Working Together to Safeguard Children - Changes to Statutory Guidance

The Department for Education has released the updated version of Working Together to Safeguard Children .

An updated version of Keeping Children Safe in Education has already been published, and comes into effect from 3rd September 2018; until then schools and colleges must continue to use the current statutory guidance dated September 2016. The updated Keeping Children Safe in Education should be read alongside Working Together to Safeguard Children which states clearly that it also applies in its entirety to **all** schools.

The Children and Social Work Act 2017 (Commencement No. 4 and Transitional and Saving Provisions) Regulations 2018 brings into force those parts of the Children and Social Work Act 2017 which make significant changes to the following sections of Working Together to Safeguard Children; Chapter 3: Multi-Agency Safeguarding Arrangements, Chapter 4: Improving child protection and safeguarding practice and Chapter 5: Child Death Reviews as well as making the necessary amendments to the Children Act 2004.

Following the responses to the government consultation on the draft version of Working Together to Safeguard Children, the introduction to the new guidance has been strengthened to emphasise that while it is the responsibility of the three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) to make arrangements to work together to safeguard children, it is vital that all organisations from the people leading them to the practitioners working with children and families and parents and carers are aware of, promote and comply with those arrangements.

Chapter 1: Assessing need and providing help

The core requirements in Working Together to Safeguard Children in chapter 1 are broadly unchanged. The changes to this chapter mainly cover emerging safeguarding themes since the last revision in 2015 and add more detail to the assessment and information sharing processes.

Early Help - Local authorities should work with organisations and agencies to develop joined-up early help services based on a clear understanding of local needs. The term professional has been replaced with practitioner throughout so the Lead Professional is now referred to as Lead Practitioner. Early help assessments should be evidence-based, be clear about the action to be taken and services to be provided.

Thresholds Guidance - the requirement to publish a threshold statement has been retained, and requires safeguarding partners to set out the local criteria for action in a way that is transparent, accessible and easily understood.
Chapter 1 adds to the existing guidance by highlighting the importance of practitioners having awareness of the additional vulnerabilities for children and young people who are:

- at risk of gang involvement and association with organised crime groups;
- frequently missing/absent from home;
- misusing drugs or alcohol themselves;

- at risk of modern slavery, trafficking, exploitation; or
- at risk of radicalisation.

Additional groups identified as being potentially vulnerable are privately fostered children, young carers, young people in secure youth establishments, those living in families where there are emerging parental mental health issues or drug and alcohol issues. The right to special protection and help for child refugees is emphasised.
Local agencies are also required to have a shared response to meet the needs of disabled children in their area and for this to be aligned with the short breaks services statement.

Training - The three safeguarding partners should consider what training is needed locally to support practitioners in continuing to develop their knowledge and skills, especially in relation to new and emerging threats to children and young people and how they should monitor and evaluate the effectiveness of any training they commission.
Sections have been added into the Assessment guidance specifically covering the assessment of young carers and assessment of children in secure youth establishments.
There is a new section covering the specific role of health practitioners in providing information to strategy discussions.

Social Worker's Role in Assessment - Social workers should have time to complete assessments, and have access to high quality practice supervision. Principal social workers should support social workers, the local authority and partners to develop their assessment practice and decision making skills, and the practice methodology that underpins this. Social workers and practice supervisors should always reflect the latest research on the impact of abuse and neglect and relevant findings from serious case and practice reviews when analysing the level of need and risk faced by the child. This should be reflected in the case recording. One of the most significant changes is that there is no longer a requirement in the guidance for the social worker *and their manager* to be jointly involved in the decision making process. It is now the social worker's responsibility to make decisions including making decisions about the most appropriate responses to referrals, commencing section 47 enquiries and convening strategy discussions.

Contextual Safeguarding - this is new section which offers an approach to understanding, and responding to, young people's experiences of significant harm beyond their families; for example exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation**.** If practitioners have concerns that a child may be a potential victim of modern slavery or human trafficking then a referral should be made to the National Referral Mechanism, as soon as possible.

Information Sharing - The section on information sharing has been expanded to remind practitioners that they should be proactive in sharing information as early as possible. It is essential for the identification of patterns of behaviour when a child has gone missing, when multiple children appear associated to the same context or locations of risk, or in relation to children in the secure estate where there may be multiple local authorities involved in a child's care.
Where a child in need has moved permanently to another local authority area, the original authority should ensure that all relevant information (including the child in need plan) is

shared with the receiving local authority as soon as possible. The receiving local authority should consider whether support services are still required and discuss with the child and family what might be needed, based on a timely re-assessment of the child's needs Support should continue to be provided by the original local authority in the intervening period. The receiving authority should work with the original authority to ensure that any changes to the services and support provided are managed carefully.

