No: 027
01 May 2013

# One Minute Guide:

## Briefing on "Working Together to Safeguard Children" 2013

New guidance on effective multi-agency working to safeguard children came into effect on 15 April 2013. It represents a shift in the way that the child protection system will operate in England, includes new guidelines for assessing the needs of vulnerable children, a new approach to the oversight of serious case reviews and a significant reduction in the volume of guidance.

### Overview

The "Working Together" guidance is reduced from 700 pages to 97. The new guidance focusses strongly on legislative requirements, no longer contains non-statutory practice guidance and is clear that "safeguarding is everyone's responsibility". The headlines include:

- Statutory timescales for assessing the needs of vulnerable children.
- A removal of the distinction between initial and core assessments, replaced by on-going, locally developed, assessments of need;
- A change in the governance arrangements for independent Chairs of local safeguarding children boards (LSCBs), who will now be appointed and held to account by the Chief Executive rather than the Director of Children's Services;
- The establishment of a national panel to hold LSCB Chairs to account on whether serious case reviews should be carried out, which independent reviewers should be commissioned to lead the review, and to challenge any decision that the report should not be published;
- A strong reiteration of the government's intention that all serious case reviews should be published in full, and more detailed guidance on what this means in practice;
- The LSCB to establish its own method of undertaking a serious care review that is broadly in line with stated principles: and
- A requirement on LSCBs to develop a local framework for learning and improvement, including regular reviews of cases that may not meet the criteria for a full serious case review, as part of an on-going process of learning and development.

### Analysis

The Munro Review of Child Protection identified an over-bureaucratised culture that stifled local innovation and professional judgement. "Working Together" 2013 is intended to reduce the burden on professionals to follow a wide range of prescriptive guidance. The guidance can be broadly split into four main headings:

**Assessments**

"Working Together" puts a strong focus on the importance of early help. The guidance requires local services to work together to provide a range of effective, evidence based services, which should be based on an inter-agency early help assessment such as the Common Assessment Framework (CAF). The LSCB is given responsibility for assessing the effectiveness of this early help offer, and must also publish a threshold document that clearly outlines the criteria for when a case should be referred to local authority children's social care.

For more serious cases, initial and core assessments of children in need will be scrapped and replaced by a single assessment of need. This is described as a "dynamic and continuous process". Local areas are given the flexibility to develop and publish their own protocols for assessment, and to set their own decision points and review points during an assessment. In Redbridge there will be a Single Assessment.

However, the revised guidance reinstates statutory timescales for several key elements of a child in need assessment. Specific timescales in the final guidance include:

- The social worker must make a decision about the type of response required within one working day of receiving a referral;
- Assessments must be completed within 45 days. This is in line with previous statutory timescales of 10 days to complete an initial assessment and 35 days for a core assessment;
- The social work manager must convene a child protection conference within 15 working days of the last strategy discussion;
- The core group of professionals tasked with developing the child protection plan must meet within 10 working days of the initial child protection conference;
- Child protection plans must be reviewed with 3 months of the initial child protection conference, with further reviews at intervals of no more than 6 months for as long as the child remains subject of a child protection plan;
- A local authority must initiate a child protection conference within 15 working days of being notified that a child subject of a child protection plan is moving into their area.

**Partnership working**

This section includes more detailed information on the staffing capacity that should be made available for safeguarding, requiring that designated professional roles should always be explicitly defined in job descriptions and that sufficient time, funding, supervision and support should be provided for staff to carry out their role effectively. The guidance specifies staff competencies for safeguarding, with a specific requirement for staff to undertake a mandatory child protection induction.

Requirements about the reporting of allegations about professionals have been tightened up, with statutory partner agencies now required to report any allegation to the local authority designated officer (LADO) within 1 working day.

The guidance also recognises the impact of on-going reforms in education and health, with a reminder of the existing duty on Academies and Free Schools to exercise their functions with a view to safeguarding and promoting the welfare of children and young people.

