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PARTNERSHIP NAME: **Children and Young People Strategic Partnership**
MEETING DATE: **Wednesday, 17 April 2013**
MEETING TIME: **2.00 pm**
LOCATION: **The Showroom, Tritton Road, Lincoln LN6 7QY**

AGENDA

Item	Title	Purpose	Pages
1	**Apologies for Absence**		
2	**Minutes of the previous meeting and Action Points of the Strategic Partnership**		1 - 8
3	**CYPSP Chairs Comments** (Debbie Barnes)		
4	**LSCB Chair Comments** (Chris Cook)		
5	**Action Group Updates**		
5a	**Lincolnshire Participation Action Group** (Kerry Mitchell)		
5b	**14-19 Partnership (RPA)** (Maggie Freeman)		
6	**Housing Strategy Update** (Debbie Barnes)		

7	**CYP Outcomes Forum** (Debbie Barnes)	9 - 32
8	**Inspection Update** (Janice Spencer)	
9	**Multi Agency Safeguarding Hub (MASH)** (Debbie Barnes)	
10	**Northumberland's Approach to Risk Management** (Debbie Barnes)	33 - 56
11	**Changes to the NHS in Lincolnshire** (Allan Kitt)	57 - 60
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Distributed on Date Not Specified

REPORT REF: 2.0

CHILDREN AND YOUNG PEOPLE'S STRATEGIC PARTNERSHIP
14 FEBRUARY 2013

PRESENT: Debbie Barnes (Chairman)

Malcolm Barham (YMCA), Tracey Blackwell (South Kesteven District Council), Councillor D Brailsford, Stuart Carlton (Lincolnshire County Council), Sally-Anne Caunter (Barkston & Syston CE School), Louise Davidson (Spilsby Primary School) Linda Dennett (Lincolnshire Community Health Services), John Herbert (Lincolnshire County Council), Kerry Mitchell (Participation & Engagement Sub Group Chair), Chris Seymour (Special Schools – Pilgrim) and Paula Whitehead (LSCB).

Also in attendance: Cornelia Andrecut (Lincolnshire County Council), Andrea Brown (Lincolnshire County Council), Laura Datta (Lincolnshire County Council), Damian Elcock (Lincolnshire County Council), Carrie Forrester (Lincolnshire County Council), David McWilliams (Lincolnshire County Council), Jessica Spry (Lincolnshire County Council), Zania Stevens (Lincolnshire County Council), Phil Taylor (West Lindsey District Council & Lincolnshire County Council) and Julia Church (Jobcentre Plus – for item 7)

ACTIONS

The Chairman welcomed all present to the meeting.

55. APOLOGIES FOR ABSENCE

Apologies for absence were received from Semantha Neal (East Lindsey District Council), Ginny Blackoe (Lincolnshire Community Health Services), Councillor Mrs P A Bradwell, Rachel North (West Lindsey District Council), John Allen (Lincoln College), Philip Roberts (North Kesteven District Council), Martin Taylor (Donington The Thomas Cowley High School), Janice Spencer (Lincolnshire County Council), Chris Cook (LSCB and Karen Parsons (Children's Links).

56. MINUTES OF THE PREVIOUS MEETING AND ACTION POINTS OF THE STRATEGIC PARTNERSHIP HELD ON 12 DECEMBER 2012

The following points were raised from the minutes of the previous meeting of the Partnership held on 12 December 2012:-

- In relation to the membership of the Partnership, David McWilliams confirmed that he had written to the District Councils, followed up by an email. School members had been confirmed and Mr McWilliams was encouraged by the response from the District Councils who indicated their commitment to attend and an interest in what their roles would be on the partnership. Zania Stevens and Andrea Brown were asked to update and circulate the membership list. *(Action: Zania Stevens/ Andrea Brown)*

- Debbie Barnes confirmed that she had spoken with Dr Tony Hill in regard to the Public Health Framework Indicators. Statutory guidance was awaited relating to Health and Wellbeing Boards and they had agreed to wait until the guidance was received before discussing the issue forward. It was agreed, therefore, to add this item to the work programme after April 2013, when the guidance was expected.

Zania Stevens

- The Chairman confirmed that Lynne McNiven had sent the Health and Wellbeing Strategy to her and advised that some changes had been made.
- David McWilliams explained that a meeting was scheduled to further discuss Branding/Visual Identity of the Children and Young People Plan. It had been suggested that the colours in the Lincolnshire County flag be used to create a neutral logo which would not be related specifically to any one Council. This was unanimously agreed by all present.
- Although not directly involved, Linda Dennett (LCHS) advised that the development of a Children's unit, chaired by LFPT, was being considered and that the autism pathway had been central to the discussions. The Chairman acknowledged that children's services currently available in Lincolnshire were not appropriate for children diagnosed with autism. In order to agree a way forward, it was agreed to arrange a further meeting with key partners to discuss this further, following which a paper would be presented at the next meeting of the partnership. Volunteers for the meeting from a variety of sectors were requested.
- Minute number 46 – Performance Leads Updates (Priority 1) – when asked if the Task & Finish Group had a homelessness provider representative, it was confirmed that Tony McGinty had ensured that a representative had been involved.
- The strategy for access to eligibility for free school meals was being revised to include additional factors for consideration. Once completed, the document would be brought back to the panel.
- Stuart Carlton provided an update in regard to Fulfilling Lives. A key lead from the voluntary sector had been requested by government and expressions of interested had been invited via Source Lincolnshire. Work was ongoing with Public Health colleagues in order to target the right area and it was expected the end of February deadline would be met.

RESOLVED

That the minutes of the previous meeting held on 12 December 2012 be confirmed and agreed as a correct record.

57. CYPSP CHAIRS COMMENTS

The Partnership received an update from Debbie Barnes which highlighted four key areas to the Partnership:-

- At the previous meeting, the Chairman explained that the government had decided to reduce the amount of Early Intervention funding by £150m nationally. Provisions have been made in Lincolnshire at 1% although it had been decided to give this money back to Local Authorities in the form of an Adoption Reform Grant. Most of this funding would be ringfenced to be spent on adoption reform only. Although scorecard targets were good, if not outstanding in some areas, it was helpful to have additional funding in order to improve on timescales for placing children, etc.
- The Chairman noted that the decision to replace GCSE examinations with the English Baccalaureate Certificates had been abandoned by the Education Secretary.
- An OfSTED Inspection in relation to safeguarding and welfare was being undertaken. The Government were currently consulting on the ability of the Local Authority to deliver school improvements and it was expected that schools not performing would be targeted.

RESOLVED

That the update be noted.

58. LSCB CHAIR COMMENTS

The Partnership received an update from Paula Whitehead, on behalf of Chris Cook, Chair of the Lincolnshire Safeguarding Children Board.

- A sub-group on Child Sexual Exploitation (CSE) had agreed to recruit a Coordinator for a 12 month period. It was expected that awareness of the issue would be actively raised. All agencies had been asked to prioritise the e-learning regarding CSE in their organisation for their staff to undertake.
- After and audit of some cases within Team Around the Child (TAC), several significant issues had been raised. An audit of 50 cases would be undertaken with lead professionals across all agencies, with cases being a random sample of open and closed cases. An overview report, including locality training, would be produced from the findings and it was expected this would be available by mid-April. — Paula Whitehead

RESOLVED

That the update be noted.

59. ACTION GROUP UPDATES

The Partnership received updates from the relevant action group leads.

Lincolnshire Participation Action Group

Kerry Mitchell explained that an additional event for young people was planned with support from a variety of partners. Young people had been involved in the planning process and collating the presentation. It was reported that this was a mixed, broad, group of young people with more becoming involved. Action for Children were to bring four young people with disabilities to the event and facilities were to be provided to make the event inclusive to all for participation.

14-19 Partnership (RPA)

A written update had been expected although not received in time for the meeting. It was agreed that this would be circulated following the meeting, once received.

Zania Stevens

60. ALICSE COHORT 2013

David McWilliams introduced this item, explaining that ALICSE was an acronym for the Advanced Leadership In a Children's Services Environment, a project which was now in its fifth year and which was well supported. A regional group had been developed to review the progress of ALICSE. The project tied in with Every Child Matters with some funding available through the Children's Improvement Board.

David McWilliams went on to introduce some of the eight people representing Lincolnshire within the East Midlands, and invited them to update the Partnership on their own personal experiences:-

- Jess Spry – felt it was a really good programme which she had found enjoyed and which enabled her to understand areas that she wouldn't necessarily have been aware of otherwise. She'd found it interesting to contrast and compare with other LA's and to be able to share best practice. At a session held the previous week, a presentation regarding Ethics, Morals and Values was given which instigated some good and varied debate. A residential session had also been held which had provided good networking opportunities. Jess was currently developing her leadership skills and was looking at the independent Chair's role currently, a piece of work she was hoping to lead on.

- John Herbert – Having attended a number of sessions held, John was interested to hear challenges faced by others. His locality task led a central team based in Lincoln but had felt it difficult to build relationships again since the restructure. Feedback from other partners within the East Midlands had also been interesting to see how they had built their own structures and how successful they had been.
- Phil Taylor – thought that the networking events had been brilliant but mainly from a networking point of view. The residential session had been well structured and varied with good ideas shared.
- Laura Datta – events attended had been interesting as she felt if usually work within an isolated environment then there wasn't usually an opportunity to speak with other people in similar roles in other LA's. As SEN School Transport was her particular area, she would be looking into developing leadership in that area, including a new IT system.
- Paula Whitehead – had found the self evaluation and the colleague evaluation processes of leadership skills useful in order to build a picture of her own skills. Child Sexual Exploitation was her area of work and she would be looking into leading and influencing multi-agency response to CSE by building strategies and action plans.
- Carrie Forrester – the events had been valuable as the time had been given to consider issues, e.g. equality –v– equity, every child had a right to go to school but was it a good school. Children's Centres would also be considered by Carrie.
- Cornelia Andrecut – felt that this was good opportunity to reflect on what you do and how you do it and how to plan going forward. It had proved challenging in terms of attendance as her role was particularly busy proving difficult for her to attend all sessions. She had chosen a task which was linked to her role and intended to use her time better.

RESOLVED

That an update would be provided of those unable to attend.

David McWilliams/
Zania Stevens

61. WELFARE REFORM

The Chairman thanked Julia Church, Partnership Manager from the Department of Work and Pensions (DWP), for attending the Partnership meeting and invited her to commence her presentation.

It was agreed to circulate the presentation to the Partnership after the meeting.

Andrea Brown

During discussion, the following points were noted:-

- Assistant could be given by way of food vouchers to local supermarkets or by utilising food banks. The Chairman confirmed that two voluntary sector organisations had been identified to administer the system on behalf of LCC.
- It was anticipated that one in six homes were likely to be affected in SKDC as a result of the Welfare Reform. Should a possession order be taken this would likely be overturned in court so it was a difficult position for all parties.
- Although Government had made it clear that foster carers should be exempt, the absolute confirmation of that position had not been received by the local authority. It was acknowledged that there would be some unusual cases but that these should be made clear from Government.
- The Chairman requested that Phil Taylor raise this at the next housing meeting with District Councils and, in particular, the exemption of foster carers.

Phil Taylor

- It was suggested that a joint approach with the DWP be taken to support more vulnerable families directly as it was felt they would be less likely to seek out help and support due to the very nature of their circumstances. Zania Stevens was asked to provide the contact details of Ms Church to Stuart Carlton.

Zania Stevens

The Chairman thanked Ms Church for her presentation and suggested that an update may be required in future.

RESOLVED

That the presentation be noted.

62. <u>INFANT FEEDING STRATEGY</u>

David McWilliams introduced this item, confirming that the information contained in the strategy was relevant and useful to all partners but, particularly relevant to the partnership, was the implementation of the action plan as it was reliant on a range of agencies to take action.

During discussion, the following points were noted:-

- Concern was noted that the action list was large even though a number of agencies were involved and it was felt that the strategy should be more overarching rather than giving specific details.

- It was suggested that the actions should be broken down and made clear and succinct in order to have the biggest impact.
- Although the group had been considering breastfeeding for some time, wider involvement from other agencies would be beneficial. It was felt that the remit of the group and the Terms of Reference be looked at to ensure the most relevant person attends.
- Linda Dennett, LCHS, agreed to feedback the comments of the Partnership to the group.

Linda Dennett

RESOLVED

1. That the strategy not be taken until feedback received following comments made.

63. PARTNER UPDATES

South Kesteven District Council (SKDC)

Tracey Blackwell, Strategic Director for South Kesteven District Council, advised that the key issues for SKDC would currently be the Welfare Reform and what was realistically required in terms of support and an appropriate strategy.

Voluntary & Community Sector

Malcolm Barham, VCS and YMCA, reported that the next year or so would be a very difficult time. Third sector organisations did not have statutory issues as a result of the Welfare Reform but they would have an enormous task ahead in terms of supporting people as a result.

RESOLVED

That the updates be noted.

64. OfSTED FRAMEWORK INSPECTION

The Chairman introduced the item by explaining that the inspection framework had changed. The previous “good” rating was now “outstanding” and the previous “satisfactory” rating was now “good”. Jess Spry was invited to give her presentation.

The presentation, entitled Multi Agency Inspection 2013, provided background information on CRA inspections, Interim CP inspections and multi-agency inspections. The key changes were to be made from June 2013 and would be three yearly cycle. The inspections would continue to be unannounced but inspectors would spend two weeks on site looking at four key judgements. However, one single judgement within one report would be provided.

Damian Elcock was invited to facilitate a workshop. Breaking into groups, the partnership were asked to utilise one key judgement and assess where they would grade their service delivery as an organisation. The groups provided feedback for their particular judgement.

