Working Together to Safeguard Children: changes to statutory guidance

Revisions to chapter three: Multi-agency safeguarding arrangements; and new regulations on relevant agencies

1. As set out in paragraphs 4-7 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 it will be the responsibility of the safeguarding partners' representatives to determine how they work together in respect of their arrangements. All three partners have equal and joint responsibility for local safeguarding arrangements, and each safeguarding partner will appoint their own representative. We do not propose to set out in statutory guidance who these representatives should be, as it is a matter for safeguarding partners. Do you agree with this approach?

No

If no, please explain why

Joint responsibility needs to be clearly defined so that clarity around absolute/ultimate responsibility is not lost. In principle, we are supportive of a partnership approach to working, however there need to be clear lines of responsibility and accountability to ensure safeguarding is adequate, particularly in situations where problems arise and things go wrong.

It is not clear who will take full ownership for local safeguarding in these proposed new arrangements. There is a contradiction within the approach: the guidance here states that "all three partners have equal and joint responsibility for local safeguarding arrangements", however in the Introduction it states that "local authorities have overarching responsibility for safeguarding and promoting the welfare of all children in this area" – which would appear to contradict the notion of all three partners having joint responsibility.

We recommend that caution is applied when placing reliance on local arrangements, which has the risk of leading to strong variation in arrangements across the country.

We would also recommend that a minimum level of staff seniority and capability should be stipulated for representatives from the respective partners to ensure they have adequate knowledge of safeguarding issues – for example from Health this could be the board lead for safeguarding at the CCG.

2.Safeguarding partners can choose specific agencies which they believe to be relevant to the work of safeguarding and promoting the welfare of children in their area. The 'Local Safeguarding Partner (Relevant Agencies) (England) Regulations' details the specific agencies which safeguarding partners can choose from. It is

important to note that certain key agencies are not listed, as their functions are commissioned or otherwise overseen by one or more of the safeguarding partners - for example, general practitioners come under NHS England, and housing under the local authority. Do you agree with this indicative list?

No

If no, please explain why

We are supportive of the principle that safeguarding partners choose the specific agencies that they believe to be relevant to their local area.

However, we recommend that the indicative list is expanded as per below to offer stronger guidance on who should be at the table. For example, in the case of inclusion of the Designated Doctor, they are often the only strategic voice that can provide useful insight into what is happening at an operational level.

We would also recommend that in order to prevent this group from becoming too large (as Local Safeguarding Children's Board groups have been in the past), that subcommittees may also be formed to enable clear two-way communication with those that can't be present.

Should any agencies be added or removed?

To be added: the Independent Health Sector; the Designated Doctor and Nurse for Safeguarding; Armed Forces (both UK and those from overseas stationed in the UK)

3. All schools (including maintained schools, special schools, independent schools, academies and free schools) have key duties in relation to safeguarding children and promoting their welfare. As set out in paragraphs 18-19 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 we expect all local safeguarding arrangements to contain explicit reference to how the safeguarding partners plan to involve, and give a voice to, all local schools and academies in their work. Do you agree that this expectation should be stipulated in statutory guidance?

Yes

Please explain your answer

We are in agreement that there should be explicit reference to how the safeguarding partners will engage local school and academies in their work. Schools are the 'eyes and ears' of children in their formative years, and we would advocate for education becoming a major partner, alongside the other three agencies, in local safeguarding arrangements.

A key part of working together will be to share information in an appropriate and sensitive manner. The Child Protection Information System (CPIS) is an example as to how health professionals can share such information. We recommend to government that in an evolving digital era, information systems can be developed to connect sector safeguarding partners such as Education

We would like to note that representative engagement with schools can be challenging, due to their diversity and independent management. We would therefore caution that appropriate communication mechanisms will need to be encouraged between schools to ensure that those liaising with safeguarding partners are able to represent the wider local area.

4. The safeguarding partners must include arrangements for scrutiny by an independent person of the effectiveness of safeguarding arrangements, and how best to implement a robust system of independent scrutiny will be a local decision. Paragraph 20 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 states that safeguarding partners should involve a person or persons who are independent, for example by virtue of being from outside the local area or having no prior involvement with local agencies. Do you agree with this?

