
- Request agency timelines of significant events/contacts.
- Commission a Reviewer or Reviewers.
- Merge the timelines.
- Identify and prepare participants for the learning event.
- Ensure the family are engaged in the process

At the heart of the review is the learning event, facilitated by the reviewer(s), which brings together the practitioners who were involved in the situation to reflect on what happened and to identify learning for future practice
After the event a short, anonymised report is prepared, together with an outline action plan and these are presented to the LSCB for discussion and approval. There is also feedback to the family of the findings.


3. Root Cause Analysis (This methodology is required by Health Agencies for formal SI Reviews by NHS England (London))

RCA was developed following a series of catastrophic problems in the 1960s NASA space programme. It has been applied in a variety of industrial contexts since, ranging from nuclear, rail and shipping, to healthcare, pharmaceutical manufacturing and social care.

RCA offers the opportunity to ‘open a window on the system’ and promotes:

- Systematic methodology
- Full systems review
- Systemic solutions development

It uses questioning approaches to uncover ever-deeper explanations for causes or contributors of adverse events, errors or problems.

RCA techniques are wide ranging, the most well-known of which is probably the ‘Fishbone diagram’. The NHS has honed these techniques and promotes those that have proved most useable and effective.

There is no implication that a single ‘root cause’ will be enough, often many causes are identified all requiring remedial action. The big challenge for reviewers applying RCA is to stay focused on the systematic process and know how to identify systemic issues which are controllable, manageable or adjustable. So, for example ‘not enough staff’, ‘staff sickness’ or ‘made a mistake’ may all be true, but they are problems or conditions rather than ‘root causes’. As such they require further analysis to determine why they were able to impact the system without intervention and, therefore, sheds light on most effective measures to address these causes or underlying factors to improve the system.

RCA focuses the reviewer’s attention on organisational or systems explanations of the actions of professionals delivering direct services to children. RCA is viewed as a tool of continuous improvement. It can be used as a ‘whole review’ approach or as a ‘set of techniques’ within other SCR methodologies. It provides simple, well-structured tools to identify exactly ‘what?’ happened before leading the reviewer to research ‘why?’

It breaks down the incident (serious injury or death) into the ‘what?’ (a chronology of events), and subjects each unwanted action or omission to examination. So, reviewers can get from ‘SW unfamiliar with procedure’ to ‘SW trained but not supervised’ to ‘supervisor distracted by other priorities’ and finally to ‘organisational priorities not clearly stated at strategic level’. In this way the actions of frontline professionals are explained in the context of overarching systemic problems.

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59901

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4. Significant incident learning process (SILP)

Leicestershire & Rutland LSCB pioneered a method of reviewing significant cases by formulating SILP with an independent company. The drivers were (and still are):

- A reaction against the hitherto bureaucracy, expense and cosmetics of Serious Case Reviews which distract energies from the family, the staff and the learning
- A reaction in favour of the engagement of those frontline staff and first line managers involved in the case in owning their action learning

Practitioners are invariably left isolated both during and after the SCR process. The key and unique principles of SILP are that alongside members of LSCB Serious Case Review Panels and agency Safeguarding Leads, frontline practitioners and first line managers will:

- have access to all the agency reports prepared for the review, setting the SILP process apart from the conventional serious case review
- fully participate in analysis and debates of all the material, including early drafts of the Overview Report. Learning is no longer confined to the panel.

Analysis, reflection and learning on a multi-agency basis are greatly enhanced by the practitioners involved in the case at the time being able and willing to share:

- their view of what was going on in and around the case
- their understanding of their role and the part they were playing
- their thinking and their context at the time
- their perspective on what aspects of the whole system influenced them
- the theories and practices they were using

As encouraged by Munro* the answers to these questions produce both the “Why” analysis and also explain the impact of organisations and systems on the events under review. Moreover, the dangers of hindsight bias are greatly reduced by this approach.

A streamlined process with slimmed down written material means the learning emerges far quicker i.e. as soon as participants read all the reports.

**How the SILP Methodology Fits With Working Together**

Working Together to Safeguard Children 2015 suggests reviews should be conducted of cases which do not meet the criteria for a serious case review. SILP is a model for these reviews which some Boards are choosing to incorporate into their framework for learning and improvement under the guidance.

**How SILP Methodology Might Be Used When Conducting a Serious Case Review**

a. In addition to operating SILP as a standalone process, SILP principles can be embedded in cases designated as Serious Case Reviews. Thus we now also deliver the hybrid model, i.e. incorporating SILP into an SCR.

b. The Learning Event and Recall Session are complementary to and enhance the role of the panel, with learning front loaded in this process.
5. Appreciative Inquiry (‘AI’)

**AI methodology:** AI involves the ‘art and practice of asking unconditional questions that strengthen a system’s or person’s capacity to heighten its positive potential’1. Rooted in action research and organisational development, Appreciative Inquiry [AI] is a strengths-based, collaborative approach for creating learning change. AI seeks to discover and connect to those things that give life to people, organisations and human systems at a time when they are most engaged, effective and healthy. 30 years of research and practice show that conversation about strengths and successes creates change and innovation as ‘human systems move in the direction of what we most persistently, actively and authentically ask questions about’. AI provides us with the ultimate tools for genuine real time learning, change and improvement.

**How does the AI methodology fit with statutory guidance on learning and improvement?**

SCR’s conducted with an appreciative eye create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong and how that felt and feels. They get to look at where, how and why events took place and use their collective hindsight wisdom to design practice improvements. ‘Reactive learning’, that takes place in response to circumstances we had no hand in creating or control over, is a limited type of learning. Conversely, deeper levels of learning, where ‘thinking and doing’ become integrated, take place when people work together as a whole system to agree what needs to be achieved, understand one another’s perspectives, make well informed and shared decisions at each step of their shared journey. In an AI SCR, we ask questions like: ‘If we created the circumstances in which this child became unsafe, what shall we do to create something different?’

“Few people get up in the morning thinking: I really want to make a lot of mistakes today. Rather people wonder, what do I need to do around here to succeed?”

**How the AI methodology might be used when conducting a Serious Case Review:**

AI provides a rigorous, inclusive and collaborative inquiry process, involving the whole system in deep learning and simultaneous change design; within a framework that is customised to suit each unique and individual child, family and local circumstance. Key aspects include:

- Everyone, including children, young people and their families, inquires together with a motivated eye.
- All contributions are heard and valued; people are respected.
- Mistakes, both individual and systemic, are accepted, understood and used as opportunities for learning and change.
- Change begins from the outset of the inquiry, healing is enabled and shared learning renews and improves practice immediately.

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Summary for Merton SCB

The Study considered 33 SCRs (under the old rubric) in order to see what part recommendations can play in aiding LSCBs, agencies and individuals ‘to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children’

Recommendations were becoming tighter and more clearly focused, but were not reducing in number per SCR compared to earlier cohort reviews. SCRs had between 10 and 94 recommendations, and on average 47 per SCR. Working Together 2010 (now replaced) advised that recommendations should be few in number, focused and specific. This influenced the later SCRs in this cohort.

Breaking down recommendations into achievable actions had resulted in a further proliferation of tasks. Adding new layers of prescriptive activity leaves little room for professional judgement.

Most recommendations concerned (more, duplicate or revised) procedures and training.

Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice.

There was rarely a research evidence base cited for the recommendation made: they tended, instead, to be based on learning from the single case which was assumed to have wider implications.

Recommendations that were easy to implement rarely addressed complex matters of professional judgement.

Action plans were thoughtful, well considered documents that tracked the implementation of recommendations carefully.

Local Safeguarding Children Boards need to take responsibility for curbing this self-perpetuating cycle of a proliferation of recommendations and tasks and allow themselves to consider other ways of learning from serious case reviews. Recommendations may not be the best way to learn from these cases.

Recommendations should be SMART - Specific, Measurable, Achievable, Relevant and Timely

Themes
Recommendations which focused on the child and their family advocated taking a broad view of the family’s circumstances, history and networks and taking account, for example, of ‘hidden men’. They included seeing, hearing and keeping the child in mind especially when very young, disabled, missing from home, educated at home, or overshadowed by parents’ needs.
Aspects of managing the case highlighted the need for timely, careful decision making at each stage of the referral, assessment and the on-going safeguarding process. Avoiding drift in decision making about neglect cases and addressing problems of high thresholds and access to children’s social care services, especially in neglect cases. The importance of understanding the limits of professional knowledge and the need to seek and share expertise, for example about child development, were features in a small number of recommendations.

Insufficient professional challenge of parents and other professionals was emphasised in some recommendations. However, the route to achieving more robust challenge and to grappling with other practice complexities like engaging hard to reach families, tended to be more training and the compliance with or creation of new or duplicate procedures.

A small number of recommendations highlighted the previously under explored issues of staffing and workforce knowledge and capacity. This included criticism of the use of unqualified staff, particularly in children’s social care, but also in the police force and health visiting.

National issues of ‘public health’ and more general messages from serious case review recommendations included ‘safer sleeping’ advice, particularly avoiding co-sleeping where alcohol or drugs had been consumed, and the danger to babies from being shaken.

Issues about the recommendations

Specific: - produced greater clarity, but also encouraged a proliferation of tasks to be achieved.

Measurable: - tended to be concrete activities like training events and changes to procedures or demands for information. Moving recommendations beyond the concrete appeared to be difficult, for example gauging how the quality and impact of awareness raising/training sessions will be measured.

Achievable: Each plan contained delegated responsibility for ensuring that actions were completed.

Relevant: Although recommendations mostly connected clearly to the case, many regularly occurring themes seldom translated into recommendations. While some recommendations had wider ranging validity, others were pertinent only to the single case. There is a risk of making potentially inappropriate or irrelevant decisions or procedures on the basis of a single case. Recommendations rarely drew explicitly on wider research based evidence to substantiate their validity.