RESOLVED

1. That the presentation and feedback from the workshop be noted.
2. That the presentation be circulated following the meeting. — Andrea Brown

65. ANY OTHER BUSINESS

No items of any other business were raised for consideration.

66. REPORTS CIRCULATED FOR INFORMATION

1. CYPSP and Health & Wellbeing Governance
   For members information only.

2. CYP Health Outcomes
   The Chairman confirmed that this report had been circulated for information, advising that a short Task & Finish group had been set up to consider the remit of both groups. Two dates had been provided – 28th March and 2nd April 2013.

3. CYPSP 2013 Meeting Dates
   For members information only.

The meeting closed at 4.40pm

Update for Health and Well Being Board on behalf of the Children and Young People Strategic Partnership

Background

On 23rd January 2013, the Executive Director of Children's Services, on behalf of the Children and Young People Strategic Partnership presented a paper titled "Children and Young People's Health Outcomes Forum". This report outlined a number of recommendations for the Health and Well Being Board to consider to ensure that Lincolnshire has effective strategic arrangements in place to co-ordinate the contributions made to improve health and wellbeing outcomes for children and young people

A short task and finish group was established and this report outlines the recommendations of this task and finish group to ensure partners work together to jointly assess need, plan, and co-ordinate the commissioning of provision to create high quality pathways of support for children and young people

Key Success factors

All members of the task group agreed the following core standards and confirmed their commitment to consistently applying the standards set out below:

- Commissioning should be informed by active engagement with children, young people and their families
- Commissioning must be planned and co-ordinated across a spectrum of children's health, education and social care needs with key transitions from maternity and into wider adult services
- Commissioning plans are aligned and informed through the joint strategic needs assessment and the joint health and wellbeing strategy
- There is clear accountability within all commissioning and delivery organisations
- Commissioners have effective access to clinical expertise on children's outcomes
- Commissioning plans are focused on outcomes for individuals which consider the needs of the family and the context in which children and young people live including the need to support them in learning
- Commissioners include that services are provided in age appropriate settings using standards like "You're Welcome "
- There is clarity on the available funding and resources to meet the needs of children and young people across all commissioners
- Commissioners understand the whole life course and impact of health and wellbeing in childhood particularly in the early years
- The needs of the vulnerable or at risk groups are considered and provision made

Actions required to achieve effective commissioning

In order to achieve the above standards, the following actions needs to be agreed and implemented:

- The Health and Well Being Board has effective links with the Children's Trust to ensure cohesive governance and leadership
    - Terms of Reference of CYPSP to be revised to reflect that it will be an established sub group of the Health and Well Being Board
    - Membership of CYPSP to be revised to ensure effective representation especially across the clinical Commissioning Groups and Schools
    - Terms of Reference of CYPSP to be revised to reaffirm the partnership as the primary commissioning forum for children's outcomes
    - CYPSP will continue to publish a Children and Young People's Plan which incorporates the priorities of the Health and Well Being Strategy reflecting the outcomes of the Joint Strategic Needs Assessment

- The Health and Well Being Board will have an agreed process to ensure children's issues receive sufficient focus
    - CYPSP will provide a 6 monthly partnership progress report, outlining performance / achievements and areas of required focus to the Health and Well Being Board
    - CYPSP will provide ad hoc reporting as priorities determine
    - Health and Well Being Board can request CYPSP to establish task and finish groups to undertake actions in line with service priorites and performance outcomes
    - The Health and Well Being Board will be a formal consultee of the Children and Young People's Plan and the CYPSP will be a formal consultee of the Health and Well Being Strategy

- The Health and Well Being Board will contribute to the defining of an early help offer for children and young people
    - Lincolnshire's early help offer will be formally consulted upon and approved by the Health and Well Being Board. CYPSP will lead on its development
    - The Health and Well Being Board will confirm its commitment that all commissioning and delivery plans prioritise "Team Around the Child " processes as Lincolnshire's agreed mechanism for co-ordinating the delivery of early help

- The Health and Well Being Board will ensure that there are effective mechanisms for listening to the views of children, young people and their families
    - The Health and Well Being Board will utilise the same mechanisms for listening to the views of children, young people and families and will maximise further opportunities through an agreed process with Health watch

Successes

Reviewing the recommendations of the Children and Young People Health Outcome Forum, the task and finish group considered that there had been significant progress made in the strategic relationship between the Health and Well Being Board and the CYPSP. These include:

- The Joint Strategic Needs assessment and the Health and Well Being Strategy jointly reflect the analysis and prioritises for the health and wellbeing of children and young people in the County
- There is a commitment to the "Team Around the Child" as the agreed mechanism for co-ordinating early help to families
- Children Centres and schools are maximised to deliver a range of family focused services. Further work is needed to ensure that public assets are maximised to ensure age appropriate settings are consistently used to improve health outcomes

The Health and Well Being Board is asked to comment on the progress of this task and finish group and support the implementation of the above recommendations

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APPENDIX 1

Report Reference: 0.0

LINCOLNSHIRE SHADOW HEALTH AND WELLBEING BOARD

Open/Exempt (please delete as appropriate) Report on behalf of
(If Exempt insert relevant paragraph)

Report to	**Lincolnshire Shadow Health and Wellbeing Board**
Date:	**22 January 2013**
Subject:	**Children and Young People's Health Outcomes Forum**

Summary: In 2012, the Secretary of State established a Children and Young People's Health Outcomes Forum which published its proposals on how health-related care for children and young people could be improved. The Forum identified several themes to ensure that improvements are achieved and these are highlighted later in this report. This paper outlines the recommendations of this report, and suggests that the Health and Wellbeing Board commissions a task and finish group to assure itself that the key factors needed for improvement are embedded in Lincolnshire.

Actions Required: The Health and Wellbeing Board is asked to note the content of this report and establish a task and finish group to measure performance in Lincolnshire against recommendations and against the key strategic questions / challenges and to develop an action plan to address areas in need of development.

1. Background

Earlier this year, the Secretary of State established a Children and Young People's Health Outcomes Forum which published its proposals on how health-related care for children and young people could be improved. The Forum identified several themes to ensure the improvements are achieved and these are highlighted later in this report. This paper outlines the recommendations, and suggests that the Health and Wellbeing Board commissions a task and finish group to assure itself that the key success factors needed for improvement are embedded in Lincolnshire.

The report on the Children and Young People's Health Outcomes Forum recognises that outcomes for children and young people could be improved if the wider health system had a greater focus on inequality. Infant mortality, obesity, childhood accidents and teenage pregnancy affects more children and young people from disadvantaged backgrounds and there is significant evidence which states that children who have a disability, who are looked after or are in the criminal justice system face even poorer health outcomes than their peers. It is further recognised that it is not just their health that is affected – it is their social, educational and economic potential. The report also confirms that greater personal responsibility in self managing health needs is more likely to be successful. The report also highlights the importance of a well trained workforce and concludes that improving education and training of the Children's Workforce can deliver real improvements.

There are of course, examples of outstanding health and social care resulting in good outcomes for children and young people and it is this evidence which must be shared to affect change. We have a unique opportunity through the Health Reforms and the establishment of Health and Well Being Boards to co-ordinate what is done in Lincolnshire to improve health and wellbeing outcomes for children and young people and to exploit the commitment of all commissioners to work together to assess needs, plan and co-ordinate commissioning to create high quality, integrated pathways of care.

The report makes a series of recommendations which are attached in Appendix 1. These include:

- **Ensuring leadership and accountability** across all agencies and partnerships and setting out responsibilities for children, young people and their families and how accountability will be exercised at every level in the system.

- **Ensuring effective contribution to effective local safeguarding**, that DH produce a full accountability framework for safeguarding children in the wider health system as soon as possible; that, as part of the new multi-agency inspections, CQC should consider how all parts of the health system, contribute to effective local safeguarding; and a recommendation that further work be undertaken on indicators that would drive improvement to protect and promote the welfare of children and young people, including a focus on measuring the effectiveness of early help/early intervention. In addition, that NICE be commissioned to develop a Quality Standard for safeguarding children.

- **Promoting integration and partnership**, including cross-government join up on policy, funding and performance management; prioritise integrated care provision in their regulatory and performance roles for all partners; and a recommendation that the NHS Number should be used as the unique identifier to bring together health, education and social care data for all children and young people.

- **Acting early and intervening at the right time**, with a focus on tackling inequality, particularly of looked after children, including calling for: all organisations to take a life-course approach coherently addressing the different stages in life and the key transitions instead of tackling individual risk factors in isolation; Directors of Children's Services to be responsible for overseeing the overall quality and delivery of health

and wellbeing services for looked after children; and CCGs with their local authority partners to ensure sufficient clinical expertise and leadership for looked after children, including a designated doctor and nurse.

- **Workforce, education and training**, including that all GPs who care for children and young people should have appropriately validated CPD reflecting the proportion of their time spent with children and young people; and recommendations for Health Education England and Centre for Workforce Intelligence.

The report is intended as a basis for a wider children and young people's health outcomes strategy. Moving forward, the relationship between local authority Children's Services and health commissioners through the Health and Well Being Board will be key.

The Forum also published the first four of a range of factsheets they are producing to help children, young people and their families be effectively involved in decisions about their health care, and help organisations and individuals in different parts of the system understand whether they are meeting the needs of children and young people.

- Read factsheet for school governors
- Read Health and wellbeing boards and children, young people and families
- Read Commissioning in the new NHS for children, young people and their families

These are attached in Appendix 2

The full report can be found at: http://www.councilfordisabledchildren.org.uk/what-we-do/work-themes/health/the-children-and-young-peoples-health-outcomes-forum

Implications for Health and Wellbeing Board

Health and Wellbeing Boards have a responsibility to co-ordinate the contributions made to improve health and wellbeing outcomes for children and young people. Specifically commissioners of services must ensure that outcomes are improving through jointly assessing need, planning and co-ordinating the commissioning of provision to create high quality integrated pathways of provision for children and young people.

The Forum has identified success factors which can be used by Health and Wellbeing Boards to measure effectiveness. These are described as:

Key success factors

- ❑ Commissioning is informed by active **engagement with children**, **young people and families** using methods appropriate for them
- ❑ Commissioning is planned and **coordinated across the whole spectrum of child's health needs**, with key transitions from maternity and into adult services, and with related services meeting their wider needs including education and children's services
- ❑ Commissioning plans are achieved through effective engagement with **Health and Wellbeing Boards** and clear alignment with local JSNA and JHWS that clearly set out the needs of children and young people

❑ There is **clear accountability** within all commissioning organisations for commissioning child health services

❑ Commissioners have effective access to appropriate **clinical expertise** on children, including from providers

❑ Commissioning plans take a **patient centred perspective** and consider the needs of the family and the context in which the children and young people live, including the need to support them in education

❑ Commissioners ensure that care is delivered in **age appropriate settings** using standards like "You're Welcome"

❑ There is clarity on the totality of **funding** available to meet local children and young people's needs across all relevant commissioners

❑ Commissioners understand the whole **life course** and the impact of health and wellbeing in childhood, particularly maternity and the early years, on health in adult life and on health inequalities

❑ The needs of particularly **vulnerable or at risk groups** of children and young people are fully considered

Finally the Forum sets of key strategic questions and challenges for Boards which are:

- Does the Health and Wellbeing Board link effectively with the local children's trust, safeguarding board and clinical commissioning groups (CCGs) to ensure cohesive governance and leadership across the children's agenda?

- Does the Health and Wellbeing Board have an agreed process to ensure children's issues receive sufficient focus?

- Has the Health and Wellbeing Board contributed to defining the early help offer, as recommended by Professor Munro?

- Is the Health and Wellbeing Board making appropriate use of local mechanisms to listen to the views of children, young people and families?

- Does the local health and wellbeing strategy analyse and prioritise the health needs of children and describe success?

- Have the views of frontline staff and clinicians been factored into the board's planning?

- Has the Health and Wellbeing Board got an agreed method of engaging with schools?

- Has the Health and Wellbeing Board got a clear plan to maximise the use of public assets (children's centres, schools, youth services, health centres, etc.) to improve health outcomes for children?

- Is the Health and Wellbeing Board satisfied that the common assessment framework is sufficiently embedded in the local partnership?

2. Conclusion

The Forum has set out recommendations for the new health system which, if accepted and put in place, will start to address the key obstacles to improving children and young people's health outcomes that exist now. The implementation of these recommendations is crucial, but we await government response on the recommendations. The Forum is clear that without consistent attention and further development of the strategy this report could go the way of many of its predecessors and fail to secure the benefits that our children and families need and the country requires.

Recommendation

The Health and Well Being Board is asked to note the content of this report and establish a task and finish group to make performance against recommendations and against the key strategic questions/ Challenges and to develop an action plan to address areas of development

3. Consultation

4. Appendices

These are listed below and attached at the back of the report	
Appendix 1	Recommendation from the report of the Children and Young People's Health Outcomes Forum
Appendix 2	Factsheet for School Governors Health and wellbeing boards and children, young people and families. Commissioning in the new NHS for children, young people and their families.

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Debbie Barnes who can be contacted on 01522 553201 or Debbie.barnes@lincolnshire.gov.uk

Appendix 1
Recommendations from the report of the children and young people's health outcomes forum

Theme 1 - Putting children, young people and their families at the heart of what happens

The Forum Concluded that where health outcomes are better it is because children, young people and their families are involved in decisions about their care, have received relevant and age-appropriate information, and that care is provided in environments appropriate for their age.