A section containing a myth-busting guide to information sharing has been added to address the introduction of the Data Protection Act 2018 and General Data Protection Regulations (GDPR). The DfE have also revised Information sharing advice for safeguarding practitioners - Guidance on information sharing for people who provide safeguarding services to children, young people, parents and carers which covers the importance of information sharing in more detail.

Chapter 2: Organisational responsibilities

Under Section 11 duties, the NHS now includes NHS organisations **and agencies and the independent sector** and has added General Practitioners. The senior board level lead should **have the required knowledge, skills and expertise or be sufficiently qualified and experienced.** There should be clear escalation policies for staff to follow when their child safeguarding concerns are not being addressed within their organisation or by other agencies and organisations should create a culture of safety, equality and protection within the services they provide.

Organisations and agencies are reminded that, irrespective of whether a referral has been made to local authority children's social care and/or the designated officer or team of officers, it is an offence to fail to make a referral to the Disclosure and Barring Service without good reason if an individual is removed (paid worker or unpaid volunteer) from work in regulated activity such as looking after with children (or would have removed them, had the person not left first)

Individual Organisation

A separate section has been added within setting out the responsibilities of Sports Clubs / Organisations for safeguarding and promoting the welfare of children. Additional information has been added to other organisations.

Schools and Colleges – Governors and trustees are also accountable. It confirms the definition of what is meant by schools and colleges and emphasises that the guidance applies to all schools.

Early Years and Childcare - must have and implement a policy and procedures to safeguard children (this should also cover the use of mobile phones and cameras in the setting)

Health - Each NHS England region should have a safeguarding lead to ensure regional collaboration and assurance through convening safeguarding forums. A new section has been added on Designated Health Professionals. NHS commissioners and providers should ensure that designated professionals are given sufficient time to be fully engaged, involved and included in the new safeguarding arrangements. All providers of NHS funded health services including NHS Trusts and NHS Foundation Trusts should identify a dedicated named doctor

and a named nurse (and a named midwife if the organisation or agency provides maternity services) for safeguarding children. In the case of ambulance trusts and independent providers, this should be a named practitioner. Clinical commissioning groups should employ a named GP to advise and support GP safeguarding practice leads. GPs should have a lead and deputy lead for safeguarding, who should work closely with the named GP. A section has been added covering the role of Public Health England.

Police – Adds that restrictions and safeguards exist in relation to the circumstances and periods for which children may be taken to or held in police stations. PCCs are responsible for health commissioning in police custody settings and should always ensure that this meets the needs of individual children.

Prison Service - are now required to inform the local authority children's social care services of an offender's *release on temporary licence (ROTL) and release date* where they have been identified as a person posing a risk to children (PPRC). Governors/Directors of women's prisons which have Mother and Baby Units (MBUs) should ensure that there is at all times a member of staff allocated to the MBU, who as a minimum, is trained in first aid, whilst within the prison there is always a member of staff on duty who is trained in paediatric first aid (including child/adult resuscitation) who can be called to the MBU if required. This also applies to MBUs which form part of the secure estate for children

Probation Service - should ask an offender at the earliest opportunity whether they live with, have caring responsibilities for, are in regular contact with, or are seeking contact with children. Where this applies, a check should be made with the local authority children's services at the earliest opportunity on whether the child/children is/are known to them and, if they are, the nature of their involvement. The risk management plan where an adult offender is assessed as presenting a risk of serious harm to children, should be shared with other organisations and agencies involved in the risk management.

Children's Homes – this is a new section covering their responsibilities in assessing the risks to each child and ensuring there are arrangements in place to protect them.

Secure Estate for Children - Each centre should work with their local safeguarding partners to agree how they will work together, and with the relevant YOT and placing authority (the Youth Custody Service) to make sure that the needs of individual children are met.

Multi-Agency Public Protection Arrangements (MAPPA) – this new section explains how MAPPA should work together with duty to co-operate (DTC) agencies to manage the risks posed by violent and sexual offenders living in the community.

Voluntary, charity, social enterprise, faith-based organisations and private sectors – has been expanded to cover roles and responsibilities across the sector

Sports Clubs / Organisations – this new section details sectors responsibility to have safeguarding policies in place. All National Governing Bodies of Sport, that receive funding from either Sport England or UK Sport, must aim to meet the Standards for Safeguarding and Protecting Children in Sport.