No

If no, please explain why

We express serious concerns over this section of the Working Together paper. This section needs to be strengthened. We are in agreement that independent scrutiny is necessary, however we are concerned that uniformity of practice may not be achieved when each local arrangement is left to scrutinise itself.

We wish to acknowledge that independently challenging partners can be difficult. We suggest that in order to achieve greater independent scrutiny, stronger national guidance is needed to define what counts as an independent person, and what qualifications, training and experience they should have, in order to strengthen local decisions.

We strongly recommend that the section on 'failure to reach agreement' needs strengthening.

5. Paragraph 24 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 makes it clear that safeguarding partners should agree the level of funding secured from each partner and relevant agency, to support the new safeguarding arrangements. Decisions on funding are for local determination, but contributions should be equitable and proportionate to meet local needs. Do you agree that this is the right approach?

No

If no, please explain why

We are in disagreement with this approach, and believe that the relative proportions of funding from different partners should be centrally determined at a national level. We caution that leaving it to the partners to decide funding proportions could lead to disagreements over funding from the outset of their arrangement.

We strongly recommend that this national formula for funding proportions should be fundamentally based on the local ICYP population size and deprivation index to prevent inequalities in funding arrangements.

6. Safeguarding partners must publish a report at least once in every 12 months, setting out what they (and their relevant agencies) have done as a result of the arrangements, and how effective the arrangements have been. These reports will be a key element of local accountability and self-assessment. At paragraph 29 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 we have set out a non-exhaustive list of parameters for these reports in guidance, to ensure a nationally consistent set of useful and high-quality publications. Do you agree with this approach?

Yes

7. The safeguarding partners should consider carefully how multi-agency safeguarding arrangements will work in their area. This includes determining how best to ensure that clear criteria for taking action are made available to relevant agencies and others in a transparent, accessible and well-understood way. Currently, Local Safeguarding Children Boards are required to produce a threshold document. We are not proposing to specify in statutory guidance how, and in what format, the safeguarding partners should make their criteria for action available. Do you agree with this approach?

No

If no, please explain why

We believe that arbitrary thresholds are often based more on resources rather than on need, and can sometimes impede a child in accessing the right interventions from the right team in a timely manner.

Our experience working across different localities has demonstrated that different localities defining their own threshold criteria can be problematic, particularly for agencies working across local authority boundaries. We are also aware that widely differing threshold criteria already exist in practice across safeguarding, which leads to confusion for practitioners and an inequitable service for, and detrimental impact to children and families. The impact that health inequalities have on long-term health and developmental outcomes is very clear in the RCPCH State of Child Health report, published in 2017.

We therefore recommend that statutory guidance is provided at a national level. We would also advocate for moving away from a reliance on thresholds as a gatekeeper to care, and instead look at developing an approach that is focused on the needs of the individual child and their family at any one time in their journey.

Revisions to chapter four: Learning from serious cases; and new regulations on local and national reviews

8. Paragraphs 15-17 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the actions the safeguarding partners should take on receipt of a notification of a child safeguarding incident, and the relationship between the safeguarding partners and Panel from then on. Do you agree with the procedure as set out?

Yes

9. The Act makes clear that the Panel and safeguarding partners respectively have responsibility to determine whether a review is appropriate, on the basis of whether the review may identify improvements that should be made to safeguard and promote the welfare of children. Regulations may require the Panel and safeguarding partners to take certain matters into account when taking the decision on cases to review, and guidance may support this. Regulation 4 sets out national review criteria which the Panel would be required to take into account when deciding whether to commission a national review. Regulation 18 sets out local review criteria which safeguarding partners would be required to take into account when deciding whether to commission a local review. Paragraphs 20 and 37 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out additional circumstances for consideration. Do you agree with these criteria and circumstances?

No

If no, please explain why

We would advocate for much stronger criteria to minimise debate about whether cases meet the criteria – this is a particular concern for issues involving neglect and interagency concerns.

We would recommend the inclusion of a flow diagram for the criteria, stipulating which panel they refer to.

10. Paragraphs 23-24 and 41-42 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the factors which the safeguarding partners and the Panel respectively should consider when commissioning reviewers for local and national reviews. Do you agree with these factors?