- **All organisations must demonstrate how they have listened to the voice of children and young people, and how this will improve their health outcomes.**

- **The revised NHS Constitution is drafted in such a way as to be applicable to all children, young people and their families.**

- **The Department of Health (DH) should bring together all relevant partners to co-produce a children's health charter based on the principles of the UN Convention on the Rights of the Child, and aligned with the NHS Constitution. The application of these principles should be audited through the regulators.**

- **Healthwatch England gives appropriate consideration to the importance of all children and young people's voices to inform its work programme, and is able to demonstrate this through its annual report. Local Healthwatch includes children and young people's voices as core to their work and demonstrates this through their reporting mechanisms.**

Theme 2 - Acting early and intervening at the right time

The report's focus on children and young people is not only an emotionally driven one. It is also based on economic reality: children and young people are crucial to the future well-being and prosperity of our nation. This is why a focus on the health of the pregnant mother, infancy and the early years and tackling disadvantage quickly is so critical. Poor mental health in pregnancy is associated with low birth weight and increased rates of mental and physical ill health in children. However, the current system does not recognise this. The Forum's recommendations are designed to address these issues:

- **All organisations in the new Health system should take a life-course approach, coherently addressing the different stages in life and the key transitions instead of tackling individual risk factors in isolation.**
- **Directors of Public Health and their local clinical commissioning groups (CCGs) should work together with maternity and child health services to identify and meet the needs of their local population.**
- **In 2013 DH should explore the development of a new outcomes measure on perinatal mental health, and implement it as soon as possible**
- **CCGs with their Local Authority partners need to ensure sufficient clinical expertise and leadership for looked after children, including a designated doctor and nurse**
- **Directors of Children's Services should be responsible for overseeing the overall quality and delivery of health and wellbeing for looked after children**
- **Social care staff and others dealing with looked after children should have responsibility for ensuring they are registered with a GP and that the GP is kept informed of the details of their care**
- **CCGs and Local Authorities should specifically recognised care leavers in early adulthood (18-25) as well as looked after children, in their commissioning, including requiring children in care health teams to include a focus on this group**

Theme Three
Integration and partnership

The report appreciated that the varied needs of many children and young people can only be met by different organisations. However, only by putting the child or young person and their family's needs first, and using sensible systems for sharing information, is it possible to move from fragmentation to proper integration. The Forum's recommendations here, therefore, are for better systems for information, as well as for the new and existing health, social care and education systems:

- **The NHS Number should be used as the unique identifier to bring together health, education and social care data for all children and young people.**

- **The NHS CB should prioritise and promote the issue of integrated care provision in their regulatory and performance roles within the NHS, and work with the Care Quality Commission (CQC) and Ofsted in developing a framework across non-health providers.**

- **DH should work with other Government departments and partners to achieve better integration of health with education, social care and other local authority led services**

- **DH and partners should select some sentinel conditions and pathways which reflect needs along the life course in order to monitor significant risk of gaps in services, including prevention, and provide focus on improving integration of care**

Theme Four
Safe and sustainable services

The report noted that there is a shared ambition to provide world class services and outcomes, delivered using the best available evidence. The Forum does not believe this is achievable with the current pattern of services and the lack of adequate training in paediatrics and child health. The development of networks and partnerships at all levels of the system is essential. Our main recommendations here are designed to achieve this and reduce fragmentation between:

- **all children and young people's services within the Specialised Services Definition Set; and all parts of the relevant pathways from specialist centres to district general hospitals to community provision and primary care.**

- **CCGs need to develop local networks and partnerships with providers to address and deliver the sustainable provision of local acute, surgical, mental health and community Children's Services and to ensure both care closer to home and no gaps in provision**

- **DH should commission a study in 2013 to quantify the harm to children and the costs that arise due to errors from unlicensed and off-label prescribing and through lack of age-appropriate formulations. Using the findings, DH should work with the industry and academia to develop properly the use of all medicines, whether old or new, starting with those producing the most harm**

- **The NHS CB, with CCGs, should address service configuration to meet the needs of children and young people on a sustainable, safe and high quality basis. In addressing safety, we looked closely at medicines – at both medication errors and the licensing and testing of medicines. DH should adapt the existing indicator in Domain 5 of the NHS Outcomes Framework to measure all drug errors that reach patients. With immediate effect, the Royal Pharmaceutical Society should work with the Colleges and the NHS Institute for Innovation and Improvement to develop a bundle of interventions in order to eliminate or reduce drug errors**

Theme Five

Workforce, education and training

All those working with children and young people should have the right knowledge and skills to meet their specific needs. This is not just within the NHS, but in schools and youth services, whose staff can make an important contribution to children and young people's health outcomes. The new health system, Health Education England (HEE) and the local Education and Training Boards (LETBs) provide the ideal opportunity to take stock of the children's health workforce needs for the whole country. We recommend:

- **HEE should prioritise children and young people, providing early strategic direction for workforce planning, education and training for the core and specialist children's health workforce.**

- **HEE should identify a lead LETB to co-ordinate education, training and workforce development to reduce variability and maintain national standards.**

- **As a matter of priority, the Centre for Workforce Intelligence, in conjunction with key professional bodies whose members provide services to children and young people, should undertake a scoping project to identify and address the issues of providing a safe and sustainable children and young people's healthcare workforce.**

The wider workforce such as teachers, social workers etc. have an important role in improving health outcomes. As well as understanding their physical health needs, children and young people need those working with them to understand the importance of good support for emotional health and well-being. This is of the utmost importance. We therefore support the DH-led consortium of organisations producing a mental health e-portal, which we hope will form part of many professions' initial training and continuing professional development (CPD) from 2014.

General practice and GPs in particular, have a critical role to play in children and young people's health as they are often the first point of contact when a health problem arises, and their response to the child's problem can determine the outcome. The next group of recommendations therefore relate to GPs and general practice staff training:

- **The Royal College of General Practitioners proposal to extend GP training to allow for adequate training in paediatrics and physical and mental child health is supported.**
- **All GPs who care for children and young people should have appropriately validated CPD**
- **All the relevant Royal Colleges should work together to agree skills and competencies in child health**
- **All general practices that see children and young people should have a named medical and nursing lead**
- **All general practice staff should be adequately trained to deal with children and young people**

Theme Six

Knowledge and evidence

Collecting information and turning it into knowledge and evidence, and putting that alongside research is central to the drive for better health outcomes. The Forum has made many suggestions in this area including, at its most basic, the interpretation of data – the need to present data in relevant age bands. As part of the drive to involve children, young people and their families in their care, the Forum looked at access to health records and good personal health information, and also at the need for new data sources.

The systems and data currently in use require significant development to meet future needs. In this chapter we make a number of detailed recommendations designed to start to put that right. Some of the main ones are:

- **The NHS CB, with support from Health and Social Care Information Centre (HSCIC), should establish electronic child health records, accessible for both patients and professionals.**
- **The NHS CB, with support from the HSCIC, should improve the quality of routinely collected data, collecting them once and using them for multiple purposes, as well as making secondary uses data readily available to and useable by clinical professionals.**
- **The Chief Medical Officer should consider how an intelligence network for children and young people's healthcare, which crosses all settings, can be established by 2013, to drive up standards and effective use of data, information and intelligence in decision making.**

Key to delivering improved health outcomes is high quality evidence, to inform the setting of standards for treatment and services. There were too few Quality Standards relevant to children and young people, but the Forum is pleased to note that an increased range of topics is now planned. This will go some way to addressing the gap, but much more needs to be done, and we recommend that:

- **The National Institute for Health and Clinical Excellence (NICE) and the NHS CB work with the professional bodies to expand and prioritise the Quality Standards work programme as it applies to children and young people.**

Theme Seven

Leadership, accountability and assurance

New organisations in the system are setting up their structures and ways of working so that they can deliver their responsibilities. The Forum believes that leadership and accountability for improving health outcomes across the whole life course must be embedded and demonstrated throughout the system – within both new organisations and those already established.

- **All organisations leading the new system – DH, Public Health England (PHE), the NHS CB, Monitor, local authorities and CCGs – should clearly set out their responsibilities for children, young people and their families and how accountability will be exercised at every level in the system, and should be transparent about the funds they spend on child health. Clinical leadership – an important feature of the new health system – must be visible at every level.**

- **DH, the NHS CB and PHE should identify national clinical leadership on children and young people, for example through a deputy reporting to the Chief Medical Officer in DH and a National Clinical Director reporting to the Medical Director within the NHS CB.**

- **Local commissioners, including CCGs and local authorities, should identify a senior clinical lead for children and young people.**

- **CQC should make maximum use of thematic reviews to examine aspects of the new health system from a children and families' perspective.**

- **CQC and Ofsted should collectively produce a clear joint statement which demonstrates how they will work together to foster integration of key services and partnership across sectors.**

Safeguarding children and young people and identifying abuse early are core responsibilities of the health system. This is such an important area that we have made a number or recommendations to help ensure that focus is not lost in the transition to the new landscape. These include:

- **DH and the NHS CB should publish a full accountability framework for safeguarding children in the wider health system as soon as possible.**

- **As part of the new multi-agency inspections, CQC should consider how all parts of the health system, including relevant adult services, contribute to effective local safeguarding.**

- **Further work should be undertaken on indicators that would drive improvement to protect and promote the welfare of children and young people. This should include a focus on measuring the effectiveness of early help/early intervention.**

- **NICE should be commissioned to develop a Quality Standard for safeguarding children.**

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CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM

School Governor Factsheet

Why is Health and Wellbeing important to my school?

Schools are very important places in which children and young people's health and wellbeing can be supported and improved. Research has shown that aside from parents, a supportive school is the most important protective factor is helping children and young people to stay healthy and avoid risks.

What's more, the healthier your pupils are the more likely they are to achieve better educational outcomes and fulfil their potential in life.

As a Governor you have a really important role to help the pupils in your school succeed by helping to create a healthy culture throughout the school.

There are many opportunities to do this like through the curriculum, targeted projects, having onsite health services, providing physical activity and healthy eating opportunities, reinforcing positive individual and peer group behaviour, having positive behaviour and bullying strategies and creating a healthy culture.

Your school will also need to draw on the support of health services and that means you need to engage with local partners to get your voice heard and get the support your pupils need. The more you engage, the better support you are likely to get for your school. You know your pupils needs best, make sure your health partners do as well!

Did you know?

The health service is going through a number of radical changes at the moment. Are you and your fellow governors aware of the impact this may have on the running of your school? Perhaps it could be an agenda item for your next meeting? Perhaps your Local Authority or local health contact could come and talk you through this? The Department of Health website has lots more information www.dh.gov.uk

Your Local Authority will be taking the lead for public health from April 2013 taking over from Primary Care Trusts. Each year they will make decisions on money for health in your area. They need to hear from you to take your school needs into account.

What do OfSTED say?

Schools' support for pupils' health and wellbeing is evaluated in the new Ofsted inspection framework. This is what it says:

When evaluating the behaviour and safety of pupils, inspectors will consider pupils' ability to assess and manage risk appropriately and to keep themselves safe. The importance of developing pupils' understanding and commitment to their own and other's health and wellbeing, is also highlighted in Ofsted's supplementary PSHE guidance for inspectors undertaking subject survey visits.

Have you thought about?

How your school is removing all the barriers it can to raise achievement and standards, and do these include poor health outcomes which may lead to behaviour and absenteeism problems?
Is your school a healthy environment?
Do you have whole-school health and wellbeing policies?
What has Ofsted said on how health and wellbeing policies in your school has contributed to the schools overall inspection ?
Are you aware of all the data that is available to your school to understand the health and wellbeing profile of your pupils ?
Do you know what parents expect of your schools contribution to better health outcomes?
How do you engage them?
How do you know if your health and wellbeing work is having an positive effect?
How do you engage and harness the view of your pupils and their health and wellbeing needs?
How is your school working with local partners, like School Nurses, to support the best health outcomes for children and young people?
Do you understand how the health system works and how this will impact of the health provision offered to your school?
Does your school make reasonable adjustments and accommodations for children with medical needs?
Is your school maintaining the school food nutritional standards?
Does your school have effective training and support in managing children with long-term medical conditions like asthma and diabetes?
Are there particular health issues in your school or local area that you need to bring to the attention of local health services and those people that plan those services?
Does your school have a quality programme of Personal, Social, Health and Economic Education (PSHE) that it is planned and monitored?

CHILDREN AND YOUNG PEOPLE'S HEALTH OUTCOMES FORUM

Health and wellbeing boards and children, young people and families

Key success factors

- A local partnership dedicated to children and young people (linked into the governance of health and wellbeing boards) is essential.
- Commissioning of NHS services for children and young people must sit alongside commissioning of all services for children (the concept of holistic commissioning).
- Health and wellbeing boards should prioritise interventions for children and young people which are proven to work.
- Commissioning of services should be informed by the views of children, young people, parents and families.
- Health and wellbeing boards should ensure a focus on early intervention, within an overall understanding of a 'lifecourse' approach to provision.

Key strategic questions and challenges for boards

- Does the health and wellbeing board link effectively with the local children's trust, safeguarding board and clinical commissioning groups (CCGs) to ensure cohesive governance and leadership across the children's agenda?
- Does the health and wellbeing board have an agreed process to ensure children's issues receive sufficient focus?
- Has the health and wellbeing board contributed to defining the early help offer, as recommended by Professor Munro?
- Is the health and wellbeing board making appropriate use of local mechanisms to listen to the views of children, young people and families?
- Does the local health and wellbeing strategy analyse and prioritise the health needs of children and describe success?
- Have the views of frontline staff and clinicians been factored into the board's planning?
- Has the health and wellbeing board got an agreed method of engaging with schools?
- Has the health and wellbeing board got a clear plan to maximise the use of public assets (children's centres, schools, youth services, health centres, etc.) to improve health outcomes for children?
- Is the health and wellbeing board satisfied that the common assessment framework is sufficiently embedded in the local partnership?

This poster was produced in June 2012 by the health and wellbeing board learning set for children and young people. It represents their key learning and does not necessarily showcase best practice but aims to provide health and wellbeing members with an accessible and helpful resource. This learning set was led by Anthony May, Corporate Director for Children and Families and Cultural Services for Nottinghamshire County Council, anthony.may@nottscc.gov.uk.