Chapter 3: Multi-agency safeguarding arrangement

This chapter covers the details for the replacement of Local Children Safeguarding Boards (LCSBs) with local safeguarding partners; the aim of which is to create flexible new local safeguarding arrangements led by three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups). It places a duty on those three partners to make arrangements to work together, and with any relevant agencies, for the purpose of safeguarding and promoting the welfare of children in their area.

Relevant agencies are defined as those organisations and agencies whose involvement the safeguarding partners consider may be required to safeguard and promote the welfare of children having regard to local need. All three safeguarding partners have equal and joint responsibility for local safeguarding arrangements.

In situations that require a clear, single point of leadership, all three safeguarding partners should agree who would take the lead on issues that arise. Should the lead representatives delegate their functions they remain accountable for any actions or decisions taken on behalf of their agency.

The three safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

Local Arrangements

Local arrangements can cover two or more local authorities, and safeguarding partners can join and collaborate on their arrangements, providing the relevant safeguarding partners have agreed this. Where more than one local authority joins together, the local authorities can agree to delegate their safeguarding partner duties to a single authority individually and collectively. Each local authority must continue to fulfil its statutory and legislative duties to safeguard and promote the welfare of children and advising them on ways to improve. The same applies for clinical commissioning groups and chief officers of police (in respect of their safeguarding partner duties only).

To be effective, these local arrangements should link to other strategic partnership work happening locally to support children and families. This will include 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.

The local safeguarding partners must ensure there is independent scrutiny of the effectiveness of the local arrangements. The safeguarding arrangements should be published by the safeguarding partners, and the guidance sets out what should be covered in the publication.

Partners must report at least annually on what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice. The guidance sets out what should be included in this report.

A copy of the report should be sent to the Child Safeguarding Practice Review Panel and the What Works Centre for Children's Social Care within 7 days of being published. Safeguarding partners should make sure the report is also widely available.

Relevant Agencies

A section has been added describing how the safeguarding partners should work with relevant agencies in their area. Relevant agencies defined as those organisations and agencies whose involvement the safeguarding partners consider necessary to safeguard and promote the welfare of local children. The safeguarding partners must set out in their published arrangements which organisations and agencies they will be working with to safeguard and promote the welfare of children; this is expected to change over time if the local arrangements are to work effectively and responsively for children and families.

A list of relevant agencies is set out in the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018. Many agencies and organisations play a crucial role in safeguarding children, and safeguarding partners may include any local or national organisation or agency in their arrangements, regardless of whether they are named in relevant agency regulations.

Organisations and agencies who are not named in the relevant agency regulations, whilst not under a statutory duty, should nevertheless cooperate and collaborate with the safeguarding partners particularly as they may have duties under section 10 and/or section 11 of the Children Act 2004.

The safeguarding partners should be clear how they will assure themselves that the relevant agencies have appropriate, robust safeguarding policies and procedures in place and how information will be shared amongst all relevant agencies and the safeguarding partners. The local arrangements should be shared with all partners and relevant agencies and information should be given about how to escalate concerns and how any disputes will be resolved, as well as details of the independent scrutiny and whistleblowing arrangements.

Schools, colleges and other educational providers

This section has has been strengthened following responses to the consultation, so there is an expectation that local safeguarding partners will name schools, colleges and other educational providers as relevant agencies. Once designated as a relevant agency, schools and colleges, and other educational providers are under a statutory duty to co-operate with the published arrangements.

Information requests

Safeguarding partners may require any person or organisation or agency to provide them, any relevant agency for the area, a reviewer or another person or organisation or agency, with specified information. This must be information which enables and assists the safeguarding partners to perform their functions to safeguard and promote the welfare of children in their area, including those related to local and national child safeguarding practice reviews . The person or organisation to whom a request is made must comply with such a request and, if they do not do so, the safeguarding partners may take legal action against them.

Independent scrutiny
The published arrangements should set out the plans for independent scrutiny, including how the arrangements will be reviewed; and how any recommendations will be taken forward. The decision on how best to implement a robust system of independent scrutiny is to be made locally, however safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement.

Funding
The three safeguarding partners and relevant agencies for the local authority area should make payments towards the expenditure needed to support the local multi-agency arrangements for safeguarding and promoting welfare of children. The safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate, as well as any contributions from each relevant agency. . The funding should be transparent to children and families in the area, and sufficient to cover all elements of the arrangements, including the cost of local child safeguarding practice reviews.