Timely: Recommendations were accompanied by a timescale for implementation, and none of the action plans gave themselves a time frame beyond one year.

Conclusion

Recommendations have become more ‘specific, measurable, achievable, relevant and timely’ but this has resulted in a further proliferation of tasks to be followed through. Adding new layers of prescriptive activity appears to leave little room for professional judgement. However, it is easier to be critical of the SMART approach than to create an alternative.

Where recommendations need to be made there is still value in this structured, methodical model but LSCBs should free themselves to construct a proportion of recommendations that
are not easy to audit or make SMART that might encourage deeper learning and take longer to embed.

Perhaps more importantly, LSCBs should be less reliant on recommendations being the central plank of the learning process in serious case reviews.

The full report is 52 pages long.
(Summary produced for Merton SCB; Feb 2015)
The role of the National SCR Panel

The role of the panel is set out in *Working Together to Safeguard Children* (2015). The panel’s remit will include advising LSCB about: application of the SCR criteria; appointment of reviewers; and publication of SCR reports.

The panel will initially advise LSCBs on:

i. any decision made by an LSCB not to initiate an SCR following a serious incident; and

ii. any SCR which an LSCB has indicated it does not plan to publish.

Serious Case Review criteria

Serious Case Review: for every case where abuse or neglect is known or suspected and either:

- A child dies; or
- A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child

Publication of reports

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB’s website for a minimum of 12 months. Therefore the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

How to contact the panel

A dedicated email address has been set up for the SCR panel. To contact the panel, email the secretariat: Mailbox.SCRPANEL@education.gsi.gov.uk

The following flowcharts set out the process for contacting the panel.

This guidance & the flowchart below should now be read in conjunction with the Third Annual Report of the National Panel of Experts in SCRs, published in November 2016.

National SCR Panel

Initiation

Serious Incident occurs where:
a child has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect.
OR
a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child’s death

LSCB considers whether and how to proceed with an SCR
If the child has died, the criteria for an SCR will most likely be met.

Questions to consider include:

- If the child has not died, are there concerns about how agencies or professionals worked together to protect the child?
- What is the scope of the review and who needs to be involved?
- Are there any criminal proceedings or other reviews of the case which will impact on the SCR?

Once an LSCB has made a decision on whether or not to initiate an SCR, the LSCBs should inform the panel by emailing the secretariat at: SCRpanel@education.gsi.gov.uk

YES

Initiation - If an LSCB has decided to initiate an SCR, the LSCB should let the panel and Ofsted know of their decision for information. The LSCB will be asked to confirm that the report of the SCR will be published.

Appointing reviewers
LSCBs should also let the panel know:

- name(s) of the reviewer(s) appointed to conduct the SCR and why you have chosen them
- the type of review you will be conducting

This will be for information. The panel has no formal role in vetting reviewers.

NO and WHY

Initiation - If an LSCB has decided not to initiate an SCR, the LSCB should let the panel know their decision, providing a copy of the local authority’s Serious Incident Notification and an explanation why the LSCB has decided the case does not meet the SCR criteria.
Publication

LSCB considers publication of the SCR report. Questions the LSCB should consider as a minimum are:

- The public interest in seeing the report and understanding the issues raised by the case;
- The importance of ensuring that lessons are learnt and shared widely to improve services to children and families;
- How these public interests can be balanced with those of any children and vulnerable adults involved in the case;
- Whether the style and content of the report make it fit for publication and, if not, how it can be improved;
- Whether there are any legal restrictions on releasing certain information in the report;
- What expert advice is needed e.g. from lawyers or medical or communications professionals; and
- How best to manage media interest in the case.

Once an LSCB has decided whether or not to publish SCR report, the LSCB should inform the panel by emailing the secretariat at: Mailbox.SCRPANEL@education.gsi.gov.uk

If at any time during the course of the SCR the LSCB comes to a view that publication of the report may not be possible, the LSCB should alert the panel to its concerns.

Yes
Publication - If an LSCB has decided to publish an SCR, the LSCB should send a copy to the panel mailbox at least one week before publication.

No and Why
Publication - If an LSCB has decided not to publish an SCR report, the LSCB should let the panel know their decision, providing an explanation of how they have considered the questions above.

Panel meetings
The panel now meets every month to review the details of cases submitted. The panel may request a meeting or further information from the LSCB before being in a position to advise about a case. If so the panel will contact the LSCB direct.
Appendix Nine  MSCB Communications Strategy – Agreed Jan 2015

Introduction and Executive Summary

The MSCB has agreed that the Communication Strategy will be led by a task and Finish Group which will be convened as required to agree and progress the pro-active communication activity on behalf of the Board.

Key principles agreed

The Communications Strategy should work through the Board’s website seeking to achieve professional familiarity with the website through a ‘no-more than two clicks approach’, where practitioners will see the MSCB pages as a useful resource for regular access to procedures, research, training and signposting; and through existing Comms/media, including Partner Agency communications approaches rather than to create its own ‘newsletter’.

It is planned that the MSCB Training Officer takes lead responsibility, with assistance from the Board Manager and practice leads in Partner Agencies, for refreshing the Professional and Practice Pages of the MSCB website to include summaries of recent local and national learning in parallel with the Termly Practice Update Briefings as part of the agreed Learning and Improvement System.

Different approaches will be taken according to the different audiences as outlined in the draft strategy – to be developed further in a detailed Action Plan when the Board has endorsed the Strategy. The Action Plan will also set out responsibility for actions and timescales.

The MSCB logo should be used to gain greater MSCB brand recognition and as a symbol of ‘safeguarding’.

A Pro-active Approach to messages to the local public will be considered with 2/3 priority key messages/stories per year to raise public awareness of safeguarding based on the Board’s Business Plan Priorities and emphasising the safeguarding children’s safeguarding element where other Partnership Boards or Partner Agencies are holding a related campaign e.g. domestic abuse or drug misuse, etc. It is unlikely that the website will be best for this but it will provide a resource which the public can be signposted to.

Themes for the Business Year will be agreed in the Communications Work Plan. (to be updated)

Work on Communication with young people will be developed further when the MSCB Participation Strategy has been agreed.

Agreed by the MSCB, January 2015, refreshed June 2017
<table>
<thead>
<tr>
<th>Spokesperson/s</th>
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<tr>
<td>• Independent Chair of the Merton Safeguarding Children Board</td>
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<td>• Director of Children, Schools and Families</td>
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<tr>
<th>Responsibilities</th>
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<tr>
<td>Communications Strategy and Plan</td>
<td>The Board is responsible for signing off the MSCB Communications Strategy and for agreeing the action plan for the next 18 months.</td>
</tr>
<tr>
<td>MSCB Annual Report and Child Death Review Panel Report – LSCBs are required to 'publish' these reports</td>
<td>When endorsed by the Board these reports will be uploaded to the MSCB website</td>
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<tr>
<td>Annual Business Plan</td>
<td>The Board will publish its agreed rolling Business Plan once per year when it has been revised and then in the Annual report will review progress of the Actions.</td>
</tr>
<tr>
<td>News releases and editorial</td>
<td>Drafted by the Board Manager of the MSCB (with advice from Merton Communications Officer as necessary) and signed off by the chairman of the Board.</td>
</tr>
<tr>
<td>Website content and content maintenance</td>
<td>The Board Manager will be responsible for the content of the website with assistance from the MSCB Training Officer who will take the lead for the practice pages for Professionals; An MSCB administrator uploads the content. The content should be informative and kept up-to-date. Need to work on ease of access to the website and its familiarity to all local professionals.</td>
</tr>
<tr>
<td>Media relations</td>
<td>All communication with the media is agreed by the Board. Only the Chairman and the Director of Children, Schools and Families have the authority to speak to the media on behalf of the Merton Safeguarding Children Board.</td>
</tr>
<tr>
<td>Freedom of Information Requests</td>
<td>The Dept of Education has previously indicated that LSCBs are exempt in their own right from FOI requests.</td>
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<tr>
<td>Reactive Media Responses</td>
<td>For any critical incidents the MSCB will co-ordinate the planning of pro-active and re-active Media responses and will liaise with the Communications Sections of other Partner Agencies as required</td>
</tr>
<tr>
<td>Serious Case Reviews</td>
<td>The Board is responsible for publishing serious case reviews and placing them on the website.</td>
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<tr>
<td>MSCB Branding</td>
<td>The chairman of the Board is responsible for the decision on whether or not the Board should go ahead and refresh its branding. With any branding refresh, the communications representative on the Board will work up branding for the chairman to sign off with the agreement of the rest of the Board. Branding to cover MSCB logo, publications, letter heads, power points, email strap-lines, <strong>The MSCB logo should not be used by any Partner or other agency without explicit written approval of the MSCB</strong></td>
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<tr>
<th>Audiences</th>
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<tr>
<td>MSCB Members and Sub-Group Members</td>
<td>The Strategy should enable effective and confidential communication to the MSCB members for the conduct of the Board’s business</td>
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</table>
as set out by statute and guidance – this is currently hosted through the Merton Partnership website

**Multi-Agency Staff & Volunteers of local agencies working with children and their families, or adults who have contact with children, in Merton**

It is important to ensure effective communication by the MSCB to and from frontline staff and managers so that everyone is aware of:
- agreed national and local safeguarding protocols & what their personal responsibilities for safeguarding children are;
- the findings from local audits and national and local case reviews/research into the quality of multi-agency safeguarding work and its operation and what changes, if any, are needed to ensure continuous improvement;
- what multi-agency training is on offer; and
- the role of the LSCB and the work it does and how practitioners may communicate with the Board and influence its work.