For further information, or to comment on this poster, please email hwb@nhsconfed.org.

INF30701

Vision

That health and wellbeing boards make an effective contribution to improving health and wellbeing outcomes for children and young people.

Supported by

Further resources

- The Department of Health Children and Young People's Health Outcomes Strategy (due to be published in July 2012)
- A plethora of Local Government Association resources, collated by the LGA: www.local.gov.uk/childrens-health
- Local authority child health profiles (published by the Child and Maternal Heath Observatory ChiMat): www.chimat.org.uk/profiles
- The NHS Atlas of Variation in Healthcare for Children and Young People: www.chimat.org.uk/variation
- NHS Confederation review of policy documents on children and young people's health and wellbeing: www.nhsconfed.org/hwb
- Assured Safeguarding – GP and Health Leader Edition (safeguarding advice for GP and health leaders developed by the East Midlands group of Directors of Children's Services): www.jriep.com
- Commissioning Child Health and Wellbeing Services (information and guidance framework developed by the East of England Strategic Network for Child Health and Wellbeing Commissioning Champions) – EOE Info and guidance framework
- National Institute for Health Research (for health-related research materials): www.nihr.ac.uk
- A guide for commissioners of children's and young people's and maternal health and wellbeing services NHS North West: www.northwest.nhs.uk/childhealth

The spectrum of children's health needs

Taken from the project scope of the Department of Health Children and Young People's Health Outcomes Forum

- Health promotion, prevention and improvement
- Primary care
- Children with poor mental health
- Urgent care for children with acute illness
- Children with long-term conditions
- Children with complex health needs
- Children with disabilities
- Looked after children
- Palliative care
- Ensuring the use of medicines for children optimises health outcomes
- The health sector's contribution to safeguarding children
- The health sector's contribution to support for troubled families

Commissioning in the new NHS for children, young people and their families

Key success factors

- Commissioning is informed by active **engagement with children, young people and families** using methods appropriate for them
- Commissioning is planned and **coordinated across the whole spectrum of child's health needs**, with key transitions from maternity and into adult services, and with related services meeting their wider needs including education and children's services
- Commissioning plans are achieved through effective engagement with **Health and Wellbeing Boards** and clear alignment with local JSNA and JHWS that clearly set out the needs of children and young people
- There is **clear accountability** within all commissioning organisations for commissioning child health services
- Commissioners have effective access to appropriate **clinical expertise** on children, including from providers
- Commissioning plans take a **patient centred perspective** and consider the needs of the family and the context in which the children and young people live, including the need to support them in education
- Commissioners ensure that care is delivered in **age appropriate settings** using standards like "You're Welcome"
- There is clarity on the totality of **funding** available to meet local children and young people's needs across all relevant commissioners
- Commissioners understand the whole **lifecourse** and the impact of health and wellbeing in childhood, particularly maternity and the early years, on health in adult life and on health inequalities
- The needs of particularly **vulnerable or at risk groups** of children and young people are fully considered

Vision

Commissioners ensure that the health and wellbeing outcomes of children, young people and their families are improved

Commissioners of all children's health and care – NHS and LA – together assess needs, plan and coordinate commissioning to create high quality, integrated pathways of care for all children and young people out of maternity and right through into adult services

Key elements of the pathway

Commissioners should think about the following key elements:

- **Primary care** – with GPs and their teams prepared and trained to work effectively with children, young people and their families
- Appropriate access for children and young people to **Community Children's services,** such as children's community nursing teams, structured so they can provide acute and palliative care in home settings and support the management of long term conditions and mental health
- Access to effective **public health services** including support for children, young people and families, especially new parents, through health visitors and family nurse partnerships and school nursing and mental health promotion
- **Secondary care services** – mental health, general paediatrics and surgery, configured in a way that provides sustainable services, including:
  - Fully staffed 24 hour paediatric services
  - 8 to late services close to home
  - Safe general, acute and specialist surgical services with paediatric trained anaesthetist input
- Safe and sustainable **specialist care** through highly specialised services which are comprehensive and located in strategic sites

Resources:

ChiMat** has a range of resources for commissioners including the PREview tool and data atlas which provides ready analysis and presentation of local, regional and national data over time.* ***www.chimat.org.uk

***The National Service Framework for Children, Young People and Maternity Services** (DH, 2004) still provides the most comprehensive standards for high quality integrated care from pregnancy right through to adulthood*

The NHSCB is developing a range of commissioning resources which can and should be applied to child health services just as to adult services ***www.commissioningboard.nhs.uk***

Key LA Public Health commissioning responsibilities
Healthy Child Programme for school-age children, including school nursing
Contraception (over and above what GPs provide) Testing and treatment of sexually transmitted infections, sexual health advice, prevention and promotion
Mental health promotion, mental illness prevention and suicide prevention
Local programmes to address physical inactivity and promote physical activity
Local programmes to prevent and address obesity, including **National Child Measurement Programme** and weight management services
Drug misuse services, prevention and treatment
Alcohol misuse services, prevention and treatment
Local smoking related activity, including stop smoking services and prevention activity
Locally-led initiatives on nutrition
Population level interventions to reduce and prevent birth defects (with PHE)
Dental – oral health promotion

Key CCG commissioning responsibilities
Children's healthcare services
Maternity Services (and routine newborn services)
CAMHS
Adult mental health services
Community health services, including speech and language, continence, wheelchair services and home oxygen services (except for public health services such as health visiting and family nursing)
Elective hospital care
Urgent and emergency care, including A&E and ambulance services (for anyone present in their geographic area), out-of-hours primary medical services except where retained by practices
Services for people with learning disabilities
NHS Continuing healthcare
Infertility services

Key NHS CB commissioning responsibilities: public health
Public health services for children from pregnancy to age 5 (Healthy Child Programme 0-5), including health visiting and family nurse partnership and responsibility for Child Health Information Systems (responsibility for children's public health 0-5 due to transfer to LAs in 2015)
Immunisation programmes
National Screening programmes
Public health services for those in prison or places of detention
Sexual assault referral services

Key NHS CB commissioning responsibilities: healthcare
Primary medical services commissioned under the GP contract, out of hours where retained by practices
Pharmaceutical services provided by community pharmacy services, dispensing doctors and appliance contractors
NHS sight tests and optical vouchers
Dental services
All health services for children, young people and adults in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites)
Health services for families of members of the armed forces (where they are registered with Defence Medical Services) (Primary care for members of the armed forces will be commissioned by the Ministry of Defence)
Specialised and highly specialised services

Based on NHS Commissioning Board Commissioning Factsheet for CCGs (July 2012)
www.commissioningboard.nhs.uk

NORTHUMBERLAND CHILDREN'S SERVICES

GUIDANCE DOCUMENT

PURPOSE OF THE DOCUMENT

This guidance is for professionals to use when completing the Vulnerability Checklist in respect of young people where there are concerns that they may suffer harm as a result of their behaviour.

This document will provide guidance when using the risk matrix when considering the vulnerability factors within the Vulnerability Checklist.

When using the risk matrix it is important that the scores reflect where there is evidence of such behaviour occurring. It is important that when scoring individual behaviour that the risks associated with the behaviour are considered at that point in time, for example, if there have been previous concerns but this behaviour is not evident at present, score should be no more than 2; if the behaviour is ongoing and concerns are such that those involved feel the young person is at risk *imminently* the score should be a 4.

Risk Matrix

0 No risk identified currently and there is no history of this behaviour.

1 Low risk – where the young person has been involved in this behaviour in the past however at present this behaviour is not of concern.

2 Medium risk – where there are historic and current concerns around this behaviour however there is a service/intervention in place which is addressing this behaviour **with positive effect.**

3 High risk – where the young person is at risk of **serious** harm; within the risk assessment information must be provided in relation to what serious harm people are concerned about.

4 Very High risk – where the young person is engaging in this behaviour **as soon as they are able to** and also where there are concerns that the risk to the young person is **imminent.**

Information must be provided within the evidence section of the Vulnerability Checklist to demonstrate clearly why a particular score has been attributed to the behaviour of concern.

SECTION 1

Emotional Health

When looking at 'mental health difficulties' it is important that this is scored in relation to *diagnosed* mental health difficulties and that such difficulties have been diagnosed by a health professional.

Physical Health

Within this section, there should only be a score provided in one of the categories and scored as advised within the Vulnerability Checklist, i.e. either 3 for *major,* 2 for *moderate,* 1 for *minor or* 0 for *no physical health concerns.*

Sexual Health

When scoring high, either 3 or 4, in any of the categories within this section, the Risk Management Information Sharing Summary Sheet must be completed and sent to the Sexual Health Service alongside the Vulnerability Checklist. This will ensure that a Sexual Health Advisor will respond to the young person and ensure appropriate advice and support is provided to them and also members of the care team.

When scoring within this section the following needs to be taken into consideration;

Early onset of sexual activity/ having sex with multiple partners - as discussed earlier, the majority of young people are not having sex before the age of 16. Girls having sex under the age of 16 are three times more likely to become pregnant than those who first have sex over 16.

Engages in unsafe sexual behaviour - Vulnerable young people may well find themselves in a number of situations resulting in sexual activity and multiple partners. They may also not be using contraception/protection consistently and/or has limited access to contraceptive and sexual health information and services.

Much older partner - If a young person is involved in a sexual relationship with someone 5 or more years older than them. It is important in relation to equality within the relationship and the young person but being pressurized or exploited in the relationship.

Young person wants to become pregnant or is already a teenage parent - A young person who wants to become pregnant may very often have low self-esteem or aspirations. Also associated with this is the lack of supportive consistent parenting, positive role models and lack of relationships with at least one trusted adult. Research also shows that a mother with low educational aspirations for her daughter at age 10 is an important predictor of teenage parenthood; as is being the daughter of a teenage mother.

History of abuse - Young people who have been subject to sexual abuse are more vulnerable to poor sexual health than many of their peers. Boundaries, expectations from others and poor self-worth are all key indicators for these young people.

Inappropriate use of pornography and social networking - Boys and young men need equal consideration in assessing risk of teenage pregnancy and professionals need to see

beyond the outwardly displayed behaviour of young men and consider the reasons behind it. Professionals need to consider how young men receive their messages regarding sexual relationships, often unregulated sources of sexual health information is gained from pornography accessed via the internet and mobiles and will often skew their perception of being sexually healthy and expectations of being in a sexual relationship, including not using any visible form of contraception or STI protection.

If a young person is experiencing any of the above the worker must also be aware that there may be elements of sexual exploitation as well.

SECTION 2

Social and Environmental

When scoring within the *LAC/Leaving Care* category, information is required within the evidence section to explain why a particular score is being attributed to it. It is important that it notes whether they are currently a LAC or whether they have Leaving Care status as well as why they are seen to be vulnerable as a result of being LAC or Leaving Care.

Within the *non-school attendance* category, a score must only be placed in this category if the young person is of statutory school age. Where a young person is post 16 and not required by law to attend education, this category does not apply.

When scoring a young person as being *homeless*, this must be where a young person currently is of **no fixed abode**. If scoring in this section, a further score within the *unsuitable housing* cannot be given.

SECTION 3

Substance misuse

When scoring in this section particular care needs to be taken to the definitions outlined within the risk matrix – ensuring that both historical use is recorded as well as current use. It is also important when scoring current use which is of particular concern that it is considered whether this behaviour could result in **serious** risk for the young person (score 3) or **imminent** risk for the young person (score 4).

Where the young person is disclosing substance misuse, if Sorted are not involved a referral needs to be discussed with the young person and made to the service.

In relation to scoring under the category *poly drug use* it is important to consider the following;

The true definition of Poly drug use is ***the use of two or more psychoactive drugs in combination to achieve a particular effect.*** For the purpose of the VCL, we want to know if the young person is using two or more drugs at the same time, i.e. Benzodiazepines & alcohol. From this you can then make an assessment of ***Risk of overdose.*** Taking into account the effect each drug has on the central nervous system. If you are unsure of this speak to Sorted and update your substance misuse training, application forms can be obtained from www.sortednorth.co.uk.

It is important that if the young person is scoring within the *poly drug use* category that immediate harm reduction information is provided to the young person. This information is available from Sorted.

SECTION 4

Offending Behaviour

When scoring in this section, it needs to be considered whether YOS are involved and this information needs to be provided within the evidence section. Information should include whether the young person is subject to any Order's; whether they are engaging in a voluntary program etc. and the scores should accurately reflect the type of offending they are engaged in as well as the frequency.

If the care team are aware of information which suggests the young person is offending however has not been charged with any offences at the time of completing the offence, the score may be low however this information needs to be detailed within the evidence section.

SECTION 5

Absconding

Absconding refers to where the young person is being reported missing to the police. Where the care team are concerned that the young person is going missing however is not being reported missing to the police, a high score can be given but the evidence for this would need to be detailed within the main body of the report and how this is going to be addressed detailed within the risk management plan.

When scoring in the *risk of harm* and *risk of sexual exploitation* care needs to be taken that the scores are not being duplicated. Within the evidence section of the Vulnerability Checklist there needs to be information provided to detail why this is of concern, being specific about the harm people are concerned about and what evidence those involved have that this is an issue for the young person.