No

If no, please explain why

We would advocate for an available pool of nationally approved reviewers to support both local and national reviews. Considerable delays can occur in finding reviewers, and this would support teams in meeting the tight timescales given for local reviews.

We would also suggest that how the reviews are funded should be included as a factor.

11. Paragraphs 25-28 and 43-46 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the procedures which the safeguarding partners and the Panel respectively should follow when supervising local and national reviews. Regulations 12-14 of the 'National and Local Child Safeguarding Practice Review (England) Regulations' add requirements regarding the Panel's supervisory powers. We do not propose to include further details in the regulations relating to procedures for reviews. Do you agree with these proposals?

Yes

12. Paragraphs 30-33 and 48-52 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the expectations for the final report which the safeguarding partners and the Panel respectively should follow. These paragraphs also cover timescales for publication and arrangements for submitting final reports. Do you agree with these expectations and timescales?

Yes

13. The Act allows the Secretary of State to make regulations to set up a list of reviewers, from which safeguarding partners could be required to select reviewers for local reviews. To maintain maximum flexibility in the system, we do not propose to set up such a statutory list at this time. Do you agree with this approach?

Yes

If no, please explain why

We would add that reviewers should be selected on the basis of the criteria set out in section 41, and suggest that specific levels of experience and qualifications are provided as a framework to support consistency in selecting appropriate reviewers for local reviews.

We also have experience of a large variation in fees being charged by independent reviewers, and would advocate for this being standardised nationally.

14. Do you have any comments on the content of the 'National and Local Child Safeguarding Practice Review (England) Regulations which you have not already covered above?

Yes

If yes, please provide details below

Please note that we are unclear on how the national panel will be informed about the reviews, and how they decide as to which ones come under their remit. If all reviews are published anyway, does this report mean to infer that the national reviews are done to a higher standard, because we feel that otherwise the Panel could grade all the local reviews according to national relevance and circulate the more important ones.

We are disappointed to note that the opportunity had not been taken for the local reviews to be appreciative enquiry sessions with relevant practitioners. From our experience, these could be completed in a day, have strong learning outputs, and mean that more time can be spent implementing and embedding the changes recommended by the local panel that are informed by the session.

We also recommend that there is a consistent approach to the evaluation of local and national reviews, and that a set of agreed outcomes are developed and utilised to measure their quality and effectiveness.

Revisions to chapter five - Child death reviews

15. In reviewing the circumstances around the death of a child, the overarching aim is to prevent future child deaths. We have heard from stakeholders that the term "preventable" has posed a hindrance to learning. Instead of asking about preventability, we propose that the child death review process should consider and identify "modifiable factors". That is, contributory factors to a death, that could be modified to reduce the risk of future child deaths. Do you agree with this approach?

Yes

If no, please explain why

We would like to add that there should be a national consensus on what constitutes modifiable factors, in order to collect and evaluate meaningful national data.

16. We have heard from stakeholders that the distinction between 'expected' and 'unexpected' child deaths can lead to confusion (partly because it may depend from whose viewpoint the question is being considered). We propose a new approach, which allows each individual death to be responded to appropriately, rather than determining whether or not a death meets certain criteria for investigation. This is about working differently, and changing the initial stages of the process. It does not imply an additional burden. Do you agree with this approach?

Yes

If no, please explain why

We agree that it can be difficult to distinguish between 'expected' and 'unexpected' deaths, and believe that each death should be examined carefully on an individual basis as part of the Rapid Response that is set out in the second edition of the Kennedy Report.

We would caution this approach with the need to offer guidance on what an 'appropriate response' is, and believe that a health decision should be made about the inclusion criteria, rather than a criminal justice one.

17. The Wood Review recommended that the area covered by child death reviews should cover 'a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death'. The new legislation gives the child death review partners flexibility to agree that two or more local authority areas may work together as a single area. We are proposing that the geographical 'footprint' of

the arrangements should be locally agreed, based on patient flows across existing networks of NHS care. Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for their new arrangements. Child death review 'footprints' should typically cover a child population such that they review 80-120 child deaths each year Do you agree with these proposals?

Yes

If no, please explain why

We would advocate for the development of a national database.