**External**

Communicating with the public is vital in the Board’s work on promoting the responsibility the whole of society has towards ensuring children are safe and secure and informing people about what they can do if they have concerns about a child. The Board’s work also contributes to building public confidence that the relevant agencies are looking out for children’s welfare.
- Young people
- Residents
- Faith and Community Groups

**Background**

Regulation 5 of the Local Safeguarding Children Boards’ Regulations 2006 sets out that one of the things that the LSCB does is: *Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so…*

The LSCB is an independent Board which includes all agencies involved in protecting the welfare of children and taking action when a child or young person is at risk of abuse or neglect. The purpose of the Board is to bring together professionals from a range of specialisms and expertise to ensure that all agencies know each other’s actions and that there is a coordinated approach to securing the welfare of children in the borough. In addition, the Board comes together to review processes and share best practice in its work to continually improve.

The LSCB also provides quality training to practitioners involved in safeguarding children who work in the organisations represented on the Board. Some of the courses are very popular and there is no problem with getting people interested in them. Others are more difficult to fill but are nevertheless important for people working in safeguarding.

**Strategy**

Ensure co-ordinated and accurate communications with all relevant parties by:
- defining objectives
- using the most appropriate communications channels tailored to the different audiences
Merton Safeguarding Children Board

- identifying events where the Board can be represented
- identifying partners’ publications which could be used to publicise the Board’s work
- developing a resource of agreed key messages which can be included in MSCB initiatives and which can be available for Partner Agencies to use and promote
- developing a programme of work and implementation plan
- agreeing for each initiative adopted by the MSCB what the Communication issues are that will follow – adapt the Front sheet for reports to the Board to address this

<table>
<thead>
<tr>
<th>Timeline</th>
<th>January 2015 – March 2016</th>
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<tr>
<td>Branding</td>
<td>The MSCB will seek to make its branding better-known as a symbol of safeguarding children.</td>
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<tr>
<th>Communications channels</th>
<th>Different Audiences will require different approaches - Messages should mirror the MSCB agreed priorities</th>
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<tr>
<td></td>
<td>Public</td>
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<tr>
<td></td>
<td>- LSCB internet pages: these are currently hosted on the council’s website.</td>
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<td></td>
<td>- My Merton – quarterly borough magazine which is distributed to every household in the borough (80,000 households) – aim at least once p year for MSCB item</td>
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<td>- Exhibition space in council reception</td>
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<td>- Local media</td>
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<td></td>
<td>- Through Partner Agency initiatives where the MSCB may be promoted</td>
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<td></td>
<td>- Promoting good news stories and achievements</td>
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|                         | Young People                                                                                                                                            |
|                         | - Through the MSCB Young People’s Participation Strategy (and possibly through schools &partner agencies’ communication strategies for young people). as this develops consider how social media may be used, if appropriate |

|                         | Professional (To work within current media channels rather than rely on email or developing a specific MSCB communication newsletter – for electronic communications provide easy e-links back to relevant sections of the website |
|                         | - Face-to-face, MSCB events and training                                                                                                                |
|                         | - Publications, Protocols,                                                                                                                                  |
|                         | - Merton Voluntary Service Council newsletter                                                                                                             |
|                         | - Young Merton Together e-briefings                                                                                                                        |
|                         | - CCG regular mailings to GPs                                                                                                                               |
|                         | - Council mailing to schools                                                                                                                                  |
|                         | - Council’s Staff Bulletin                                                                                                                                   |
|                         | - Other agency communications processes – to be mapped – including Agency Intranet systems                                                             |
|                         | - Professional Press                                                                                                                                             |
**Aims**
- To inform the public about what to do if they are concerned about the welfare of a child
- To inform young people about abuse and how they can seek help to prevent or stop it
- To raise awareness across the multi-agency workforce of what members of staff should do if they are concerned about the welfare of a child
- To raise awareness of the Merton Safeguarding Children Board among practitioners and their managers
- To promote learning and improvement, including through the quality training and briefings provided by the LSCB to practitioners

**Key Messages**

**Child-focused messages**
- Everyone has the responsibility to ensure children are kept safe and well
- Every child has a right to grow up in a safe and loving environment
- No child or young person should be neglected or abused – abuse can take several forms, including witnessing abuse and online abuse

**MSCB-focused messages**
- The safety of children is at the heart of the decisions and actions taken by the MSCB
- The MSCB will work to ensure that the voice of the child is included in its activities including making decisions
- The MSCB is committed to working with professionals in children’s welfare to promote the safety and wellbeing of young people in Merton
- The MSCB knows the value of the flow of accurate, timely and targeted communications in its work to provide young people at risk with a safe environment
- The MSCB invites constructive appraisal in its endeavour to continuously improve

**Assessing effectiveness of communications**
- Annual questionnaire to a sample of practitioners about how well informed they feel about the Board’s activities (Survey Monkey?)
- Regular agenda item at the Board’s meetings on communications effectiveness and the action plan progress
- Merton Safeguarding Children’s Board to review communications strategy and action plan, as part of its annual rolling Business Plan review

**Evaluation**
- Balanced, factual press coverage
- Increased awareness of what the MSCB is and the work it does and recognition of the branding
- Fully informed staff on key local safeguarding issues and developments
- One safeguarding editorial piece in each issue of the borough magazine
- 2/3 proactive news stories per year on safeguarding issues
Appendix Ten

Merton Safeguarding Children Board & London Borough of Merton

Children and Young People’s Participation Strategy - 2016

Introduction

We have the highest ambitions for all our children and young people, and we judge our success by a range of criteria including being able to demonstrate that the views and ambitions of children and young people have informed and improved our service offer.

We believe that actively involving children and young people when making decisions:

- sends a powerful message that children and young people of all ages should be listened to and;
- recognises children and young people as major stakeholders in society with important contributions to make in their education and how we design and deliver services they receive.

We also recognise the need to seek feedback from young people and seek views of parents/carers on the services they and their children receive.

Merton’s Children and Young People’s Plan

Our Children and Young People’s Plan identifies eight core values, one of these focuses on ensuring effective user voice. This highlights the importance we give to listening and responding to our young people and service users.

- **We listen, respond to and value our children and young people.** Children and young people have rights to participate in decisions affecting their lives and participation provides opportunities for them to develop important life skills. Services should not only listen but should help children and young people shape services they receive. We should also canvas and respond to the views of parents and carers.

User Voice Drivers

In addition to the core value noted above, our user voice ambitions are underpinned by key legislation and policies which instruct and expect professionals to listen to children and take account of children’s wishes and feelings. These include:

- The Children Act 1989 for England and Wales recognises children as citizens with the right to be heard. The Act made it a legal requirement for the views of children to be taken into account in any court decisions affecting them. The Children Act 2004 (section 53) amends sections 17, 20 and 47 of the Children Act 1989. It requires that when working with children in need, their wishes and feelings should be ascertained and used to inform making decisions.
- Article 12 of the 1989 UN Convention on the Rights of the Child asserts that right in general.
A key objectives of the Quality Protects initiative ‘To demonstrate that the views of children and families are actively sought and used in the planning, delivery and review of services’ (Objective 8.1 Quality Protects Briefing no.3, Young people’s participation, Department of Health, 2000).

Positive for Youth, cross- Government statement of policy for young people aged 13-19, December 2011. The policy specifically for local authorities states that young people have a right to have their voice heard in decisions that affect their lives and that every Local Authority should have a group of young people that can represent their peers’ views in decision making and audit the quality of local services.


In June 2013, Merton’s Health and Wellbeing Board agreed the terms of a charter for disabled children promoted nationally by Every Disabled Child Matters and the Children’s Trust Tadworth. The charter is designed to prompt local Health and Wellbeing Boards to prioritise improving the quality of life and outcomes for disabled children and young people. Its terms include commitments to a range of activities, including engaging more strongly with disabled young people and their families, to ensure high quality services.

User Voice in Practice

The Children, Schools and Families Department listens to the views of children and young people, carers, parents and other service users through four key avenues. These are:

- An approach expected of all practitioners and managers which puts children’s wishes and feelings at the centre of decision making and planning.
- Merton’s youth participation promise.
- Targeted user feedback.
- Complaints and compliments.

These enable ‘user voice’ to have an impact on the design and delivery of services from the strategic to operational levels.

Practice which puts children’s wishes and feelings at the centre of decision making and planning.

This reflects the core value of the Children’s Trust as stated above, as well as meeting the requirements of the Children Act 2004 (section 53) which requires that when working with children in need, their wishes and feelings should be ascertained and used to inform decision making. Practitioners and managers across Merton’s children’s workforce are expected to engage well with children and young people and to ensure that their views are listened to and influence decision making and planning for their support needs.

Youth participation promise

In 2009 Merton’s Children’s Trust launched the ‘youth participation promise’ as our commitment to the ‘hear by right’ practice standards. This aimed to increase the participation of children and young people in the design and delivery of children’s services, as well as developing channels which enable school councils and the youth parliament to link with, and
impact upon, the adult democratic process. The youth participation promise is delivered through mechanisms including school councils, Merton’s Youth Parliament, and Young Advisers. The key elements of the promise are to enable children and young people to:

- be listened to
- take responsibility
- be involved in making choices and decisions
- be involved in how we spend money for children’s services.

Targeted user feedback

Our ‘targeted user feedback’ approach involves obtaining feedback from children, young people, parents and carers who are supported by Children, Schools and Families services. We have a range of children and young people’s forums that enable our users to participate in consultation and governance activities. Our special interest forums include:

- Children in Care Council for children and young people aged 14 plus in care and leaving care.
- Your Shout Group for disabled young people aged 14-25.
- Young Carers Forum

We also expect individual service areas to obtain feedback routinely from service users through mechanisms including regular user surveys. Although historically we have surveyed a range of users including parents in assessment and child protection processes; young people accessing universal youth services and our foster-carers, we recognise the need for more comprehensive surveying of service users.