When scoring in the *risk of sexual exploitation* section, please refer to the CSE indicators below;

CSE Low Risk Behaviours:

- Regularly coming home late or going missing through the day or overnight
- Overt sexualised behaviour, sexualised risk taking including posting/surfing on internet
- Unaccounted for cigarettes, monies, clothes and/or goods etc
- Associating with unknown adults or other known to sexually exploit children
- Reduced contact with family/friends
- Sexually transmitted infection
- Experimenting with drugs/alcohol
- Poor self-image, self-worth, eating disorder and or some self -harm

CSE Medium Risk Behaviours

- Getting into cars with unknown adults or known adults who pose a risk to children
- Being groomed on internet
- Clipping (offering to have sex then running on payment)
- Receiving a reward for recruiting other peers to CSE
- Disclosure of physical/ sexual assault followed by withdrawal of complaint
- Reports of involvement in CSE, for example known to frequent or seen in 'hot spots'
- Older boyfriend/Girlfriend
- Non-school attendee or excluded due to behaviour
- Staying out overnight with no explanation
- Breakdown of family/care placements due to behaviour
- Unaccounted monies/goods/mobiles, frequent drugs and/or alcohol use etc
- Consistent self-harm

CSE High Risk Behaviours

- Child under 13 engaging in sexual activity with another over 15 years
- Pattern of homelessness and staying with adult(s) believed to be sexually exploiting
- Child under 16 meeting different adults for sex
- Removed from known 'red light' districts by Police or other professionals due to risk of CSE
- Child taken to house, B&B for sex with adults, disclosure of physical/sexual assault and then withdrawal
- Missing from home or care, child abduction and/or forced imprisonment
- Disappearing from home, care or education with no contact or support
- Child being bought/sold
- Under 16 with multiple miscarriages and terminations
- Indicators of CSE in conjunction with chronic alcohol and drug use, mental health issues and/or self-harm

It is important to note that where there are concerns around absconding and/or sexual exploitation, the key worker should liaise with the Social Worker for Missing Children for advice and support. The Social Worker for Missing Children should also be involved in completion of the Vulnerability Checklist where possible.

Risk Management Plan

It is important when considering the plan that a focus is maintained upon the concerns and following on from this what can be put into place to keep the young person safe. It should consider what needs to happen, why this needs to happen i.e. what the outcome will be for the young person and who is responsible for ensuring it happens.

The risk management plan as with completing the Vulnerability Checklist must involve the young person, parents/carers where possible as well as including professionals currently working with the young person.

Within the risk management plan, frequency of contact/visits with the young person from all professionals must be detailed. It is also important to note how often the plan will be reviewed,

when the plan will next be reviewed and who will be the key worker/person responsible for coordinating the plan.

NORTHUMBERLAND COUNTY COUNCIL
CHILDREN'S SERVICES
POLICY, PRACTICE AND PROCEDURE MANUAL

Office use only	
Version No:	1
Date Issued:	January 2013
Previously Issued:	-
Authorised:	January 2013
Date Reviewed:	-

Risk Management		**Role Responsible**
Procedure/Guidance		
1.	**Purpose**	
1.1	To provide practice guidance and advice in respect of children and young people who have been identified as vulnerable and potentially at risk of significant harm as a result of their behaviour.	
2.	**Scope**	
2.1	This procedure applies to all staff within Children's Services and staff from other agencies who are working directly or indirectly with children, young people and their families.	
3.	**References**	
3.1	Risk Management Policy	
3.2	Children missing from care procedure	
4	**Guidance/Procedure**	
4.1	**Introduction**	
4.2	Children's Services deal with a variety of young people who may pose certain risks to themselves or others. The various teams and professionals that make up Children's Services identify and manage these risks in different ways and use a range of risk assessment tools.	
4.3	This procedure provides a framework that should be used when individual agency risk assessments indicate that the risk posed to or by a young person is considered to be high or very high. The procedure is not intended to replace individual agency procedures nor replace other actions that workers may take to safeguard young people.	
4.4	The purpose of the procedure is to ensure that a coordinated approach is taken when considering the level of vulnerability of individual young people who are deemed to be at high or very high risk and a multi agency plan developed. This will assist front line	

Risk Management		Role Responsible
	staff to evidence their decision making in respect of individual	
4.5	The procedure should also; • Provide clear definitions of the type of risk and the level of vulnerability for individual young people. • Identify the nature and level of risk in case allocation and the interventions necessary to moderate the risk. • Provide guidance for managing the different levels of risk. • Identify roles and responsibilities. • Promote the sharing of information where children and young people are deemed to be at high or very high risk. • Provide appropriate management oversight.	
5.	**Procedure**	
5.1	Individual workers who are concerned about the safety and welfare of a child or young person should undertake a risk assessment using their individual agency's risk assessment processes followed by the Vulnerability Check List (VCL).	
5.2	The following guidance is available to support workers in using the VCL	
5.3	When completing the VCL the worker will identify the level of vulnerability of the young person using the following matrix.	
5.4	Level of Vulnerability — Threshold	
5.5	Low - No evidence at present to indicate likelihood of serious harmful behaviour. No further action required.	
5.6	Medium - Some risk identified but consequences not likely to result in imminent serious or significant harm. This risk should be managed through the normal supervision process and agreed actions recorded on the young persons case file.	
5.7	High - The risk of significant harm arising as a result or consequence of the identified behaviour(s) could occur at any time.	
5.8	Very High - The risk of serious or significant harm is imminent and the young person will commit the behaviour(s) as soon as they are able or the opportunity arises.	
5.9	Immediate action is required and will	

Risk Management			Role Responsible
		involve intensive multi agency support and/or **surveillance.**	
5.10	If any further information becomes known to the lead professional following the initial risk assessment then the level of vulnerability should be reviewed.		Lead Professional
5.11	Where a young person is in custody/secure accommodation and are due to be released/discharged, a VCL should be completed at the pre-discharge meeting based on the concerns prior to being placed into custody/secure accommodation. This will ensure an appropriate plan is in place post release/discharge.		
5.12	It must be noted that consultation with those agencies involved within the Risk Management process is important. It is important where there are issues that the relevant agencies are part of any risk assessment undertaken even if the services are not yet involved with the young person.		Lead Professional
5.13	The completion of the Vulnerability Checklist and the Risk Management Plan are the responsibility of the care team however it is important that a 'keyworker' is identified who has the best relationship with the young person to take the lead in coordinating the meetings. This should be kept under review within the care team and information provided within the Vulnerability Checklist.		Care Team
5.14	Where a Vulnerability Checklist has been completed and a young person is high risk, a Social Worker must be involved. If a Social Worker is not involved a referral should be made to the area team and an Initial Assessment undertaken.		Care Team/Area Team Manager
6.	**Action following risk classification**		
6.1	Following the identification of the level of vulnerability the following actions should be undertaken;		
6.2	Low	- The risk assessment documentation should be countersigned by the line manager. This document should be included on the young persons case file.	Lead Professional
6.3	Medium	- The risk assessment should be discussed with the line manager within 5 working days and a risk management plan devised that identifies actions to manage or moderate the level of risk.	Lead Professional
6.4	High/Very High	- The risk assessment should be discussed with the line manager that day and a multi-agency planning meeting convened within 5 working days. This meeting should be chaired by a	Lead Professional

Risk Management		Role Responsible
	team manager. The meeting should be minuted and identify actions to moderate the risk, the professional responsible for undertaking the action and timescales.	Lead Professional/ Team Manager
	Cases identified as high or very high risk should be discussed with a senior manager and reviewed as part of the regular supervision process.	Team Manager
6.5	The lead professional identified within the risk management plan will notify other agencies of the nature and level of the assessed risk as appropriate.	Lead Professional
6.6	Where an assessment indicates a high or very high level of risk information should be referred to the multi-agency Risk Management Group (RMG). This information should include the risk assessment tool and the subsequent plan for the young person.	Team Manager
6.7	The Risk Management Group will consider (using RM1) the circumstances and plans of all young people referred to it as being at high or very high risk and will keep a central High Risk Register.	RMG
6.8	Young people will be included on this register if the assessment of the multi-agency Risk Management Group concurs with the individual agency's risk assessment.	RMG
6.9	A multi-agency risk management plan will be maintained for all young people whose names appear on the risk register. This plan will identify the support services that will be or are being provided to manage the identified risks. The plan will also identify the agencies responsible for providing the support and the timescales.	RMG
6.10	A copy of the plan will be provided to all agencies identified as providing support and the plan will be reviewed on a monthly basis until the young person is no longer considered to be at high or very high risk.	RMG
6.11	The risk management plan is not intended to replace any action which an individual agency may consider necessary to safeguard and protect the welfare of a child or young person. Rather, the plan is intended to enhance the planning process in respect of individual children and ensure coordinated multi agency planning is in place.	RMG
6.12	The risk management plan should be included on the child or young person's case file.	Lead Professional/ Team Manager
6.13	The risk management log will be maintained by the Head of	Head of

Risk Management		**Role Responsible**
	Community Support who will keep the information in line with the requirements of the Data Protection Act.	Community Support
6.14	The RMG will seek confirmation from local authorities who place young people in Northumberland (with the exception of Kyloe House) where there is deemed to be a risk to self or others that appropriate risk management strategies are in place.	RMG
7.	**Action to be taken following reduction in risk classification**	
7.1	Action to be taken following reduction in risk classification If a young person has been deemed 'high/very high risk' and part of the Risk Management Group, and then has subsequently reduced to 'medium/low risk' they will no longer be reviewed as part of the RMG. It is expected that the care team will continue to review the young person via 3 weekly care team meetings updating the VCL. This should continue for a period of 6 months. If the scoring increases to 'high/very high risk' a re-referral to RMG will be made.	Lead professional/ care team
7.2	Following 6 months of the VCL being reviewed on a 3 weekly basis, a CIN Review is to be held chaired by a Team Manager to review the plan in place. As part of this meeting, if there have been no further concerns/scores increasing to 'high/very high risk', care team to consider frequency of reviews/care team meetings required.	Care Team/ Team Manager

A matter of life and death

What lessons can you learn when a 14 year-old from local authority care is found dead? Mark Douglas and Rachel Farnham look at how Northumberland found inspiration in adversity and launched a new initiative to safeguard other adolescents

On the morning of Christmas Eve 2005 Ethan, a fourteen year-old boy, was found dead in the bedroom of his girlfriend's home having suffered an overdose of heroin. The subsequent toxicology reports indicated a range of illegal substances had been consumed within the previous 24 hours but the cause of death had been asphyxiation as a result of the heroin-based substances. The combination and amount of illegal drugs consumed by Ethan meant he had gone to sleep, his breathing had slowed down and as a result of respiratory failure he died in his sleep. When paramedics were called to the home all attempts to resuscitate Ethan failed and he was subsequently pronounced dead at the scene.

For most people the death of a young person, even where illegal drugs are involved, would be considered tragic and a reflection of the increasing harm caused to our young people and communities by criminality and the illegal supply of hard drugs. The death would also be considered a reflection of the decay and breakdown of traditional values and communities and would lead to calls for more support and tougher actions to tackle the ills of society.

However, this particular death caused particular concern as Ethan was in care and had access to a range of professionals and services that were intended to protect him. These professionals were all involved in planning his care and providing support to address the issues that led to him being estranged from his family and being looked after.

A police and local authority investigation soon established that after having been missing from a children's home for two nights Ethan had spent the previous evening with his girlfriend and friends. He had been involved in a fight with two other young people during which he had picked up a bag of morphine-based pills that had been dropped by another young person. The investigation also found that although he had been missing for two days and was reported missing, and although he was known to be vulnerable because of his drug use, none of the adults who saw Ethan contacted the police or the local authority.

It was established that Ethan met his mother the evening before his death and despite having been clearly under the influence of substances she chose not to report the fact she had seen him or that he had advised that he was not intending to return to the children's home that night. In addition, when Ethan arrived at his girlfriend's home, despite his age and him being under the influence of substances the adults in the home agreed he could stay for the evening and sent him off to bed. The following morning Ethan was found dead in bed.

Although Northumberland does not experience the same levels of drug and alcohol misuse as many inner city or urban areas, it is recognised that across the county there are small but significant groups of young people at risk from illegal drugs and that the age young people are exposed to illegal substances is decreasing.

Serious case review

The death of any young person who is looked after by a local authority will begin a process under the 'Working Together to Safeguard Children' (DoH March 2010) guidance to establish whether there have been failings in the systems supporting young people and whether a local safeguarding board should consider undertaking a formal review. Chapter 8 of Working Together states:

8.11 LSCB's should consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially-life threatening injury or serious impairment of physical or mental health and development through abuse or neglect; or
- a child has been seriously harmed as a result of being subjected to sexual abuse; or
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; or
- a child has been seriously harmed following a violent assault perpetrated by another child or adult;
- the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter agency and inter disciplinary working.

In the case of Ethan it was decided that an independent management review should be undertaken to establish what lessons could be learned and what actions needed to be taken to minimise the risks to other young people in similar circumstances. The management review identified that there was a gap in support available to young people and adolescents who were at risk of significant harm as a result of their own behaviours and that communication between agencies had led to a lack of coordinated intervention. The review recommended that the local authority should consider how it could improve these aspects of its work with vulnerable adolescents. As a result of this recommendation Northumberland's multi-agency Risk Management Group was established.

According to the three year review, one in five children who are subject to SCRs are over 11 and It was recognised that the work needed to be informed by findings from research and practice .

In addition, the subsequent 2010 publication by the Children's Society ('Safeguarding Young People: Responding to Young People aged 11 – 17 who are Maltreated') also highlights the complexities of safeguarding for this older age group of young people and how young people's own behaviour can make professional judgement about maltreatment and risk much more complex.

'Working Together' identifies the following principles that should guide practice where there are concerns about a child's safety and welfare and these were applied in the development of the group:

Work to safeguard and promote the welfare of children should be:

- Child-centred
- Rooted in child development
- Focused on outcomes for children
- Holistic in approach
- Ensuring equality of opportunity
- Involving children and families in the process
- Building on strengths as well as identifying difficulties

- Integrated in approach
- A continuous process and not an event
- Providing and reviewing services
- Based in research

The Risk Management Group

The Risk Management Group is a multi-agency approach developed in the months after the death of Ethan. A group of professionals from a range of agencies worked together to develop a risk assessment tool for front line practitioners and managers to determine the levels and immediacy of risk. The tool was underpinned by a set of simple procedures that ensure appropriate risk management plans are in place for young people that are assessed at high or very high risk of serious injury or death and that there is senior management oversight and participation in the sharing of risk.