We would also advise guidance is added around careful management of these new merged local areas to ensure that all members see it as their responsibility to liaise and report on cases for the whole area

18. We propose that families should be assigned a "key worker" to act as a single point of contact who they can turn to for information on the child death review process, and who can signpost them to sources of support. This is already best practice and should not imply an additional burden. More information on the role of the key worker is available in chapter 6.5.1 of the Child Death Review Statutory Guidance. Do you agree with this proposal?

Yes

If no, please explain why

We note that caution is needed to avoid duplication with the work of the Coroner's Office, who fulfil this role for sudden, unexpected deaths. We also note that this position will need to be included in commissioning as in many areas there is no such key worker in place.

We would recommend adding more specific guidance to aid this practice, including detail of appropriate training, support and competencies that this key worker would need to have.

We would also like to note that a key worker will generally not be applicable for neonatal deaths, for which the named neonatal consultant will be the main point of contact, and we would encourage this to be acknowledged.

19. We propose that every child's death is reviewed at a child death review meeting involving practitioners directly involved in the the child's care, prior to being discussed anonymously by the Child Death Overview Panel (CDOP). The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved. It would (for example) take the form of a final case discussion

following a Joint Agency Response to a sudden unexpected death in infancy; or a hospital-based mortality meeting following a death on a neonatal unit. The purpose of the child death review meeting is to ensure local learning and reflection. In contrast, the purpose of the CDOP is to provide independent scrutiny of each case, ensuring this is from a multi-agency perspective. Do you agree with this proposal?

No

If no, please explain why

Whilst we are supportive of this as an ideal, we note that in practice it is often very difficult for all practitioners involved with a child to meet following their death. It may also be impractical due to the current system whereby CDOP are required to collate information from many different resources in order to undertake independent scrutiny into the death.

This proposal represents a large variation to this current practice and risks duplication of effort. We would advocate instead for developing existing morbidity and mortality meetings with standardised reporting templates to be submitted to CDOP.

Currently each CDOP collects and codes data based on local experience, rather than based on national guidance or research evidence. We would advocate for the development of an analytic framework to enable the right data to be captured, analysed, presented and evaluated in ways that informs evidence-based decision-making throughout the system, and believe this is important for better functioning of CDOPs.

In order to achieve a significant reduction in future deaths, strategies to tackle the problems identified must be resourced, implemented and evaluated. We would like to add that locally, child death overview panels do not have the capacity or resources to achieve this. Reports to Local Children Safeguarding Boards, Clinical Commissioning Groups or Local Authorities do not receive the priority or attention they deserve and thus result in inaction. Our State of Child Health short report on Sustainability and Transformation Partnerships (STPs) published in May 2017 highlighted a consistent lack of recognition of ICYPs in STPs.

There are many good examples from the occupational, transport and industrial health literature to tackle hazards that exist in order to prevent future morbidity and mortality and it would be beneficial for the child death review process to learn from these examples.

20. Practitioners involved in the care of the child who died should be invited to attend the child death review meeting. If they cannot attend, they should submit a report, for which a Form B may be used. We propose that Child Death Overview Panel administrators work closely with child death review partners to gather and collate these reports. Please see Chapter 4 of the Child Death Review Statutory Guidance for more information on this process. Do you agree with this proposal?

Yes

If no, please explain why

We support that this is re-instating current good practice that is already established.

21. A revised Form C is proposed at Appendix 5 of the Child Death Review Statutory Guidance. We have heard from stakeholders that two of the form's domains - 'family and environment' and 'parenting capacity' - are not helpful distinctions. We propose changing these domains to 'Social environment including family and parenting capacity', and 'Physical environment', respectively. Do you agree with this proposal?

Yes

If no, please explain why

We would like to note that what is important is not the title of the domains, but the content and definition of the factors collected to enable consistent and standard analysis.

We would advocate for clear explanations on how parental capacity is defined and measured, and what physical environmental factors will be included.

22. We have heard from stakeholders that in many cases reports from child death review meetings (particularly hospital mortality meetings) are not routinely sent to CDOPs. We propose that all child death review meetings should routinely send a report to the CDOP, to inform its independent review of the case. This approach is intended to strengthen the link between the local review and the CDOP process, while also allowing for the right balance between local reflection and independent scrutiny of practice. Do you agree with this proposal?