Commissioned services – including our early intervention and prevention and short-breaks services - are also expected to obtain views of service users and these inform routine contract monitoring.

Complaints and Compliments

We also use our complaints procedure to ensure that children’s voices are heard and feed into service developments. We will continue to encourage children and young people to tell us what’s good and bad about the services they receive from us, and we will use this information to learn from our mistakes and to improve services. We want young people to know how important their voices and opinions are and to provide them with support when they need it – for example, we have re-commissioned our advocacy and independent visitor services for 2013-16 with this in mind. We recognise that more needs to be done to promote complaints from children who are not satisfied with services – we have amended complaints materials and introduced a texting provision to this end although children’s formal complaints remain low.

In April 2010 we introduced ‘resolution meetings’ aiming to resolve complaints quickly and before potentially lengthy formal processes - these have been successful for all parties. These meetings involve the complainant, the service manager involved and the customer service officer (CSO). The CSO mediates between both parties to identify and resolve the outstanding issues, and the meeting gives the complainant the opportunity to raise concerns directly with senior managers. Results show that these meetings are working, perhaps
because they offer a much more personal service and clearly demonstrate to the complainant that we take their complaint seriously, and can help them get closure on a difficult episode or issue in their lives.

Our goal is to make sure that we continue to listen and learn from the complaints and compliments we receive and to use this process to ensure that there is continuous improvement in our services to our young people.

**Framework commitments**

We want to continue to find engaging ways for children, young people, parents and carers to represent their views, and to consult with our service users and other children and young people on their terms and on familiar territory.

- We will continue to embrace a variety of models of feedback and participation, recognising that one style may not fit all.
- We will continue to develop participation methods for children and young people’s views to be more strongly heard in key governance structures eg Merton’s Children’s Trust and Local Safeguarding Children Boards. We will also publicise routes for feeding issues raised by young people and other service users to decision makers.
- We always try to understand what our feedback is telling us. We will analyse our feedback and consider what we have been told when planning our services to ensure we continuously improve. We will log summaries of our feedback findings in a central repository for cross departmental use.
- We will, where appropriate, publish our feedback findings in Young Merton Together to share our findings with others across the Children’s Trust and Local Children Safeguarding board.
- We will ensure that services and service users who take part in events or share their views always get feedback about what has happened to their input and any outcome from it.
Appendix Eleven  Information Sharing Protocol

Merton Safeguarding Children Board

Information Sharing Protocol

Agreed by the MSCB March 2017

It should be noted that the DfE issued revised Information Sharing Guidance for Practitioners on 26 March 2015 – this guidance will be updated to match the revised guidance.

Who does the Information Sharing Protocol affect?

The protocol affects all staff engaged with work involving children and families (including parents known to adult services) that requires information to be shared with, or is given to them by other organisations.

The benefits of this Information Sharing Protocol

- Help remove barriers to effective information sharing.
- Provide guidance to assist in complying with legislation.
- Help to ensure that consent to share personal information is obtained whenever it is required.
- Help to ensure that information is shared when there is a requirement to do so.
- Help to ensure that all agencies comply with relevant legislation.
- Raise awareness amongst all agencies of the key issues relating to information sharing and give confidence in the process of sharing information with others.

Principles of Information Sharing

Effective information sharing underpins integrated working and is a vital element of both early intervention and safeguarding. Each partner can hold different pieces of information which need to be placed together to enable a thorough assessment to be made.

To share information about a person you need a clear and legitimate purpose to do so, as this will determine whether the information sharing is lawful. For partners working in statutory services, the sharing of information must be included within the powers of the service. This will also apply if partners from the voluntary sector are contracted to provide a service on behalf of a statutory body.

Sharing of information will comply with the Caldicott Principles.

Obtaining and sharing information

The sharing of information must have due consideration with the law relating to confidentiality, data protection and human rights. Having a legitimate purpose for sharing
information is an important part of meeting those legal requirements. It is important only to share as much information as is needed and records should be accurate, relevant and up to date.

**Confidential information**

*Confidential information* is:

- Private or sensitive personal information.
- Information which is not already lawfully in the public domain or readily available from another public source.
- Information that has been provided in circumstances where the person giving the information could reasonably expect that it would not be shared with others.

This is a complex area and you should seek advice from your organisation’s Information Manager, if you are unsure about confidentiality

Signatory agencies to this protocol may lawfully share confidential information without obtaining consent only if this an overriding public interest. Judgement is required on whether there is sufficient public interest using the facts of each case individually. Public interest can arise when protecting children from significant harm, promoting the welfare of children or preventing crime and disorder.

Proportionality and necessity are factors to be taken into consideration when deciding whether or not to share confidential information. In making the decision, practitioners must weigh up what might happen as a result of the information being shared against what might happen if it is not and apply their professional judgement.

The nature of the information to be shared is also significant where the information is sensitive and has implications for the practitioner’s relationship with the individual, recognising the importance of sharing information in a timely manner if it is in the child best interest to do so.

Where there is a clear risk of significant harm to a child you must share the information to safeguard the child

**Obtaining consent**

Consent must be informed, in other words the person giving consent needs to understand:

- Why the information needs to be shared
- Who will see it
- How much will be shared
- What are the purposes and implications of sharing

It is good practice for signatories to set out their policy on sharing information when clients first join a service and when securing information, the process should be transparent and
respect the individual. Consent must not be obtained by coercion and must be sought again if there are to be significant changes in the use to be made of the information.

A child or young person, who is able to understand and make their own decisions, may give or refuse consent to share information. This would generally include children aged over 12, although younger children may have sufficient understanding. The child’s view should be sought as far as possible. If a child is competent to give consent or refusal but a parent disagrees each individual case should be considered and again professional judgement should be applied and documented.

When assessing a child’s ability to understand, practitioners should explain in a way suited to their age, language and likely understanding. Where a child cannot consent, a person with parental responsibility should be asked to do so, on their behalf, although there are circumstances where this might be inadvisable. Where parenting is shared only one person with parental responsibility for a child needs to give consent.

In some cases it may not be appropriate to let a person know that information about them is being shared nor to seek their consent to share the information. For example, this would arise when sharing information is likely to hamper the prevention or investigation of a serious crime or put a child (or adult) at risk of significant harm.

In these circumstances, practitioners need not seek consent from the person or their family nor inform them that the information will be shared; but should record their reasons for sharing information without consent or informing the person about whom the consent is being shared.

Similarly, consent need not be sought when practitioners are required to share information through a statutory duty or court order. However, in most circumstances they should inform the person concerned that they are sharing the information, why they are doing so and with whom.

### Sharing Information Appropriately and Securely

Information should be shared in accordance with the principles of the Data Protection Act 1998 and follow the policy and procedures of the signatory service.

Information should always be shared safely, either by secure IT connection, secure email or secure transfer of paper documents. Information should never be sent via a non secure method.

Practitioners should:

- Only share the information which is necessary for the purpose.
- Understand the limits of any consent given, particularly if it is from a third party.
- Distinguish between fact and opinion.
- Only share it with the person or people who need to know and check that the information is accurate and up to date.
- Record decisions on sharing information and the reasons for doing so or not.
- If deciding to share the information, record what was shared and with whom.
- If deciding to not share the information, record the reasons for this decision.
Retaining and storing Information

Information must not be retained for longer than necessary for the purpose for which it was obtained. Signatory services should ensure that they have physical and electronic security in place for the stored data and that there is awareness, training and management of the systems where the information is stored.

Regular review

This agreement will be reviewed bi-ennially by the Policy Subgroup of the MSCB and amended, as required before that to take account of changes in law, guidance and lessons learned from sharing data.

Signatories to the Protocol

This protocol is provided to meet the needs of partners and it is intended that all signatories will use the protocol. The MSCB holds a signed copy of the Information Sharing Protocol

Information Sharing Checklist

- Do I already have informed consent to share this information?
- Is the information sensitive and personal?
- Do I need consent to share the information?
- Have I a legal duty or power to share the information?
- Whose consent is needed?
- Whose information is this?
- Would seeking consent place someone at risk, prejudice a Police investigation, or lead to unjustifiable delay?
- Would sharing the information without consent cause more harm than not sharing the information?
- How much information is it necessary to share in this situation?
- Am I giving this information to the right person?
- Am I sharing this information in a secure way?
- Does the person I am giving it to know that it is confidential?
- What will they do with it?
- Is the service user aware that the information is being shared (where this would not place someone at risk or prejudice a Police investigation)?
- Have I distinguished between fact and opinion?
- Does the person who is giving consent understand the possible consequences of sharing the information?
Flowchart of key questions for information sharing

You are asked to or wish to share information

- Yes
  - Is there a clear and legitimate purpose for sharing the information?
    - Yes
      - Does the information being shared enable the person to be identified?
        - Yes
          - Is the information confidential?
            - Yes
              - Do you have consent?
                - No
                  - Is there sufficient public interest to share?
                    - No
                      - Do not ... No
                    - Yes
                      - You can share

- No
  - Not sure
    - Seek advice

Share Information:
1. Identify how much information to share.
2. Distinguish fact from opinion.
3. Ensure that you are giving the right information to the right person.
4. Ensure you are sharing the information securely.
   - Inform the person that the information has been shared if they were not aware of this and it would not create or increase risk of harm.

Record the information sharing decision and your reasons in line with your agency’s or local procedures.

If there are concerns that a child may be at risk of significant harm or an adult may be at risk of serious harm, then follow the relevant procedures without delay. Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.
Legislation/Guidance
The Data Protection Act 1998
The Human Rights Act 2000
The Children Act 2004
The Crime & Disorder Act 1998
Freedom of Information Act 2000
NHS Act 2006
Working Together to Safeguard Children 2015
and Information Sharing (Advice for practitioners providing safeguarding services to children, young people, parents and carers) March 2015

Seven golden rules for Information Sharing, HM Government: March 2015

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely (see principles).