Transitional Arrangements
From 29th June 2018, local authority areas must begin their transition from LSCBs to safeguarding partner and child death review partner arrangements.
The Safeguarding partners must publish their arrangements, and should notify the Secretary of State for Education when they have done so, by sending the published link to safeguarding.reform@education.gov.uk. They should also notify the chair of the relevant LSCB(s). They must have published their arrangements by **29th June 2019**, but may do so at any time before the end of that period.

Following publication of their arrangements, safeguarding partners have up to three months from the date of publication to implement the arrangements. The implementation date should be made clear in the published arrangements. All new local arrangements must have been implemented **by 29th September 2019**.

If the safeguarding partner arrangements are in place and ready to operate before the child death review partner arrangements for a local area, the safeguarding partners may begin work, without waiting for the child death review partner arrangements to begin. Once the arrangements have been published and implemented, the LSCB for the local area will cease to exist.

In the meantime, LSCBs must continue to carry out all of their statutory functions, including commissioning SCRs where the criteria are met, until the point at which safeguarding partner arrangements begin to operate in their local area. They must also continue to ensure that the review of each death of a child normally resident in the LSCB area, is undertaken by the established child death overview panel (CDOP), until the point at which new child death review partner arrangements are in place.

LSCBs will need to plan how and when to hand over all relevant data and information they hold to the safeguarding partners. They should comply with the Data Protection Act 2018 and the General Data Protection Regulation, and provide a clear audit trail on the handling of all documentation. They should set out any decisions on SCRs, which are outstanding at the time of handover.

Note:- The LSCBs should ensure the retention of pertinent historical records, including (for example) any that might be relevant to the Independent Inquiry into Child Sexual Abuse. They should also arrange to pass on copies of these records to the new safeguarding partners for their area.

Chapter 4: Improving child protection and safeguarding practice

16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states: Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel (the Panel) if –

(a) the child dies or is seriously harmed in the local authority's area, or

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The local authority must notify any event that meets the above criteria to the Panel within 5 working days of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within 5 working days. The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, regardless of whether or not abuse or neglect is known or suspected.

The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. The Panel will also maintain oversight of the system of national and local reviews and judge how effectively it is operating.

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review. They should carry out a rapid review of the case, and complete this within fifteen working days of becoming aware of the incident. Once complete, the safeguarding partners should send a copy to the Panel. They should also share with the Panel their decision about whether a local child safeguarding practice review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate.

The chapter contains guidance for determining whether a serious child safeguarding case meets the criteria for a local and national review. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice.

On receipt of the information from the rapid review, the Panel will decide whether it is appropriate to commission a national review of a case or cases. As well as considering notifications from local authorities, information from rapid reviews and local child

safeguarding practice reviews, the Panel will take into account a range of other evidence, including inspection reports and other reports and research.

The Panel should take decisions on whether to undertake national reviews and communicate their rationale appropriately, including to families. The Panel will notify the Secretary of State when a decision is made to carry out a national child safeguarding practice review. The Panel will conduct national reviews according to the same procedures used for local child safeguarding practice reviews.

The safeguarding partners will be responsible for commissioning and supervising reviewers for local reviews. The guidance sets out the criteria they should consider when selecting a reviewer. The safeguarding partners should agree with the reviewer the review method taking into account the Working Together to Safeguard Children guidance and the principles of the systems methodology recommended by the Munro review.

Safeguarding partners must send a copy of the full report to the Panel and to the Secretary of State no later than 7 working days before the date of publication. They should also provide the report, or information about improvements, to Ofsted within the same timescale. Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than 6 months from the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. Safeguarding partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018 provide the framework for the review of serious child safeguarding cases and the role and remit of the Child Safeguarding Practice Review Panel. Panel members were appointed in June and their role will become clearer as they begin to review cases and issue further guidance. In the letter issued by Edward Timpson (Panel Chair) alongside Working Together to Safeguard Children he says

"Working Together sets out the process for handling serious child safeguarding cases. However, we have agreed with Government that it is important not to be too prescriptive at the outset. Therefore in the first six months our focus will be on working with you to make sure that we develop a system which is dynamic and effective as well as one which secures the timeliness we all appreciate is required. As a result, Working Together 2018 does not set timescales for conducting rapid reviews or the Panel response – these will be set out in practice guidance the Panel intends to issue once we have tested our approach and agreed how the system should best operate. We expect to be in a position to agree these revisions with Government following discussion with our key partners in six months' time. However, we need to establish a timely process now for how we respond to serious child safeguarding incidents and so from 29 June we expect:

- *Local Authorities to notify the Panel of any serious incident within five working days; and,*

- *Safeguarding Partners, or Local Safeguarding Children Boards where the new partnership arrangements are not yet in place, to undertake a rapid review into all serious child safeguarding cases promptly and complete this within fifteen working days of becoming aware of the incident."*

Transitional Arrangements for Serious Case Reviews

After new safeguarding partner arrangements are set up, LSCBs in the area will have a statutory 'grace' period of up to 12 months to complete and publish outstanding SCRs. Where an SCR has not been completed at the point the new safeguarding partner arrangements begin to operate, for example, if they have only recently been commissioned, the LSCB should seek to complete and publish the SCR within 6 months of the date of the decision to initiate a review, but has a maximum of 12 months to do so. In this 12 month grace period the LSCB may not commission any further SCRs or continue with any other former activities. LSCBs must complete all SCRs by 29 September 2020 at the latest.

Chapter 5: Child death reviews

Chapter 5 provides guidance for child death review partners. Child death review partners consist of local authorities and any clinical commissioning groups for the local area (as set out in the Children Act 2004, amended by the Children and Social Work Act 2017.)

Child death review partners for two or more local authority areas may combine and agree that their areas be treated as a single area for the purpose of undertaking child death reviews.

In making arrangements to review child deaths, child death review partners should establish a structure and process to review all deaths of children normally resident in their area and, if appropriate and agreed between child death review partners, the deaths of children not normally resident in their area but who have died there. Child death review partners must make arrangements for the analysis of information from all deaths reviewed.

Child death review partners may, if they consider it appropriate, model their child death review structures and processes on the current Child Death Overview Panel (CDOP) framework

It is for child death review partners to determine what representation they have in any structure reviewing child deaths. The child death review partners should consider the core representation of any panel or structure they set up to conduct reviews and this would ideally include: public health; the designated doctor for child deaths for the local area; children's social care police; the designated doctor or nurse for safeguarding; primary care (GP or health visitor); nursing and/or midwifery; lay representation; and any other professionals that child death review partners consider should be involved.

Child death review partners should agree locally how the child death review process will be funded in their area.

Child death review partners should publicise information on the arrangements for child death reviews in their area. This should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group), which local authority and clinical commissioning group partners are involved, what geographical area is covered and information on designated doctor for child deaths.

Child death review partners should publish their arrangements for reviewing child deaths, and should notify NHS England when they have done so, at England.cypalignment@nhs.net.

All practitioners participating in the child death review process should notify, report, and scrutinise child deaths using the standardised templates. These should be forwarded to the relevant CDOP (or other structure child death review partners have put in place to help review child deaths). The mechanism for collecting this data will evolve as the National Child Mortality Database becomes operational.

The purpose of a review and/or analysis is to identify any matters relating to child deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them of this.

Where a Joint Agency Response is required, practitioners should follow the process set out in Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016) .

The learning from all child death reviews should be shared with the National Child Mortality Database, once operational, which may in addition take into account information from other reviews in order to identify any trends or similarities with deaths.
Child death review partners for a local authority area in England must prepare and publish a report, and . they may therefore wish to ask the CDOP (or equivalent) to produce an annual report for child death review partners on local patterns and trends in child deaths, any lessons learnt and actions taken, and the effectiveness of the wider child death review process in order to assist child death review partners to prepare their report.

Transition
From 29th June 2018, local authority areas must begin their transition from LSCBs to child death review partner arrangements. The transition must be completed by 29 September 2019.

LSCBs must continue to ensure that the review of each death of a child normally resident in the LSCB area, is undertaken by the established child death overview panel (CDOP), until the point at which new child death review partner arrangements are in place.

After new safeguarding partner and child death review partner arrangements are set up, LSCBs in the area have a statutory 'grace' period of up to 4 months to complete any outstanding child death reviews. Any CDOP set up under LSCB arrangements may not undertake any new child death reviews during this 4-month period.

The latest date for completion of any review is 29th January 2020, where a review has not been completed, the LSCB must pass the information to the child death review partners. Child death review partners should consider any incomplete child death reviews passed to them by former CDOPs, and take appropriate action.

If the child death review partner arrangements are in place and ready to operate before the safeguarding partner arrangements for a local area, the child death review partners may begin child death reviews and their analysis of information from them, without waiting for the safeguarding partner arrangements to begin.