Yes

If no, please explain why

We advocate that hospital neonatal and child mortality meetings routinely report to CDOPs to ensure a high quality of data for the National Child Mortality Database

23. Chapter 7 of the Child Death Review Statutory Guidance outlines expectations in a number of specific circumstances, including: deaths of UK-resident children overseas; deaths of children with learning disabilities; deaths of children in adult healthcare settings; suicide and self-harm; deaths in inpatient mental health settings and deaths in custody. Do you feel we have covered an appropriate range of specific situations?

Yes

Are the suggested approaches for each of these appropriate and workable?

Yes

24. We have heard from stakeholders that some types of deaths (e.g. suicides) may best be reviewed at a themed CDOP meeting. This may apply when deaths from a particular cause are of small number and/or require specialist expertise to inform the discussion. In these circumstances, we propose that neighbouring CDOPs and designated doctors for child death liaise and co-ordinate their approach. Do you agree with this approach?

Yes

If no, please explain why

We agree that themed meetings on a more national basis would be welcome, particularly for those causes of deaths that are associated with high levels of morbidity in non-fatal cases.

Transitional arrangements

25. Paragraphs 14-15 of the transitional guidance explain the proposal that child death overview panels have a 'grace period' of up to two months following the start of the child death review partner arrangements in their area in which to complete any outstanding child death reviews. Do you agree with this proposal?

No

If no, please explain why

We believe this period is too short and should be at least six months

26. Paragraphs 23-25 of the transitional guidance explain the proposal that Local Safeguarding Children Boards should have a 'grace period' of up to 12 months following the start of the safeguarding partner arrangements in their area in which to complete and publish outstanding serious case reviews. Do you agree with this proposal and with the guidance on handling information?

Yes

27. Paragraphs 27-31 of the transitional guidance set out how safeguarding partners should manage information emerging from serious case reviews. Do you agree with these proposals?

Yes

Any other comments

Are there any other comments you wish to make concerning the changes proposed?

Please see next page

Working Together to Safeguard Children: changes to statutory guidance
Summary of RCPCH response
December 2017

The Royal College of Paediatrics and Child Health welcomes these revisions to the Working Together and Child Death Review guidance. In responding to this consultation, we have consulted with paediatric experts from our Child Protection Standing Committee, our cross-paediatric Specialty Board, and clinical and regional area leads for paediatrics. We would welcome the opportunity to further expand on any of our responses and to contribute to the final version of the guidance.

We highlight our general concern for chapter 3 and the proposed new approach to responsibility for local safeguarding arrangements. We note that this currently lies with the LSCB, whose sole focus is safeguarding, and have seen this work well in practice. We express concern about the proposed partnership structure and the potential for blurring of responsibility in ensuring effective safeguarding.

We also have a few points we would like to note that do not come under the specific questions asked:

Regarding chapter 1:

p.16 proposes that every child's death be reviewed at a 'child death review meeting'. In hospital settings, this might mean a hospital mortality meeting. We recommend including "neonatal / late neonatal deaths will be covered by the new perinatal review process"

'Supervision' is mentioned in p30, 60 and 67. We believe that supervisions is of high importance and deserves its own separate section

Regarding chapter 2:

'Health' appears under the heading of CCGs, however we feel that HEALTH should be its own heading with the following subheadings: NHSE; CCGs; NHS Provider Trusts; the independent sector.

We recommend that it needs to be recognised in this section that health professionals have the clinical expertise, and that clinical authority should be as well represented as executive authority in these new safeguarding arrangements. We would therefore advocate for separate sections on the following: Designated health professionals (doctors, nurses); Named health professionals (doctors; nurses; midwives); GP leads.

Regarding chapter 5:

We express concern about the arrangements for delayed deaths, particularly out of hours, and would advocate for the need to liaise closely with the local paediatric team.

We would like to note that the revisions to chapter 5 do not fundamentally tackle the concerns that the child death review system has, to date, not significantly reduced deaths. We suggest this is partly due to a lack of public health capacity to transform concerns about modifiable factors into local prevention strategies as well as a lack of capacity nationally to develop and implement policy in this area.