Although the group was originally intended to address the risks from substance misuse, it quickly became clear that within the county there are a small, but significant number of young people at high risk to themselves as a result of high risk offending, substance misuse, mental health issues, lack of family support, chaotic living arrangements and absconding from home or care settings. These young people are at imminent risk of significant harm without interventions from one, or a number of agencies and they do not always naturally fall within Child Protection Procedures.

The Risk Management Group brought together all agencies in the County who work with young people to develop a consistent approach to risk management and developed a tool and procedures to support front line staff. The guidance also includes information on how to use the assessment and planning tools (vulnerability checklist (VCL)), the nomination to the risk management group, the monitoring process (RMG Log) and the criteria for removal from the risk log.

The process

The risk management process can be applied to any adolescent considered to be at high or very high risk due to their own behaviour. The practitioner undertakes an assessment of the risks based on a scoring matrix. If the score indicates a high or very high risk they share the assessment with their line manager. A multi-agency meeting is then held to undertake a risk assessment. Young people who are low or medium risk of harm remain the responsibility of the key agency who is working with them and subject to their risk management process. Practice guidance provides advice around the escalating nature of risk and of the importance of immediacy of harm when determining the levels of risk to young people but makes clear that professional judgement remains critical to the process.

Most young people who are referred to the risk management group are already known to the statutory services although a number of previously unknown children have been identified as having emerging vulnerabilities and support is provided to them to prevent their situation worsening.

If the assessed risk remains high or very high after the multi-agency moderation then the young person is referred in to the risk management group and a detailed plan developed before the meeting to manage and moderate the risks on a multi-agency basis. If the assessed level of risk is agreed at the risk management group then the young person's name and details of the risk management plan are entered onto a risk management log or register. This log is held by the Head of Safeguarding Services who is aware of all young people in Northumberland presenting with high risks.

Assessments and plans are reviewed every three weeks and through the coordination of support and resources evidence of risk reduction is gathered. Only once the risk has reduced to medium or low is the young person's name removed from the log and the management and oversight of the plan returns to the appropriate agency. Any agency represented at the risk management group meeting can request changes or additions to the risk management plan and these are debated and agreed by the group. This ensures multi agency ownership and responsibility for the plans regarding high-risk behaviours but also holds agencies to account for the agreed actions.

What we have learned

As a result of the developing practice, the group have been able to:

- Provide clear definitions of the type of risk and level of vulnerability for individual young people. Before the group was established the range of agencies working with these young people all used different risk assessment tools, applied different thresholds and approaches to managing and reducing risk. The group was able to develop a single risk assessment tool in a single document to inform the multi-agency intervention.
- Develop a consistent approach to assessing risk across all agencies working with adolescents. The group was developed to support front-line staff in managing risk and to ensure that the risk was understood and shared by all including up to Director level. When the risk assessment tool and procedures were rolled the feedback from frontline staff was overwhelmingly positive. Staff reported that the risk assessment tool helped them to quantify risk, collect and develop evidence-based plans that were defendable if a further tragedy was to occur. Importantly the risk assessment tool was used to help young people and their families understand the risks and ensure they engage in the plans to reduce the risk.
- Gain a greater understanding of what works in terms

of interventions with adolescents at moderate risk. Working with adolescents is an extremely challenging process that requires staff to balance the self-determination that all adolescents display against the need to intervene to keep them safe.

- Identify roles and responsibilities across agencies and ensure staff accountability. This aspect of the group was seen as particularly positive as no single agency was left to feel solely responsible for the risks while the tools and procedures ensured appropriate accountability.
- Promote the sharing of information where young people are deemed to be at high or very high risk. This included sharing and using police intelligence and information from other local authorities to assist risk management. Similarly, information gained from staff working with young people was shared with the police to ensure that action was taken to target individuals and emerging community issues.
- Establish a new partnership arrangement involving the Police and Children's Services to safeguard and monitor young people who run away from home or care settings. This work has been particularly successful in identifying emerging issues such as the risks of sexual exploitation and ensuring that strategies are developed at the most senior levels.
- Provide a mechanism for funding decisions to be made. For example it has helped in identifying the need for accommodation for young people or in accessing specialist assessments or support around high risk behaviours. The group has also identified gaps in service provision and has been used to apply for external grant funding to develop services for adolescents. As a result, Northumberland has developed its own accommodation project to ensure young people who are leaving care, custody or residential drug rehabilitation centres have access to high quality supported accommodation on their discharge.
- Engage a hard-to-reach group of complex young people. Research into serious case reviews identify this group as particularly vulnerable. The group reduced the level of risk for more than a hundred young people who have been through the process to date.
- Share the practice of the group including the procedures and risk assessment tools with a number of local authorities nationally who have adopted the approach in their work with young people. Sharing best practice is especially important as it contributes to the safeguarding of vulnerable adolescents beyond Northumberland's boundaries.
- Ensure that young people and their parents or carers are fully involved in the assessment of risk and that they are involved in the decision making to reduce those risks.

Case Study: Jane

Jane came to the attention of the Youth Offending Service when she was arrested for a burglary offence aged 15. In the Police Station she disclosed regular heroin use, poly-drug use and showed signs of depression. Police also had concerns about her associations with an older group of established heroin users, possible sexual exploitation and her mum's inability to safeguard her.

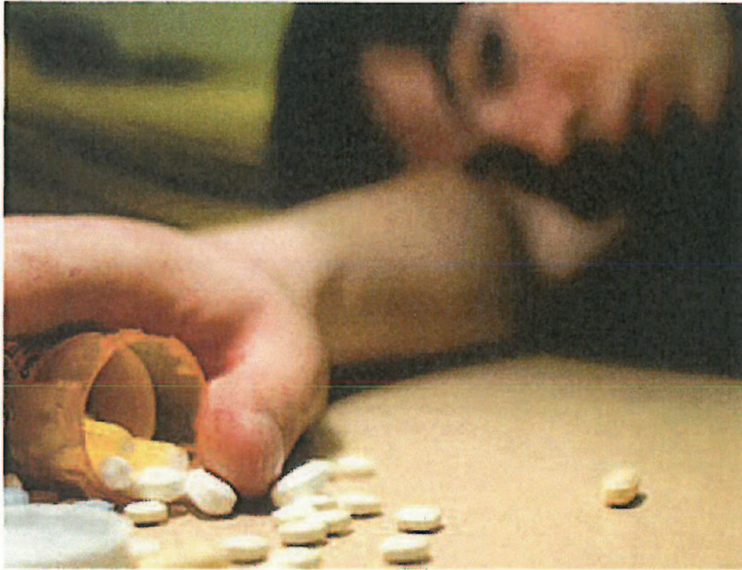
Jane appeared to be at high risk of fatal overdose. A multi-agency plan was quickly established which resulted in all three being subject to child protection plans.

The core group of professionals met to complete the risk assessment for Jane for the Risk Management Group. The RMG endorsed the assessed level of risk and the plan and added Jane to the 'Risk Log'. The senior manager chairing the group also decided Jane should be taken into care to manage her absconding and drug misuse more effectively. It was recognised that Jane may not agree to be voluntarily accommodated as the links she had with older drug users would be difficult to break. Because of these concerns the YOS Manager suggested that Jane's bail conditions could be varied to require her to 'reside as directed by Children's Services'. These interventions were allowed the group to safeguard Jane and reduce the risks of re-offending.

Jane's case was monitored by RMG for 12 weeks, with review assessments being completed every 3 weeks. The risk score gradually reduced and Jane's name was removed from the log. At this point the case returned to normal agency level risk management.

Jane was subsequently accommodated (S.20) with the agreement of her mum and placed in foster care. The comprehensive risk management plan worked well and Jane even agreed to voluntary urinalysis in order to monitor her drug use. There were difficult points where Jane absconded and returned to her friends, but the multi agency risk assessment and planning, involving the police, meant that she was actively sought out and returned to her foster home.

Jane's case demonstrates good practice in risk management for a very vulnerable teenager. Risks were identified and interventions put in place quickly to manage the immediate issues. An evidence-based risk assessment tool was completed by a multi-agency group, the RMG gave management oversight of the assessment and plan and also allocated additional resources (accommodation) to further reduce the risk.



in developing a bid for £230,000 capital funding to create a supported housing scheme for young people with a history of substance misuse who were leaving care, custody or residential drug treatment. With additional funding provided by the council this has allowed the purchase of a number of properties across the county where young people can move onto and receive high levels of supervision and support. These homes have provided high quality and stable accommodation for young people at a point of transition where their levels of vulnerability are heightened and the project has been recognised by organisations such as the Lucy Faithful Foundation as an example of best practice.

The process of the risk management group has enabled Northumberland to clearly identify the types of risks that exist for young people within different communities across the county and allocate resources to reduce these risks. In addition, the group has gathered important intelligence regarding drug use within the county. The police have used this information proactively having fullly participated in the group. This in turn has influenced drug treatment services for young people as specific initiatives have been undertaken to ensure early intervention and prevention remain a priority for services.

Further benefits include the strengthening of partnership working particularly with the Police. The Police saw the value in attending the group and have contributed to harm reduction through the sharing of intelligence; the intelligence-led targeting of individuals and by ensuring safeguarding arrangements for young people are robust.

The work of the risk management group has also been extended and a new protocol has been agreed as part of the broad approach to risk that involves the Police and Children's Services monitoring young runaways through RMG. This has led to greater levels of prevention and intervention around areas such as child sex exploitation and specifically to an increase in the use of harbouring notices and arrests of individuals believed to be involved in the trafficking of children.

One further development has been the use of the group to identify unmet need in relation to services for adolescents such as appropriate accommodation. The failure to provide suitable accommodation is recognised, both regionally and nationally as a key risk factor that increases vulnerability for young people. The risk management group was successful

As a professional working in the area of safeguarding it is important to recognise that it will never be possible to remove all risks from children's lives or prevent all incidents that lead to significant harm. However, it is important that practices and systems are continually developed to improve assessment processes, that front line staff are supported when working with complex cases and that risk regarding individual children is shared by all agencies and at all levels within those agencies. The risk management process has provided a framework within Northumberland that has brought agencies closer in their understanding of risk and how it is managed but most critically it has contributed to the success of staff in preventing any further adolescent deaths within the county from these high risk behaviours.

Mark Douglas is Head of Safeguarding and Looked After Children's Services and has senior management responsibility for children's social care in Northumberland. Rachel Farnham is a Children's Services Manager and has responsibility for the Risk Management Group and ensuring appropriate, multi agency risk management plans are in place for vulnerable adolescents.

Northumberland County Council is willing to provide copies of the RMG procedures and tools along with an evaluation report on the project and a DVD made by young people who have been through the process. More information from Rachel.Farnham@northumberland.gov.uk

Vulnerability Checklist Review

This document is to be used to review the level of vulnerability of a young person referred to the Northumberland Risk Management Group (RMG).

Personal Details of Young Person

First name:
Surname:
Address:
DOB / Age:
Legal Status:

Agencies Involved

Children's Services		Education	
Police		Sorted	
YOS		Other	
CAMHS			

Risk Matrix

Rate using the following scale:

0. No apparent risk	No history or evidence at present to indicate likelihood of risk from behaviour.
1. Low apparent risk	No current indication of risk but young person's history indicates possible risk from identified behaviour.
2. Medium apparent risk	Young person's history and current behaviour indicates the presence of risk but action has already been identified to moderate risk.
3. High apparent risk	The young person's circumstances indicate that the behaviour may result in a risk of serious harm without intervention from one or more agency.
4. Very high apparent risk	The young person will commit the behaviour as soon as they are able and the risk of significant harm is considered imminent.

Vulnerability and Protective Factors

Section 1:

Emotional Health

Low Self Esteem	
Low Mood	
Depression	
Self Harm	
Severe Paranoia / Anxiety	
Suicidal Intent	
Suicidal Ideation	
Diagnosed Mental Health Difficulties, i.e., ADHD psychosis, OCD, schizophrenic	
Eating Disorder	

Physical Health

Major (under consultant care) (3)	
Moderate (regular GP involvement) (2)	
Minor (self-managed or with support of carer) (1)	
No Physical Health Issues (0)	

Sexual Health

Early onset of sexual activity	
Having sex with multiple partners	
Engages in risky sexual behaviours which could result in contracting a sexually transmitted infection	
Has much older partner	
Wants to become pregnant/is a young parent	
History of abuse	
Inappropriate use of pornography/social networks	

If scoring high – complete sexual health referral form

Section 3:

Substance Misuse

Alcohol	
Amphetamine	
Cannabis	
Cocaine/Crack	
Heroin	
Ecstasy	
Benzodiazepines	
Solvents/Gas/Aerosols	
Other (state)	
Poly Drug Use	
Frequency - Regular - Occasional	
Injecting - No - Yes/Previously	
Contact with Substance Users - No using friends - Some using friends - All friends using	
Family Substance Users - No family users - Known close family users - Significant family misuse	
Risk of Overdose	

Section 4:

Offending Behaviour

Involvement in Criminal Justice System	
Risk of Custody	

Section 2:

Social and Environmental

Looked After Child / Leaving Care	
Family/Relationship Difficulties	
Non School Attendance/NEET	
Homelessness	
Unsuitable Housing	
Social Isolation	

Section 5:

Absconding (reported missing to Police)

Frequency of going missing	
Risk of Harm	
Risk of Sexual Exploitation – see CSE risk indicators	
Length of Episodes	

If scoring high key worker to liaise with Social Worker for Missing Children

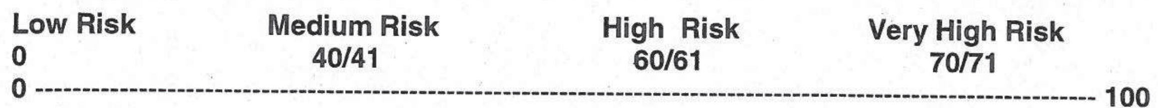
The check list above should be completed using the scoring matrix on page 1 and the total score used to identify an indicative risk using the scale on page 3. The identification of the level of risk should take into account the age and level of functioning of the child as well as professional judgement.