For health, there is a strong focus on the responsibilities of the NHS Commissioning Board to ensure that the health commissioning system is working effectively to safeguard children, and that effective mechanisms are in place for LSCBs and Health and Wellbeing Boards to raise any concerns locally. The guidance also stresses the importance of designated and named professionals for safeguarding children, and places a duty on Clinical Commissioning Groups to ensure that this expertise is retained locally.

The role of Clinical Commissioning Groups has been expanded to include responsibility for safeguarding quality assurance through contractual arrangements with all provider organisations, and there is a greater emphasis on the role of GPs. GP practices are now required to have a lead and deputy lead for safeguarding, working closely with named GPs.

There is greater detail on the responsibilities of the police, with a clear requirement that each police force should have officers trained in child abuse investigation. Police officers are also reminded to consider the effect that incidents such as domestic abuse might have on children, and that children encountered as offenders or alleged offenders are entitled to the same safeguards and protection as any other child.

The responsibilities of a range of other agencies have also been clarified:

- Housing authorities are reminded of their role in safeguarding vulnerable young people, including young people who are pregnant or leaving care;
- Probation Trusts are reminded of their role in identifying offenders who pose a risk of harm to children. This also applies to children who may be at heightened risk of involvement in (or exposure to) criminal or anti-social behaviour, and of other poor outcomes due to the offending behaviour of their parent / carer(s);
- Youth Offending Teams are required to have a lead officer responsible for ensuring that safeguarding is at the forefront of their business;
- Faith organisations and voluntary and private sectors are reminded of their duty to have appropriate arrangements in place to safeguard and promote the welfare of children.

**Local Safeguarding Children Boards (LSCBs)**

The role of the LSCBs as the key body for scrutinising local arrangements and holding partners to account is present throughout the guidance, and Working Together adds a number of significant responsibilities to their existing duties. This includes new responsibilities for oversight of early help arrangements, clarifying threshold decisions (and putting in place arrangements to resolve any disagreements around threshold points and action), and developing a local framework for learning and development.

The guidance also changes the governance arrangements for the independent LSCB Chair, and it is now the responsibility of the Chief Executive to appoint or remove the Chair, and to hold them to account for the effective working of the LSCB. This responsibility previously sat with the Director of Children's Services. Among a number of more technical points, "Working Together" sets out in greater detail the content of the LSCB's annual report.

**Serious Case Reviews**

The final part of the guidance deals with learning and improvement, with a strong focus on serious case reviews. No particular methodology or model is suggested for a serious case review although "LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro".

There will also be a "national panel of independent experts on Serious Case Reviews". This will oversee the serious case review process, advising and challenging LSCB Chairs on whether or not to initiate an SCR, whether to appoint certain reviewers, and whether to publish SCR reports. If the LSCB decides not to initiate a serious case review, the Chair may be required to attend the national panel to explain their decision.

The guidance is also clear that transparency is a key element of this process, and reemphasises the requirement that serious case review reports must be published in full and be published on the LSCB's website for a minimum of 12 months, and to make it readily available thereafter.

These statutory reviews are seen as part of a wider framework of learning and development, to be developed locally by individual LSCBs. This should include management reviews on cases that do not meet the SCR criteria, or reviews of cases where practice was particularly good, with LSCBs free to decide how best to conduct these reviews. This framework includes the existing requirement for LSCBs to ensure that a review is undertaken for each death of a child who is normally resident in their area, through a separate Child Death Overview Panel (CDOP).

**Commentary**

The revised guidance meets the government's intention to reduce the level of central prescription and represents a fundamental shift in national child protection policy, placing greater emphasis on local areas to develop their own processes and encouraging stronger reliance on the professional judgement of individual practitioners. There is also a strong focus on the role of the LSCB as a potentially powerful force for scrutinising local arrangements and holding partners to account.

In London, "Working Together" is supported by the London Child Protection Procedures which are being revised in response to its publication.

To view "Working Together to Safeguard Children", March 2013, please click on the link below
http://www.workingtogetheronline.co.uk/documents/Working%20TogetherFINAL.pdf