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

The Caldicott Principles

1. Justify the purpose(s)
   Every proposed use or transfer of patient identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.
2. **Don’t use patient identifiable information unless it is absolutely necessary**  
   Patient identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. **Use the minimum necessary patient-identifiable information**  
   Where use of patient identifiable information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

4. **Access to patient identifiable information should be on a strict need-to-know basis**  
   Only those individuals who need access to patient identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

5. **Everyone with access to patient identifiable information should be aware of their responsibilities**  
   Action should be taken to ensure that those handling patient identifiable information - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. **Understand and comply with the law**  
   Every use of patient identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

7. **The duty to share information can be as important as the duty to protect patient confidentiality**
Appendix Twelve  Measuring LSCB Effectiveness

An effective LSCB is:

- A strong enquirer and challenger of effective frontline practice with children, young people and families and can describe the features
- Understands the intended and actual impact of practice
- Sees and uses children’s journeys and experiences as a key measure of the difference being made locally
- Understands performance information and uses to understand story behind data – a questioner
- Understands early help and child protection thresholds but accepts the importance of professional judgement in assessing risk for children and families – is adaptive in response
- Understands and acts upon the experiences of other agencies in helping and protecting children, young people and families
- Is deeply searching for system feedback and learning from that knowledge
- Already has and regularly reviews local multi-agency professional guidance and procedures for helping and protecting children and young people – including advice for adult services
- Understands and works strategically with the Health and Well Being Board in respect of the shared agenda for helping and protecting children, young people and families
- Reviews the breadth and impact of early help, support for children ‘in need’ and child protection practice – including outcome and ‘destination’ measures
- Understands the impact and quality of supervision for professional frontline staff
- Leads a case-auditing system that provides learning about the quality of practice, the recording of decisions and practice intent, the quality of management oversight, professional judgement and minimisation of risk
- Evidences independence, accountability, transparency and robust challenge of the local system

How should an LSCB secure its understanding about:

- The quality for front-line social work practices to help and protect children, young people and families?
- The effectiveness and impact of the help and protection that is offered to children, young people and families?
• The quality of front-line practice in universal services working to help and protect vulnerable children and families?

• What should an LSCB know about the local community and the prevalence of domestic violence in families and the mental ill health or substance misuse of parents/carers?

• What should the LSCB do in response to this knowledge?

• Where, on a child or family journey through early help or child protection systems, are the significant thresholds that the LSCB should regularly examine for effectiveness?

• What investigation, and how often, should the LSCB make about thresholds for helping and protecting children, young people and families?

• What evidence should inform the multi-agency training plan and how should the priorities be agreed?

• What activities should be in place to enable the LSCB to challenge the local authority and its partners on the effectiveness of the help and protection offered to children, young people and families locally?

Jackie Tiotto, OFSTED Nov 2012
# Merton Safeguarding Children Board

## Quality Assurance Sub Group

### Terms of Reference

<table>
<thead>
<tr>
<th>Agreed:</th>
<th>Lead:</th>
<th>Review:</th>
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<tbody>
<tr>
<td>20 Jan 2015 at the MSCB</td>
<td>MSCB Board Manager &amp; QA Sub Group Chair</td>
<td>Annually in March at Business Planning Awayday</td>
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<td>Revised June 2017</td>
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1. **Purpose**

1.1. **Vision/Outcomes**

To seek to ensure children and young people are safeguarded and protected by overseeing the quality of single and multi-agency work carried out in partnership across the children and young people and adult sectors, to safeguard and promote the welfare of children.

1.2. **Key responsibilities**

Within the agreed MSCB Learning and Improvement System (Agreed July 2014) and Performance Management Framework (Agreed September 2014):

- It has specific responsibility to analyse the incidence of child abuse and neglect within Merton and to advise the Board on this; and to oversee the assurance of the quality of the direct agency and multi-agency work with children and families.

- To analyse single agency and multi-agency data to understand incidence of need, abuse, neglect and harm to children and young people in Merton and any developing trends in order to make recommendations to the MSCB and to other relevant Partnership Bodies.

- To analyse agency and multi-agency performance data as a guide to quality of response to children and families.

- To oversee the quality assurance of multi-agency and individual agency safeguarding and promotion of welfare of children; identifying issues and trends in agency and multi-agency performance and practice, including learning from agency audits.

- To develop and advise on ways of individual agency and partnership case working and best practice based on knowledge and learning gained through data, local audit, national and local experience and research. (This may include the need to make recommendations on case management where there is a disagreement between agencies.)

- To advise the Chair of the MSCB on the need for and oversee any serious incident or other reviews, including the commissioning of independent or serious case reviews, and to commission the dissemination of multi-agency learning achieved through such reviews, by the Training and Development Sub Group.

- To contribute to and take account of learning and actions from agency section 11 audits and how these impact on the day to day casework and clinical practice. (Section 11 Audits will be commissioned by the Board and
managed by the Business Implementation Group through the agreed Annual Agency QA and Peer Review Process, overseen by the MSCB Chair.)

The Board may also delegate other relevant activities to the Quality Assurance Sub Group, as appropriate.

1.3. Governance

The Quality Assurance Sub Group reports to and is accountable to the MSCB as one of a number of sub groups detailed to drive and deliver specific aspects of agency and partnership work to safeguard children and young people. The Sub Group will report to the MSCB at each of the MSCB meetings.

The Sub Group will work to an annual work plan, agreed by the MSCB (or executively by the MSCB Chair) each March which draws on the agreed priorities of the MSCB, as set out in the MSCB Business Plan.

The Sub Group Chair will report to the MSCB on the Sub Group’s progress against the Work Plan at each meeting of the MSCB; and, as necessary, to the MSCB Chair between meetings.

2. Membership and Meeting Structure

2.1. Chair: Assistant Director of Children’s Social Care, Merton Children Schools and Families

Vice Chair: Designated Nurse, Merton Clinical Commissioning Group

The Chair will sit as a member of the MSCB.

2.2. Core membership

Health
Designated Nurse for Safeguarding, Merton & Wandsworth CCG
Named Nurse, SW London & St George’s Mental Health Trust/CAMHS
St George’s Hospital Trust
Named Nurse, Epsom & St Helier Trust
Named Nurse, CLCH
Named GP –Vacancy (Audit meetings)

Merton Council
Service Manager Quality Assurance and Practice Development, CSF
Service Manager for Policy, Planning & Performance, Policy, Planning & Performance (Business meetings only)
Principal Social Worker, CSF
Merton Safeguarding Children Board

Senior Education Representative, LB of Merton CSF
Senior Early Years & Childcare representative, LB of Merton CSF
MASH and CP Service Manager (Business meetings)
MASH Team Manager (Audit meetings)
CASA Manager
Quality Assurance Manager, Merton CSF (Audit meetings)

Police
Child Abuse Investigation Team (Audit meeting as required)
Borough Police (Audit meeting as required)

Probation
Asst. Chief Officer, London Probation (Audit meetings as required)

Voluntary & Community Sector representative(s) – to be agreed

One of the Head Teacher Representatives to be asked to attend Audit Meetings

Other representatives as invited by the Chair.

Where there is any change in commissioning arrangements it will be important that the relevant service providers are appropriately represented within this group

Sub Group Members will be expected to represent their agency/sector and have experience of and good knowledge of current safeguarding standards and to communicate any proposals/decisions/actions to their own agency; and to relevant constituent organisations within their sector where they represent more than one agency.

2.3. **Quoracy**

At least three partners including: Children’s Social Care, Health and Education Not including the chair
Police to attend at least three meetings per year

2.4. **Other attendees**

MSCB Business Management and Administration.

2.5. **Deputising arrangements**

Members are expected to nominate deputies to attend in their place if necessary. Such deputies must be aware of their role within the group.
2.6. **Meetings frequency**

Business Meetings will be held bi-monthly on a schedule which allows good time for a report to be drawn up for the MSCB main meetings.

Multi-Agency Audit Meetings will be held at least 3 times per year.

Multi-Agency data will be analysed quarterly in arrears.

The Sub Group will at times work ‘virtually’ between scheduled meetings to ensure completion of tasks, sharing data, responding to documents and auditing cases or undertaking case reviews or learning and improvement reviews as necessary. This may involve face to face meetings or electronic conversations.

2.7. The aim will to be to provide Agenda and working documents 5 working days in advance of Sub Groups meetings; and to provide draft Minutes and Action Log 10 working days in arrears.

3. **Additional Responsibilities**

3.1. To work within the objectives and principles set out in the overall Merton Partnership Equalities and Diversity Policy and to agreed values and standards of behaviour in public service.

3.2. The promotion of the welfare and protection of children will be central to the Sub Group’s work and this will include ensuring understanding of the experience of children and young people and listening to their voice.

3.3. In line with the agreed Learning and Improvement System to ensure that the views and experiences of practitioners are considered.

3.4. To advise and commission promotion of the learning from local the QA and Audits through the Training and Development Sub Group and the MSCB Training Officer.

3.5. To advise the MSCB of priority areas of action required as a result of the Sub Group’s analysis of data and QA work.

3.6. To advise the Policy Sub Group of any lessons/matters in relation to policy or protocol that require attention.

3.7. To monitor Multi-Agency and Single Agency Safeguarding Audit Plans and learning outcomes; and provide information on these to the Annual Agency QA and Peer Review process as part of the monitoring of Agency Section 11 Standards.