Summary of issues since last review:

VCL Scores:

Original Score	
Current Score	

Indicative Risk Continuum:



Evidence (Provide evidence of any changes in your assessment of risk, for example, positive outcomes relating to the plan in place, change in circumstances etc)

Please remember to note:

- **What is it that you are worried about?**
- **What is working well? (include strengths, exceptions, resources, goals, willingness etc)**

What needs to happen to decrease risk and improve safety.

Section 1: **Emotional Health:**   **Physical Health:**   **Sexual Health:**
Section 2: **Social & Environmental**
Section 3: **Substance Misuse**
Section 4: **Offending Behaviour**
Section 5: **Absconding**

Views of the Young Person:

What do you think needs to happen to make people less worried about you? What would the next steps be to help with this?
On a scale of 0 to 10, where 10 means the problem is sorted as much as it can be and zero means things are so bad that there needs to be some professional help, where does the young person rate their situation at the time of the assessment? 0 --10

Views of Parents / Carers:

What do you think needs to happen to make people less worried about you? What would the next steps be to help with this?
On a scale of 0 to 10, where 10 means the problem is sorted as much as it can be and zero means things are so bad that there needs to be some professional help, where does the parents / carers rate the situation at the time of the assessment? 0 --10

Risk Management Plan:

Risk Management Plan needs to identify plans to keep the young person safe and must include the frequency of visits from professionals involved. It should consider what needs to happen, why this needs to happen i.e. what the outcome will be for the young person and who is responsible for ensuring it happens.

Completed by:	**Date:**

Lincolnshire Teaching Primary Care Trust
Cross O'Cliff
Bracebridge Heath
Lincoln, Lincs
LN4 2HN

Tel: 01522 513355
Calls via typetalk are welcome
Fax: 01522 540706
Website: www.lincolnshire.nhs.uk

Please ask for: Edie Butterworth
Telephone: 01522 513355
E-mail address: edie.butterworth@lpct.nhs.uk
Date: 12 February 2013

Dear Colleague

Changes to the NHS in Lincolnshire

As you will be aware the Government set out its radical new vision for the health service in England; Equity *and Excellence: Liberating the NHS* (published July 2010).

Over the past two years we have been progressing the transition and moving towards the new system. I would therefore like to take this opportunity to inform you of the changes to the local NHS in Lincolnshire following these reforms.

Primary Care Trusts (PCTs) will be abolished on the 31 March 2013 and this means that from that time NHS Lincolnshire will no longer exist as a statutory organisation. Clinicians and GPs are at the centre of the changes to the NHS and from April 2013 Clinical Commissioning Groups (CCGs) will take on the responsibility for commissioning (buying) the majority of healthcare for the population of Lincolnshire.

Please note that all future correspondence should be directed to the lead CCG in your area from the 1 April 2013 as noted below.

1. Clinical Commissioning Groups in Lincolnshire

Name and details of CCG	Contact Details
NHS Lincolnshire East CCG Representing 30 practices across the East Lincolnshire area with a registered population of 240,000. The CCG incorporates three localities - East Lindsey, Skegness and Coast, and Boston and includes three hospitals Boston Pilgrim, Skegness Community and Louth Hospital within the patch. The CCG will lead on the commissioning of Lincolnshire Community Health Services NHS Trust, East Midlands Ambulance NHS Trust, LIVES and services	Accountable Officer: Gary James Address: Cross O'Cliff Bracebridge Heath Lincoln LN4 2HN Tel: 01522 513355 Website: https://www.lincolnshireeastccg.nhs.uk/

associated with the urgent care pathway, and will be the associate commissioner for North Lincolnshire and Goole Hospitals NHS Trust.	Twitter: @NHSLincsEast
NHS Lincolnshire West CCG Representing 38 member practices, the CCG covers the north-western part of Lincolnshire and includes the City of Lincoln, West Lindsey District Council area (including Gainsborough, Scotter and Hibaldstow) and the northern part of North Kesteven District Council's area as far south as Metheringham. It is responsible for commissioning healthcare for over 220,000 people over an area of about 420 square miles. The CCG will lead on commissioning of United Lincolnshire Hospitals NHS Trust and St Barnabas Hospice.	Accountable Officer: Dr Sunil Hindocha Address: Cross O'Cliff Bracebridge Heath Lincoln LN4 2HN Tel: 01522 513355 Website: https://www.lincolnshirewestccg.nhs.uk/ Twitter: @NHSLincsWest
NHS South West Lincolnshire CCG Representing 19 practices across the South West Lincolnshire area, with a registered population of 128,000, covering the towns of Sleaford and Grantham and the villages of Ruskington, Ancaster and Corby Glen. It also contains Grantham Hospital within its patch. The CCG is the lead commissioner of Lincolnshire Partnership Foundation NHS Trust and the lead for any issues concerning Nottingham University Hospitals NHS Trust. It will also host the commissioning Safeguarding Team	Accountable Officer: Allan Kitt Contact details will be available soon on the following website: https://www.southwestlincolnshireccg.nhs.uk/ Twitter: @SWLincs_NHS
NHS South Lincolnshire CCG Representing 15 practices across the South Lincolnshire area, with a registered population of 157,000, covering 585 square miles including the towns of Spalding, Holbeach, Long Sutton Bourne, Market Deeping and Stamford, and containing two hospitals within its patch; Johnson Hospital, Spalding and Stamford and Rutland Hospital. They will be the lead CCG in Lincolnshire on commissioning services from Peterborough and Stamford Hospitals NHS Foundation Trust.	Accountable Officer: Gary Thompson Address: Stamford & Rutland Hospital. Ryhall Road Stamford Lincs PE9 1UA Tel: 01522 573939 Website: https://www.southlincolnshireccg.nhs.uk/ Twitter: @NHS_SouthLincs

2. National Commissioning Board

From April 2013 the NHS Commissioning Board will take on many of the current functions of the PCTs as well as some nationally-based functions currently undertaken by the Department of Health. The new arrangements will make sure all primary care services are commissioned using the same model, which up until now has been done differently by PCTs and their predecessors.

You can find out more about the National Commissioning Board by viewing their website at http://www.commissioningboard.nhs.uk/

3. Commissioning Board Area Teams

There are 27 Commissioning Board Area Teams (CBAT) – the team covering Lincolnshire is the Leicestershire and Lincolnshire Commissioning Board Area Team. GP, pharmacy, dental and optical services will be commissioned by the CBAT. Other key responsibilities include development and assurance of CCGs, emergency planning amongst others. In addition, ten CBATs (including Leicestershire and Lincolnshire) will lead on specialised commissioning across England. A smaller number of CBATs will commission other services, such as military and prison health.

For all issues concerning Primary Care Commissioning as detailed above, please forward all correspondence to:

David Sharp
Area Director Leicestershire and Lincolnshire Commissioning Board Area Team
Fosse House
6 Smith Way
Enderby
Leicester LE19 1SX

4. Public Health

The Public Health function of the PCT is being transferred to Lincolnshire County Council. For all public health issues please contact:

Dr Tony Hill
Director of Public Health
Lincolnshire County Council
15/17, The Avenue
Lincoln
LN1 1PD

Tel 01522 553960

5. Greater East Midlands Commissioning Support Unit (GEM)

All the Lincolnshire CCGs will receive their commissioning support through the Greater East Midlands Commissioning Support Unit known as GEM. GEM is an NHS Organisation and is part of the National Commissioning Board.

The local office of GEM will be based at Cross O'Cliff Court, Bracebridge Heath, Lincoln, LN4 2HN. Please contact Fleur Taylor, Chief Operating Officer Central, at this address or on tel 01522 513355.

6. **NHS Property Services**

The Estates and Facilities function will transfer to NHS Property Services Ltd (PropCo) on the 1 April 2013.

PropCo has been set up by the Department of Health to manage all the Primary Care Trust estate not transferred to Providers. Whilst it is a Limited company it will be an important part of the NHS family. The organisation will own sites across England but will retain a local focus providing strategic and operational management of NHS estates, property and facilities.

You can find out more information at www.property.nhs.uk

7. **Lincolnshire Workforce Advisory Board**

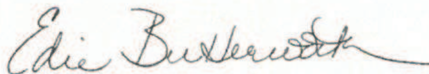
The Lincolnshire Workforce Advisory board is becoming part of the East Midlands Local Education and Training Board (LETB).

The East Midlands LETB will be the vehicle for providers and professionals (working with Health Education England) to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public.

You can find out more about them at: www.eastmidlandsletb.net

To find out more on the NHS reforms please visit the Department of Health website at http://www.dh.gov.uk/en/index.htm

Yours faithfully



Edie Butterworth
Transition Director, NHS Lincolnshire

HM Government

Working Together to Safeguard Children

A guide to inter-agency working to safeguard and promote the welfare of children

March 2013

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Summary

About this guidance

1. This guidance covers:

   - the legislative requirements and expectations on individual services to safeguard and promote the welfare of children; and
   - a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

2. This document replaces Working Together to Safeguard Children (2010); The Framework for the Assessment of Children in Need and their Families (2000); and Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 (2007). Links to relevant supplementary guidance that professionals should consider alongside this guidance can be found at Appendix C.

What is the status of this guidance?

3. This guidance is issued under:

   - section 7 of the Local Authority Social Services Act 1970, which requires local authorities in their social services functions to act under the general guidance of the Secretary of State;
   - section 11 (4) of the Children Act 2004 which requires each person or body to which the section 11 duty applies to have regard to any guidance given to them by the Secretary of State; and
   - section 16 of the Children Act 2004, which states that local authorities and each of the statutory partners must, in exercising their functions relating to Local Safeguarding Children Boards, have regard to any guidance given to them by the Secretary of State.

4. This guidance applies to other organisations as set out in chapter 2.

5. This guidance will come into effect from 15 April 2013. This document should be complied with unless exceptional circumstances arise.

Who is this guidance for?

6. This statutory guidance should be read and followed by local authority Chief Executives, Directors of Children's Services, LSCB Chairs and senior managers within organisations who commission and provide services for children and families, including social workers and professionals from health services, adult services, the police, Academy Trusts, education and the voluntary and community sector who have contact with children and families.[1,2]

7. All relevant professionals should read and follow this guidance so that they can respond to individual children's needs appropriately.

[1] Department for Education *Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services.*

[2] The reference to social workers throughout the documents means social workers who are registered to practice with the Health and Care Professions Council.

Introduction

1. Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone's responsibility. Everyone who comes into contact with children and families has a role to play.[3]

2. Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

   - protecting children from maltreatment;
   - preventing impairment of children's health or development;
   - ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
   - taking action to enable all children to have the best outcomes.

3. In 2011-12 over 600,000 children in England were referred to local authority children's social care services by individuals who had concerns about their welfare.

4. For children who need additional help, every day matters. Academic research is consistent in underlining the damage to children from delaying intervention. The actions taken by professionals to meet the needs of these children as early as possible can be critical to their future.

5. Children are best protected when professionals are clear about what is required of them individually, and how they need to work together.

6. This guidance aims to help professionals understand what they need to do, and what they can expect of one another, to safeguard children. It focuses on core legal requirements, making it clear what individuals and organisations should do to keep children safe. In doing so, it seeks to emphasise that effective safeguarding systems are those where:

   - the child's needs are paramount, and the needs and wishes of each child, be they a baby or infant, or an older child, should be put first, so that every child receives the support they need before a problem escalates;
   - all professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;
   - all professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care;

[3] In this document a child is defined as anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout.

- high quality professionals are able to use their expert judgement to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;
- all professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes;
- LSCBs coordinate the work to safeguard children locally and monitor and challenge the effectiveness of local arrangements;
- when things go wrong Serious Case Reviews (SCRs) are published and transparent about any mistakes which were made so that lessons can be learnt; and
- local areas innovate and changes are informed by evidence and examination of the data.

7. Ultimately, effective safeguarding of children can only be achieved by putting children at the centre of the system, and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.

A child-centred and coordinated approach to safeguarding

Key principles

8. Effective safeguarding arrangements in every local area should be underpinned by two key principles:
    - safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
    - a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

Safeguarding is everyone's responsibility

9. Everyone who works with children - including teachers, GPs, nurses, midwives, health visitors, early years professionals, youth workers, police, Accident and Emergency staff, paediatricians, voluntary and community workers and social workers - has a responsibility for keeping them safe.
10. No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.
11. In order that organisations and practitioners collaborate effectively, it is vital that every individual working with children and families is aware of the role that they have to play and the role of other professionals. In addition, effective

safeguarding requires clear local arrangements for collaboration between professionals and agencies.

12. This statutory guidance sets out key roles for individual organisations and key elements of effective local arrangements for safeguarding. It is very important these arrangements are strongly led and promoted at a local level, specifically by:

   - a strong lead from local authority members, and the commitment of chief officers in all agencies, in particular the Director of Children's Services and Lead Member for Children's Services in each local authority; and
   - effective local coordination and challenge by the LSCBs in each area (see chapter 3).

A child-centred approach

13. Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children.

