

Area of activity	Key questions
Overarching question	How can local arrangements be led equally by the three safeguarding partners effectively and ensure the best outcomes for children and young people?
Structural arrangements (Includes merging areas/regionalisation/governance/leadership)	 What arrangements facilitate and drive action beyond usual institutional and agency constraints and boundaries in order to focus on how outcomes for children and young people are improved? What changes need to be made to current governance structures to align processes, improve line of sight as well as scrutiny and accountability? What models of governance will provide a streamlined approach to strategic partnership work to safeguard children? (i.e. Merging areas/considering role of other public boards including Health and wellbeing boards, Adult Safeguarding Boards, Channel Panels, Improvement Boards, Community Safety Partnerships, the Local Family Justice Board and MAPPAs.) What do the identified leaders (the local authority chief executive, the accountable officer of a clinical commissioning group, and a chief officer of police) need to be able to confidently and competently agree and be accountable for the multi-agency arrangements and processes in an area in a coherent and unified way? How can contributions by the health services, the police and local government be effectively coordinated and deployed to create a safer, more consistent arrangement towards protecting and safeguarding children and young people? How can new arrangements balance the role of coordinating services with that of ensuring effectiveness?



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	 How do health, police and local authority hold to account one another and the services they deliver individually and collectively? How are different aspects of wellbeing, safeguarding and child protection being governed and scrutinized within multi agency arrangements to safeguard children?
Independent scrutiny and assurance	 How can we be confident that the strategic multi agency arrangements we make to protect children are fit for purpose, consistently reliable and able to ensure that children are being protected effectively? What model of independent scrutiny will ensure true independence within multi agency safeguarding arrangements? What arrangements ensure that scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement? What role/function/tasks/time allocation and resource will enable an independent scrutineer to effectively undertake their role? How do we root our quality assurance activity in frontline practice and sustain effective feedback loops to build practice learning? (i.e. How are frontline challenges brought to the partnership? How is frontline practice engaged with the improvement work of the new partnership?) What arrangements will provide a high level of public assurance that the system to protect children is kept closely under scrutiny and review with proactive action to secure that? How can independent scrutiny measure, promote and improve the quality and impact of practice so that outcomes for children improve?



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Learning reviews	 What does a system which is sufficiently focused on rapid, proactive or analytical assessment of the lessons necessary to improve the arrangements for protecting children look like? How should learning reviews be structured to ensure that they are an effective tool in helping the national and local systems for protecting children to improve? How can reviews prevent or reduce the risk of recurrence of similar incidents? What does a streamlined system of inquiries amongst all agencies look like? (i.e. the investigations carried out by the police, the deliberation of judicial processes, domestic homicide reviews.) How do we ensure and evidence transparency in local models of inquiries into serious events? What processes will enable effective commissioning, management, dissemination and embedding of learning and publication of reviews? What models of learning lead to sustained practice change? How do we ensure the quality of reports and skill of authors? What evidence needs to be collected to understand the impact of learning on outcomes for children, young people and families? What are the ways of working with the new national panel to effectively share and embed learning both locally and nationally?
Role of children, young people and families	 What are the strong models of coproduction that enable children and young people to be an intrinsic and critical partner in influencing local safeguarding arrangements (including scrutiny, challenge and planning activity)? What models effectively engage parents and carers involved in safeguarding services in scrutiny, challenge and strategic planning activity?



	What models build more resilient children and families through the process?
Role of wider partners (particularly schools, colleges and other educational providers)	 What is the role of schools and other wider community partners in safeguarding within the new arrangements? Why are some schools, colleges and other educational providers/community partners not effectively engaged in their safeguarding role? What barriers do they face? What arrangements will effectively ensure that all schools (including multi academy trusts), colleges and other educational providers, in the local area are fully engaged, involved and included in the new safeguarding arrangements? What support is required? How is a culture of partnership working outside of formal board structures created? What models have proven to be effective? How is collective accountability for safeguarding ensured across such a wide array of partners with so many variables in their roles/responsibilities?
Addressing local practice challenges	 What models are effective at early identification and analysis of new safeguarding issues and emerging threats across the safeguarding partnership? How are priorities agreed and addressed across local areas? What partnership approaches across traditional boundaries/regions are most effectively safeguarding children and young people who are at risk because of issues including gangs, knife crime, county lines, domestic violence, trafficking and sexual exploitation?
Information sharing	What are the current barriers to accurate and timely information sharing to safeguard children?



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	 What models of multi-agency information sharing facilitate accurate and timely decision making for children and families? What approaches to multi agency information sharing give organisations and agencies confidence that information is shared effectively, amongst and between them, to improve outcomes for children and their families?
Regional alignment of child death reviews	 What are the current barriers to regional alignment of CDOP? What models of regional alignment have been effective at undertaking the CDOP function? How can child death review partners be an effective model of learning from the deaths of children to allow for coherent national learning? How can the new arrangements support a reduction in the rate of child deaths in the future? How will this be measured and evidenced? How should arrangements support families who have experienced the death of a child?
Resourcing	 What new opportunities are there for maximising value for money and sustainability in new arrangements? What are the professional development needs of the multi-agency workforce in any proposed changes? How will these be met? What needs to happen to ensure that resources remain focused on providing frontline services? How should the partnership identify and deliver efficiencies whilst maintaining and improving arrangements to safeguard children?