3.8. To contribute to the MSCB Annual Report, as required.
3.9. To review / trouble-shoot cases referred to it where there is disagreement in the network about the agreed plan or its delivery

3.10. To monitor case escalations (as per London CP Procedures) and complaints direct to the MSCB

4. **Performance measures**

4.1. To analyse and comment on agreed multi-agency data & performance measures from Partner Agencies in order to gain a comprehensive view of incidence, trends and delivery of safeguarding services; and to report on this with a commentary to the MSCB at least quarterly and for the MSCB Annual Review. 4 times per year to the MSCB and annually in the Annual Report.

4.2. To undertake a minimum of four multi-agency and themed case audits per year, comprising three cases and reviewing agency and multi-agency work, including practitioner, line-manager and service manager views.

4.3. To review each agency or Sector’s Safeguarding Quality Assurance Strategy and Audit Plan at least once per year on a rolling programme and to receive summary reports of lessons and outcomes of such Agency Audits. (This will include the Multi-Agency Assessments and MASH services)

4.4. To commission via the Training Sub Group termly Practitioner Learning Briefings to include lessons from the Sub Group’s multi-agency case audits and Learning and Improvement case reviews.

5. **Work Programme**

The Sub Group Chair will submit a draft Work Plan to the MSCB for endorsement at the Annual Planning Awayday in March each year. The work plan will reflect the priorities of the MSCB Business Plan.

The Sub Group will report to each Business Implementation Group Meeting its progress against the work plan.

*Approved by the MSCB on June 2015, revised for approval 27 June 2017*
Merton Safeguarding Children Board
Policy Sub Group

Terms of Reference

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<tr>
<th>Agreed:</th>
<th>Lead:</th>
<th>Review:</th>
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<tbody>
<tr>
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<td>Policy Sub Group Chair &amp; MSCB Board Manager</td>
<td>Annually in March at Business Planning Awayday</td>
</tr>
<tr>
<td>Revised June 2017</td>
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1 Purpose

1.1 Vision/Outcomes

To take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency policies, protocols and procedures \(^1\) to ensure children and young people are safeguarded and protected and their welfare is promoted.

1.2 Key responsibilities

Within the agreed MSCB Learning and Improvement System (Agreed July 2014):

*A key principle agreed by the MSCB is that the London Child Protection Procedures should take precedence in order to avoid confusion or multiplication; and ease of working across local Authority boundaries. Creation of separate MSCB policy, protocols or procedural guidance should be exceptional. When such additional or alternative local guidance is agreed it should always state its status vis-à-vis the London Child Protection Procedures.*

- To lead the inter-agency implementation (and review) of the London Child Protection Procedures in Merton

- To draft supplementary and localising guidance to ensure that the London Child Protection Procedures are locally relevant in Merton, as required.

- To keep agreed local policy, protocols and procedures under review in a timely way (at least bi-ennially) and to ensure that they are reviewed in the light of any new legislation or guidance and from any learning or outcomes from Learning and Improvement Reviews (local or national).

- To scrutinise, oversee and advise individual agency procedures to ensure compatibility with the agreed inter-agency safeguarding procedures; including to draft and maintain a specimen safeguarding policy for use by commissioned agencies.

- To comment on behalf of the MSCB, as appropriate, on the safeguarding children and promotion of welfare aspects of policies, protocols and procedures being drafted by other local bodies or partnerships – where these are wider than safeguarding but are about supporting children and families.

\(^1\) See appendix for reference to Policies, Protocols and Procedures
• To promote agreement and understanding across agencies about operational definitions and intervention thresholds in multi-agency work.

• The Policy Sub Group will keep an overview of all the MSCB Policies, Protocols and Procedures; however, some of these will be delegated to other Sub Groups for co-ordination.

• As a general rule the Policy Sub Group will take responsibility for policies in relation to safeguarding children from harm and neglect within their families or substitute families. (Core early intervention and child protection procedures and looked after children procedures; private fostering; specialist areas such as parental mental ill-health, parental alcohol and substance abuse, and parental disabilities; FGM, cultural-based abuse and ‘honour’ violence). The Policy Sub Group will also hold responsibility for review of overarching Protocols such as the Information Sharing Protocol.

• The Promote and Protect Young People Sub Group will be responsible for policies where abuse is extra-familial such as CSE, missing children, child on child abuse, other forms of exploitation (such as radicalization), online-safety, abuse by those in a position of trust or in institutions – including faith organisations and community organisations (LADO).

• The Learning and Development sub Group will be responsible for the MSCB Training Strategy and any agreed policies arising from it.

• To review (the need for new) policies where there have been lessons from case reviews or audits which demonstrate the use of policies in practice.

• To ensure that all Policies, Protocols and Procedures have Implementation Plans and to monitor those Plans.

• To ensure that policies are embedded through the commissioning process when safeguarding and welfare services are commissioned or procured through others.

• The Board may also delegate other relevant activities to the Policy Sub Group, as appropriate.

1.3 Governance

The Policy Sub Group reports to and is accountable to the MSCB as one of a number of sub groups detailed to drive and deliver specific aspects of agency and partnership work to safeguard children and young people.

The Sub Group will report to the MSCB as required, at least annually and by
exception where necessary; it will draw to the MSCB and Partner Agencies’ attention where there is a need for change in guidance.

The Sub Group will work to an annual work plan, agreed by the MSCB (or executively by the MSCB Chair) each March which draws on the agreed priorities of the MSCB, as set out in the MSCB Business Plan.

The Sub Group Chair will report to the MSCB on the Sub Group’s progress against the Work Plan at each meeting of the MSCB; and, as necessary, to the MSCB Chair between meetings.

2 Membership and Meeting Structure

2.1 Chair: A senior representative of one of the partnership agencies

Vice Chair: A senior representative of one of the agencies

The Chair will sit as a member of the MSCB.

2.2 Core membership

Health
Designated Nurse for Safeguarding, Merton CCG
Representative, SW London & St George’s Mental Health Trust/CAMHS
Named Nurse, Epsom & St Helier Trust
Named Nurse, Community Health Services

Merton Council
Senior Social Care Representative, CSF
Service Manager, Commissioning, CSF
Senior Education Representative, CSF
Senior Early Years & Childcare representative, CSF
CASA Manager, Early Intervention (as needed), CSF
Family and Adolescent Services representative, CSF
Think Family Coordinator
Adult Services Representative

Police & Probation – to be co-opted as required and expected to contribute virtually to consultations

Voluntary & Community Sector representative(s)

Schools Representatives to be consulted through LSCB School Reps & termly meetings of Designated Persons in Schools

Other representatives as invited by the Chair.
Sub Group Members will be expected to represent their agency/sector and have experience of and good knowledge of current safeguarding standards and to communicate any proposals/decisions/actions to their own agency; and to relevant constituent organisations within their sector where they represent more than one agency.

2.3 Quoracy

At least three separate partner agencies including: Merton Council and Health (Not including the chair)

2.4 Other attendees

MSCB Business Management and/or Administration.

2.5 Deputising arrangements

Members are expected to nominate deputies to attend in their place if necessary. Such deputies must be aware of their role within the group.

2.6 Meetings frequency

Meetings will be held at least four times per year on a schedule which allows good time for a report to be drawn up for the MSCB main meetings.

The Sub Group will at times work ‘virtually’ between scheduled meetings to ensure completion of tasks, sharing drafts, responding to documents. This may involve face to face meetings or electronic conversations. The Sub Group will create task and Finish Groups as required.

The aim will to be to provide invitations and Agenda at least 10 working days in advance and working documents 5 working days in advance of Sub Groups meetings; and to provide draft Minutes and Action Log 10 working days in arrears.

Each meeting will agree the core agenda for subsequent meetings as part of the annual work programme.

3 Additional Responsibilities

3.1 To work within the objectives and principles set out in the overall Merton Partnership Equalities and Diversity Policy and to agreed values and standards of behaviour in public service.
3.2 The promotion of the welfare and protection of children will be central to the Sub Group’s work and this will include ensuring understanding of the experience of children and young people and listening to their voice.

3.3 In line with the agreed Learning and Improvement System to ensure that the views and experiences of practitioners are considered.

3.4 To advise the MSCB of priority areas of action required.

3.5 To inform the Learning and Development Sub Group of the need for training or briefings in relation to new or revised guidance.

3.6 To contribute to the MSCB Annual Report, as required.

4 Performance measures

4.1 To maintain and publish a register of all agreed MSCB policies, protocols and procedures and ensure that they are reviewed at least biennially to an agreed schedule; including scrutiny of annual reports on their operation where required e.g. Annual Private Fostering Report.

4.2 The Sub Group will report to the Business Implementation Group Meeting its progress against the work plan, as required.

4.3 To provide a summary of the Sub Group’s work for the Annual Report.

5 Work Programme

   The Sub Group Chair will submit a draft Work Plan to the MSCB for endorsement at the Annual Planning Away Day in March each year. The work plan will reflect the priorities of the MSCB Business Plan.

The refreshed Terms of Reference are to be agreed at the MSCB Meeting on June 2017.
Appendix to the Policy Sub Group Terms of reference

Glossary

**Strategy** is a high level plan to achieve one or more goals. Strategy generally involves setting goals, determining actions to achieve the goals, and mobilizing resources to execute the actions. A strategy describes how the ends (goals) will be achieved by the means (resources). The senior leadership of an organization is generally tasked with determining strategy. It involves activities such as strategic planning and strategic thinking.

MSCB Strategies will be agreed by the MSCB not the Sub Groups.

**Policy** is a system of principles to guide decisions and achieve agreed outcomes. A statement of intent, and is then implemented as a procedure or protocol. The process of making important organizational decisions, including the identification of different priorities, and choosing among them on the basis of the impact they will have. For an LSCB policies will be agreed based on current legislation, national guidance, local assessments of need, resources and understanding of validated research and best practice.

**Protocol** is an accepted code of conduct or acceptable professional behaviour, including rules and guidance. For the MSCB Protocol will be used to denote a specific agreement, including both policy and procedure, by the MSCB for its Partner Agencies about a set of responsibilities to meet a particular issue – e.g. Information Sharing Protocol, Mental Health Protocol.

**Procedure** – sets out the actions, stages and people responsible for undertaking a process. It will be derived from agreed policy. It will give greater detail than a policy or protocol and forms a set of guidance or instructions to be followed.

For the MSCB Procedures will be multi-disciplinary and multi-agency and will clarify roles and responsibilities, communication and (possibly) timescales across agencies for different aspects of work to safeguard children and promote their welfare.

The MSCB has agreed that it should only agree new procedures where they do not currently exist in the London Child Protection Procedures; or adapt, clarify or localise the London procedures to ensure that they can be put into practice within Merton.

Procedures will be drafted by the relevant Sub Groups and consulted on before being presented to the MSCB for endorsement. Every MSCB Procedure will be ‘owned’ by one of the Sub Groups and will be reviewed for its relevance and measurement against legislation statutory guidance and best practice at least biennially; where there is a need it will be reviewed earlier.

The Policy Sub Group will maintain a register of agreed policies, protocols and procedures and will ensure that they are up-to-date.
Appendix 2 to the Policy Sub Group Terms of Reference

Drafting MSCB Documentation - Document control & creation

Every document including a draft in process needs an ‘owner’ – usually a role (or subgroup) not just an individual’s name.

Drafts should have a version number for each time there is a substantial change, v1, v2, v3, etc. until the ‘final draft’.

All documents should have page numbers – authors of long documents should consider if paragraph numbering is needed.

All final agreed documents must show on the front page where and when they were signed off; and the date of the next review.

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Author</th>
<th>Date of the Next Review</th>
<th>Lead officer</th>
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<tr>
<td>February 2015</td>
<td>MSCB Board Manager</td>
<td>March 2016</td>
<td>MSCB Chair</td>
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<tr>
<td>V1 etc. or FINAL AGREED</td>
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Routine annual reviews of content of strategies, policies and procedures, etc. should be avoided as it creates more work – best to go for biennial reviews – if there is a need for earlier review they can always be brought forward sooner. The review should include a review of how effectively the Policy was implemented and what its impact has been and whether a review of its contents is required.

If we are creating a new policy or procedure which is separate to the London Child Protection Procedures we should state in the introduction why this is needed and how it differs. It may be that all that is needed is a localising addendum making it clear how that London procedure operates in Merton and any difference in terminology, proforma or leadership or key contacts. There will be a localised version of the London Procedures showing this information for Merton against the London Procedures index so that practitioners can be clear where there is additional or separate Merton guidance.

Procedures should use flowcharts ad diagrams for ease of explanation where possible and signpost key roles/officers and contact details to aid multi-agency and multi-disciplinary working.

All policies, protocols and procedures should include an implementation plan for approval and monitoring.

In terms of governance fewer items will come to the MSCB for sign off. Sub Groups will be expected to undertake virtual consultation prior to Policies, etc. going to the Board for
endorsement. The cover sheet should say that key agencies have been consulted etc. and that there is agreement or what the discrepancies are if the BiG or the MSCB needs to make a ruling.

Papers going to the Board will have a front sheet setting out the purpose of the paper and what the Board is being asked to do as a result of the paper – we should try to minimise those that are just for ‘information’ – we should use other processes for that unless a briefing of some kind is the only way to take something forward in which case it is for action – i.e. briefing and implementation. Where the Board is being asked for decisions or endorsement of recommendations the Executive Summary part of the Front Sheet will make it clear and re-list the actions needed by the Board (even if they are more fully explained in the accompanying paper).

All Sub Groups should adopt a similar process for managing papers.

As part of the Constitution Review (Feb 2015) it has been agreed that Agencies will be expected to respond to drafts and request for comments and it cannot be assumed that no response means agreement. Certain documents may require signatures from Agencies to demonstrate endorsement and acceptance. The MSCB will introduce a further section for the front sheets for items MSCB Meetings for Partners to sign to show that they are in agreement (or not) with proposed documentation and a similar system will be used for Sub Groups when consulting in meetings or remotely.

When a paper is issued for consultation to Partner Agencies the MSCB will keep a track of response (or lack of response) to aid decision-making.

Under the guidance of the Policy Sub Group the MSCB Support Team and MSCB Training Officer/s will have responsibility for ensuring that the Professionals’ section of the MSCB website has all local policies and guidance and that these are reviewed regularly according to the agreed schedule. The Policy Sub Group will take responsibility for ensuring the reviews.
Merton Safeguarding Children Board

Promote & Protect Young People Sub Group

Terms of Reference

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1. Purpose

1.1 Vision/Outcomes

To take overall lead responsibility on behalf of the MSCB to ensure that there are effective and up-to-date multi-agency policies, protocols and procedures to ensure children and young people are safeguarded and protected and their welfare is promoted; concentrating on risk of abuse outside the family.

1.2 Key responsibilities

Within the agreed MSCB Learning and Improvement System (Agreed July 2014) and the revised London-wide CSE Operating Protocol June 2017

A key principle agreed by the MSCB is that the London Child Protection Procedures should take precedence in order to avoid confusion or multiplication; and ease of working across local Authority boundaries. Creation of separate MSCB policy, protocols or procedural guidance should be exceptional. When such additional or alternative local guidance is agreed it should always state its status vis à vis the London Child Protection Procedures.

- To lead the inter-agency implementation (and review) of the London Child Protection Procedures in Merton relating to extra-familial abuse or harm.

- To draft supplementary and localising guidance to ensure that the relevant London Child Protection Procedures are locally relevant in Merton, as required.

- The Promote and Protect Young People Sub Group will be responsible for policies where abuse is extra-familial such as CSE, missing children, child on child abuse, other forms of exploitation (such as radicalization), e-safety, trafficking, abuse by those in a position of trust or in institutions – including faith organisations and community organisations; and policies and procedures in relation to allegations against those in a position of trust LADO).

- To take lead responsibility for the Child Sexual Exploitation Strategy, Procedures and Action Plan on behalf of the MSCB.

This will include the direct management of the Multi-Agency Sexual Exploitation (MASE) Panel, which will track and advise the multi-agency professional teams responsible for young people who are identified at serious risk of harm from sexual exploitation and/or who are at risk from going missing from time to time. (MASE Panels have their own Terms of Reference agreed across London)
- To keep the relevant agreed local policy, protocols and procedures under review in a timely way (at least biennially) and to ensure that they are reviewed in the light of any new legislation or guidance and from any learning or outcomes from Learning and Improvement Reviews (local or national).

- To comment on behalf of the MSCB, as appropriate, on the safeguarding children and promotion of welfare aspects of policies, protocols and procedures being drafted by other local bodies or partnerships – where these are wider than safeguarding but are about supporting children and families.

- To review (the need for new) policies where there have been lessons from case reviews or audits which demonstrate the use of policies in practice.

- To ensure that all Policies, Protocols and Procedures have Implementation Plans and to monitor those Plans.

- The Board may also delegate other relevant activities to the P&PYP Sub Group, as appropriate.

1.3 Governance

The P&PYP Sub Group reports to and is accountable to the MSCB as one of a number of sub groups detailed to drive and deliver specific aspects of agency and partnership work to safeguard children and young people.

The Sub Group will report to the MSCB as required, at least twice each year and by exception where necessary; it will draw to the MSCB and Partner Agencies’ attention where there is a need for change in guidance.

The Sub Group will work to an annual work plan, agreed by the MSCB (or executively by the MSCB Chair) each March which draws on the agreed priorities of the MSCB, as set out in the MSCB Business Plan.

The Sub Group Chair will report to the MSCB on the Sub Group’s progress against the Work Plan at each meeting of the MSCB; and, as necessary, to the MSCB Chair between meetings.

2 Membership and Meeting Structure

2.1.1 Chair: A Head of Service in Children’s Social Care and Youth Inclusion

Vice Chair: A senior representative of the Metropolitan Police

The Chair will sit as a member of the MSCB.
2.2 Core membership

Health
Designated Nurse for Safeguarding, Merton CCG
Representative, SW London & St George’s Mental Health Trust /CAMHS
Named Nurse, Epsom & St Helier Trust
Named Nurse Community Health Care Provider
LAC Designated Nurse

Merton Council
Principal Social Worker, CSF
Senior Social Care Representative, CSF
Senior Education Representative, CSF
CSE :Lead
Multi Agency Safeguarding Hub (MASH), CSF
14+ LAC Team, CSF
Teenage Pregnancy & Substance Misuse Coordinator, CSF
Vulnerable Children’s Team Manager, CSF
Education Welfare Service Manager
Youth Justice Team Manager/ Families and Adolescence Services (My Futures)
Virtual Behaviour Service
Youth Service

Police
Detective Inspector, Merton Borough

Probation – to be co-opted as required and expected to contribute virtually to consultations

Voluntary & Community Sector representative(s)

Commissioned Services’ Representatives
Other representatives as invited by the Chair.

Sub Group Members will be expected to represent their agency/sector and have experience of and good knowledge of current safeguarding standards and to communicate any proposals/decisions/actions to their own agency; and to relevant constituent organisations within their sector where they represent more than one agency.

2.3 Quoracy
At least three separate partner agencies including: Merton Council and Police and Health (Not including the chair)

2.4 Other attendees
MSCB Business Management and/or Administration.
2.5 Deputising arrangements

Members are expected to nominate deputies to attend in their place if necessary. Such deputies must be aware of their role within the group.

2.6 Meetings frequency

Meetings will be held at least eight times per year for P&PYP on a schedule which allows good time for a report to be drawn up for the MSCB main meetings. MASE Meetings will be held at least ten times per year, usually monthly.

The Sub Group will at times work ‘virtually’ between scheduled meetings to ensure completion of tasks, sharing drafts, responding to documents. This may involve face to face meetings or electronic conversations. The Sub Group will create task and Finish Groups as required.

2.7 The aim will to be to provide invitations and Agenda at least 10 working days in advance and working documents 5 working days in advance of Sub Groups meetings; and to provide draft Minutes and Action Log 10 working days in arrears.

2.8 Each meeting of the P&PYP Sub Group will agree the core agenda for subsequent meetings as part of the annual work programme.

3 Additional Responsibilities

3.1 To work within the objectives and principles set out in the overall Merton Partnership Equalities and Diversity Policy and to agreed values and standards of behaviour in public service.

3.2 The promotion of the welfare and protection of children will be central to the Sub Group’s work and this will include ensuring understanding of the experience of children and young people and listening to their voice.

3.3 In line with the agreed Learning and Improvement System to ensure that the views and experiences of practitioners are considered.

3.4 To advise the MSCB of priority areas of action required.

3.5 To inform the Learning and Development Sub Group of the need for training or briefings in relation to new or revised guidance.

3.6 To contribute to the MSCB Annual Report, as required.
4 Performance measures

4.1 To ensure that the relevant MSCB policies, protocols and procedures are reviewed at least biennially to an agreed schedule; including scrutiny of annual reports on their operation where required e.g. LADO Report, e-safety Report.

4.2 To provide quarterly monitoring reports on the operation of the MSCB CSE Strategy and Action Plan.

4.3 To ensure that the MASE Panel meets regularly, as required and that appropriate confidential records and advice is recorded in relation to identified young people.

4.4 The Sub Group will report to the Business Implementation Group Meeting its progress against the work plan, as required.

4.5 To provide a summary of the Sub Group’s work for the Annual Report.

5 Work Programme

The Sub Group Chair will submit a draft Work Plan to the MSCB for endorsement at the Annual Planning AwayDay in March each year. The work plan will reflect the priorities of the MSCB Business Plan.

To oversee multi agency response to at risk areas for young people to include:

- Child Sexual Exploitation
- Young Runaways/Missing Children
- Child Trafficking
- Online Safety
- Radicalisation, Extremism and the Prevent Duty
- Bullying/Violent Relationships
- Sexually Harmful Relationships
- Children Missing From Education

To ensure the Group links with other multi-agency initiatives regarding vulnerable children, such as the Child Wellbeing Model, Teenage Pregnancy Partnership Board etc.

To support and advise on the development of the Mediation service for young runaways as required.

The Protect & Promote Young People Group will monitor relevant performance measures as set out in the MSCB Business plan.

Refreshed June 2017
Merton Safeguarding Children Board

Learning & Development Sub Group

Terms of Reference

Agreed:
June 2015
Revised June 2017

Lead:
Learning & Development Sub Group Chair & MSCB Board Manager

Review:
Annually in March at Business Planning AwayDay
Terms of Reference

1. Purpose

1.1 Vision/Outcomes

To take overall lead responsibility on behalf of the MSCB to ensure that there are effective arrangements to inform and keep up-to-date the multi-agency and multi-disciplinary workforce in knowledge and skills for safeguarding children and promoting their welfare.

1.2 Key responsibilities

Within the agreed MSCB Learning and Improvement System (Agreed July 2014) and the guidance of the London Safeguarding Children Board in Competence Still Matters 2014:

- To undertake an annual analysis of the safeguarding Training Needs of the agencies serving children and families in Merton, including adult-focussed agencies.

- To review the agreed Multi-Agency Training Strategy in the light of any changes in Training Needs and make recommendations to the MSCB on changes to the strategy. The strategy will include single agency standards and multi-agency standards for learning and improvement. It will also cover the learning and development needs of the MSCB itself, including induction and mentoring of new MSCB members.

- To draft the MSCB Multi-Agency Training Programme approval by the MSCB and plan and commission its delivery.

- To provide advice to agencies or sectors on safeguarding training.

- To provide up-date briefings for practitioners and managers on a termly basis to offer an opportunity to keep aware of local and national lessons and changes in safeguarding legislation, guidance, research, practice and quality assurance. The briefings will also act as an inter-face between the MSCB and frontline practitioners for practitioners to be able to give their views to the MSCB.

- To plan and deliver the MSCB Multi-Agency Annual Conference for practitioners and managers to increase awareness and dialogue with
frontline practice and to ensure that young people are involved in its commissioning and delivery. The Conference will be based on a theme which is a priority within the MSCB’s current Business Plan.

- To work closely with the other sub groups to ensure that their activities and lessons are translated into learning opportunities and are incorporated into briefings or training.

- To take the lead responsibility for ensuring that lessons from local case reviews and case audits are promoted.

- To keep updated the section of the MSCB’s website dedicated to professionals to support them in maintaining awareness of up-to-date learning, research, best practice, local policy and guidance.

- To evaluate the MSCB courses delivered, monitoring their quality and impact.

- To work within the allocated MSCB budget for Learning and Development.

- To work co-operatively with other LSCBs and agencies in appropriate joint learning ventures, as appropriate.

- To seek opportunities to involve young people and service users in planning and delivering learning and improvement processes to ensure that the child’s voice and the service user’s voice is included and understood.

- The Board may also delegate other relevant activities to the Policy Sub Group, as appropriate.

1.3 Governance

The Learning and Sub Group reports to and is accountable to the MSCB as one of a number of sub groups detailed to drive and deliver specific aspects of agency and partnership work to safeguard children and young people.

The Sub Group will report to the MSCB as required, at least annually and by exception where necessary.

The Sub Group will work to an annual work plan, agreed by the MSCB (or executively by the MSCB Chair) each March which draws on the agreed priorities of the MSCB, as set out in the MSCB Business Plan.

The Sub Group Chair will report to the MSCB on the Sub Group’s progress against the Work Plan at each meeting of the MSCB; and, as necessary, to the MSCB Chair between meetings.
2 Membership and Meeting Structure

2.1 **Chair:** A senior representative of one of the partnership agencies (not Children’s Social Care)

**Vice Chair:** A senior representative of one of the agencies

The Chair will sit as a member of the MSCB.

2.2 **Core membership**

**Health**
Designated Nurse for Safeguarding, Merton CCG
Representative, SW London & St George’s Mental Health Trust/CAMHS
Named Nurse, Epsom & St Helier Trust
Named Nurse, Community Health Care Provider

**Merton Council**
School Improvement Adviser, Professional Development
Workforce & Practice Development Manager (CSC)
Early Years & Childcare Training Co-ordinator, CSF
CASA Manager, Early Intervention (as needed), CSF
Team Manager, Vulnerable Children’s Team
Adult Services – representation and expected to contribute virtually to consultations when not in attendance

**Police & Probation** – to be co-opted as required

**Voluntary & Community Sector** representative(s)

Schools Representatives to be consulted through LSCB School Reps & termly meetings of Designated Persons in Schools

Other representatives as invited by the Chair, including young person representative(s), if possible.

Sub Group Members will be expected to represent their agency/sector and have experience of and good knowledge of current safeguarding standards and to communicate any proposals/decisions/actions to their own agency; and to relevant constituent organisations within their sector where they represent more than one agency.

2.3 **Quoracy**

At least three separate service areas not including the Chair or MSCB staff.

2.4 **Other attendees**
MSCB Training Officer/s and / or Administration. MSCB Manager, as required.

2.5 Deputising arrangements

Members are expected to nominate deputies to attend in their place if necessary. Such deputies must be aware of their role within the group.

2.6 Meetings frequency

Meetings will be held at least three times per year on a schedule which allows good time for a report to be drawn up for the MSCB main meetings.

The Sub Group will at times work ‘virtually’ between scheduled meetings to ensure completion of tasks, sharing drafts, responding to documents. This may involve face to face meetings or electronic conversations. The Sub Group will create Task and Finish Groups as required.

The aim will to be to provide invitations and Agenda at least 10 working days in advance and working documents 5 working days in advance of Sub Groups meetings; and to provide draft Minutes and Action Log 10 working days in arrears.

Each meeting will agree the core agenda for subsequent meetings as part of the annual work programme.

3 Additional Responsibilities

3.1 To work within the objectives and principles set out in the overall Merton Partnership Equalities and Diversity Policy and to agreed values and standards of behaviour in public service.

3.2 The promotion of the welfare and protection of children will be central to the Sub Group’s work and this will include ensuring understanding of the experience of children and young people and listening to their voice.

3.3 In line with the agreed Learning and Improvement System to ensure that the views and experiences of practitioners are considered.

3.4 To advise the MSCB of priority areas of action required.

3.5 To contribute to the MSCB Annual Report, as required.

4 Performance measures
4.1 To undertake an Annual Safeguarding Training Needs Analysis and Evaluation – including an evaluation of Agency and Multi-Agency Training, and report on this to the MSCB.

4.2 To devise and commission/deliver an annual MSCB Training Programme based on the Training Needs Analysis.

4.3 To provide termly half day up-date Briefing Seminars on current local and national lessons.

4.4 To review the content of the Professional Section of the MSCB website at least quarterly to ensure that it remains up-to-date and useful.

4.5 To plan and deliver the MSCB Annual Conference for Practitioners and Managers (this can be in partnership with Member agencies)

4.6 The Sub Group will report to the Business Implementation Group Meeting its progress against the work plan, as required.

4.7 To provide a summary of the Sub Group’s work for the Annual Report.

5 Work Programme

The Sub Group Chair will submit a draft Work Plan to the MSCB for endorsement at the Annual Planning AwayDay in March each year. The work plan will reflect the priorities of the MSCB Business Plan.

The Terms of Reference are to be agreed at the MSCB Meeting on June 2017.