14. Children are clear what they want from an effective safeguarding system and this is described in the box on page 10.

15. Children want to be respected, their views to be heard, to have stable relationships with professionals built on trust and for consistent support provided for their individual needs. This should guide the behaviour of professionals. Anyone working with children should see and speak to the child; listen to what they say; take their views seriously; and work with them collaboratively when deciding how to support their needs. A child-centred approach is supported by:

   - the Children Act 1989 (as amended by section 53 of the Children Act 2004). This Act requires local authorities to give due regard to a child's wishes when determining what services to provide under section 17 of the Children Act 1989, and before making decisions about action to be taken to protect individual children under section 47 of the Children Act 1989. These duties complement requirements relating to the wishes and feelings of children who are, or may be, looked after (section 22 (4) Children Act 1989), including those who are provided with accommodation under section 20 of the Children Act 1989 and children taken into police protection (section 46(3) (d) of that Act);
   - the Equality Act 2010 which puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual child and the process of assessment. No child or group of children must be treated any less favourably than others in being able to access effective services which meet their particular needs; and

- the United Nations Convention on the Rights of the Child (UNCRC). This is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information.

Children have said that they need

- **Vigilance: to have adults notice when things are troubling them**
- **Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon**
- **Stability: to be able to develop an on-going stable relationship of trust with those helping them**
- **Respect: to be treated with the expectation that they are competent rather than not**
- **Information and engagement: to be informed about and involved in procedures, decisions, concerns and plans**
- **Explanation: to be informed of the outcome of assessments and decisions and reasons when their views have not met with a positive response**
- **Support: to be provided with support in their own right as well as a member of their family**
- **Advocacy: to be provided with advocacy to assist them in putting forward their views**

16. In addition to individual practitioners shaping support around the needs of individual children, local agencies need to have a clear understanding of the collective needs of children locally when commissioning effective services. As part of that process, the Director of Public Health should ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the health and wellbeing board.

Chapter 1: Assessing need and providing help

Early help

1. Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.

2. Effective early help relies upon local agencies working together to:

   - identify children and families who would benefit from early help;
   - undertake an assessment of the need for early help; and
   - provide targeted early help services to address the assessed needs of a child and their family which focuses on activity to significantly improve the outcomes for the child. Local authorities, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency cooperation to improve the welfare of children.

Section 10

Section 10 of the Children Act 2004 requires each local authority to make arrangements to promote cooperation between the authority, each of the authority's relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of all children in the authority's area, which includes protection from harm and neglect. The local authority's relevant partners are listed in Table A in Appendix B.

Identifying children and families who would benefit from early help

3. Local agencies should have in place effective ways to identify emerging problems and potential unmet needs for individual children and families. This requires all professionals, including those in universal services and those providing services to adults with children, to understand their role in identifying emerging problems and to share information with other professionals to support early identification and assessment.

4. Local Safeguarding Children Boards (LSCBs) should monitor and evaluate the effectiveness of training, including multi-agency training, for all professionals in the area. Training should cover how to identify and respond early to the needs

of all vulnerable children, including: unborn children; babies; older children; young carers; disabled children; and those who are in secure settings.

5. Professionals should, in particular, be alert to the potential need for early help for a child who:
    - is disabled and has specific additional needs;
    - has special educational needs;
    - is a young carer;
    - is showing signs of engaging in anti-social or criminal behaviour;
    - is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health, domestic violence; and/or
    - is showing early signs of abuse and/or neglect.

6. Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need. Practitioners need to continue to develop their knowledge and skills in this area. They should have access to training to identify and respond early to abuse and neglect, and to the latest research showing what types of interventions are the most effective.

Effective assessment of the need for early help

7. Local agencies should work together to put processes in place for the effective assessment of the needs of individual children who may benefit from early help services.
8. Children and families may need support from a wide range of local agencies. Where a child and family would benefit from coordinated support from more than one agency (e.g. education, health, housing, police) there should be an inter-agency assessment. These early help assessments, such as the use of the Common Assessment Framework (CAF), should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989 (paragraph 26).
9. The early help assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a General Practitioner (GP), family support worker, teacher, health visitor and/or special educational needs coordinator. Decisions about who should be the lead professional should be taken on a case by case basis and should be informed by the child and their family.

10. For an early help assessment to be effective:

    - the assessment should be undertaken with the agreement of the child and their parents or carers. It should involve the child and family as well as all the professionals who are working with them;
    - a teacher, GP, health visitor, early years' worker or other professional should be able to discuss concerns they may have about a child and family with a social worker in the local authority. Local authority children's social care should set out the process for how this will happen; and
    - if parents and/or the child do not consent to an early help assessment, then the lead professional should make a judgement as to whether, without help, the needs of the child will escalate. If so, a referral into local authority children's social care may be necessary.

11. If at any time it is considered that the child may be a child in need as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children's social care. This referral can be made by any professional.

Provision of effective early help services

12. The early help assessment carried out for an individual child and their family should be clear about the action to be taken and services to be provided (including any relevant timescales for the assessment) and aim to ensure that early help services are coordinated and not delivered in a piecemeal way.

13. Local areas should have a range of effective, evidence-based services in place to address assessed needs early. The early help on offer should draw upon the local assessment of need and the latest evidence of the effectiveness of early help and early intervention programmes. In addition to high quality support in universal services, specific local early help services will typically include family and parenting programmes, assistance with health issues and help for problems relating to drugs, alcohol and domestic violence. Services may also focus on improving family functioning and building the family's own capability to solve problems; this should be done within a structured, evidence-based framework involving regular review to ensure that real progress is being made. Some of these services may be delivered to parents but should always be evaluated to demonstrate the impact they are having on the outcomes for the child.

Accessing help and services

14. The provision of early help services should form part of a continuum of help and support to respond to the different levels of need of individual children and families.

15. Where need is relatively low level individual services and universal services may be able to take swift action. For other emerging needs a range of early help services may be required, coordinated through an early help assessment, as set out above. Where there are more complex needs, help may be provided under section 17 of the Children Act 1989 (children in need). Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989.

16. It is important that there are clear criteria for taking action and providing help across this full continuum. Having clear thresholds for action which are understood by all professionals, and applied consistently, should ensure that services are commissioned effectively and that the right help is given to the child at the right time.

17. The LSCB should agree with the local authority and its partners the levels for the different types of assessment and services to be commissioned and delivered. Local authority children's social care has the responsibility for clarifying the process for referrals.

18. The LSCB should publish a **threshold document** that includes:
    - the process for the early help assessment and the type and level of early help services to be provided; and
    - the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services under:
        - section 17 of the Children Act 1989 (children in need);
        - section 47 of the Children Act 1989 (reasonable cause to suspect children suffering or likely to suffer significant harm);
        - section 31 (care orders); and
        - section 20 (duty to accommodate a child) of the Children Act 1989.

19. Anyone who has concerns about a child's welfare should make a referral to local authority children's social care. For example, referrals may come from: children themselves, teachers, a GP, the police, health visitors, family members and members of the public. Within local authorities, children's social care should act as the principal point of contact for welfare concerns relating to

children. Therefore, as well as clear protocols for professionals working with children, contact details should be signposted clearly so that children, parents and other family members are aware of who they can contact if they require advice and/or support.

20. When professionals refer a child, they should include any information they have on the child's developmental needs and the capacity of the child's parents or carers to meet those needs. This information may be included in any assessment, including the early help assessment, which may have been carried out prior to a referral into local authority children's social care. Where an early help assessment has already been undertaken it should be used to support a referral to local authority children's social care, however this is not a prerequisite for making a referral.

21. Feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold to be considered by local authority children's social care for assessment and suggestions for other sources of more suitable support.

Information sharing

22. Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.

23. Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

24. Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. To ensure effective safeguarding arrangements:

    - all organisations should have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals and with the LSCB; and
    - no professional should assume that someone else will pass on information which they think may be critical to keeping a child safe. If a professional has concerns about a child's welfare and believes they are suffering or likely to suffer harm, then they should share the information with local authority children's social care.

25. *Information Sharing: Guidance for practitioners and managers (2008)* supports frontline practitioners, working in child or adult services, who have to make

decisions about sharing personal information on a case by case basis.[4] The guidance can be used to supplement local guidance and encourage good practice in information sharing.

Assessments under the Children Act 1989

Statutory requirements

26. Under the Children Act 1989, local authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare. Local Authorities undertake assessments of the needs of individual children to determine what services to provide and action to take. The full set of statutory assessments is set out in the box below.

[4] Department for Education guidance on information sharing.

Statutory assessments under the Children Act 1989

- A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled. In these cases, assessments by a social worker are carried out under **section 17** of the Children Act 1989. Children in need may be assessed under section 17 of the Children Act 1989, in relation to their special educational needs, disabilities, or as a carer, or because they have committed a crime. The process for assessment should also be used for children whose parents are in prison and for asylum seeking children. When assessing children in need and providing services, specialist assessments may be required and, where possible, should be coordinated so that the child and family experience a coherent process and a single plan of action.

- Concerns about maltreatment may be the reason for a referral to local authority children's social care or concerns may arise during the course of providing services to the child and family. In these circumstances, local authority children's social care must initiate enquiries to find out what is happening to the child and whether protective action is required. Local authorities, with the help of other organisations as appropriate, also have a duty to make enquiries under **section 47** of the Children Act 1989 if they have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard and promote the child's welfare. There may be a need for immediate protection whilst the assessment is carried out.

- Some children in need may require accommodation because there is no one who has parental responsibility for them, or because they are alone or abandoned. Under **section 20** of the Children Act 1989, the local authority has a duty to accommodate such children in need in their area. Following an application under **section 31A,** where a child is the subject of a care order, the local authority, as a corporate parent, must assess the child's needs and draw up a care plan which sets out the services which will be provided to meet the child's identified needs.

The purpose of assessment

27. Whatever legislation the child is assessed under, the purpose of the assessment is always:

    - to gather important information about a child and family;
    - to analyse their needs and/or the nature and level of any risk and harm being suffered by the child;
    - to decide whether the child is a child in need (section 17) and/or is suffering or likely to suffer significant harm (section 47); and
    - to provide support to address those needs to improve the child's outcomes to make them safe.

28. Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child. A good assessment will monitor and record the impact of any services delivered to the child and family and review the help being delivered. Whilst services may be delivered to a parent or carer, the assessment should be focused on the needs of the child and on the impact any services are having on the child.

29. Good assessments support professionals to understand whether a child has needs relating to their care or a disability and/or is suffering, or likely to suffer, significant harm. The specific needs of disabled children and young carers should be given sufficient recognition and priority in the assessment process. Further guidance can be accessed at *Safeguarding Disabled Children - Practice Guidance (2009)* and *Recognised, valued and supported: Next steps for the Carers Strategy (2010).*[5,6]

30. Practitioners should be rigorous in assessing and monitoring children at risk of neglect to ensure they are adequately safeguarded over time. They should act decisively to protect the child by initiating care proceedings where existing interventions are insufficient.

31. Where a child becomes looked after the assessment will be the baseline for work with the family. Any needs which have been identified should be addressed before decisions are made about the child's return home. An assessment by a social worker is required before the child returns home under the Care Planning, Placement and Case Review (England) Regulations 2010. This will provide evidence of whether the necessary improvements have been made to ensure the child's safety when they return home.

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[5] Department for Education Safeguarding Disabled Children - Practice Guidance (2009).

[6] Department for Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077.

The principles and parameters of a good assessment

32. High quality assessments:

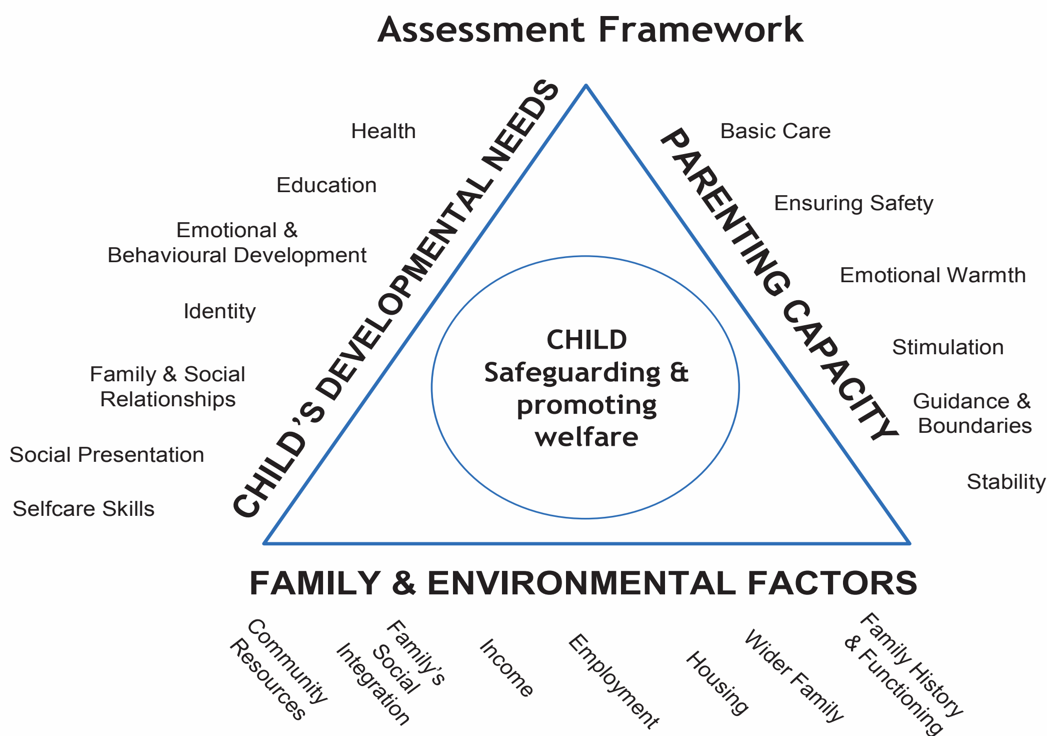
- are child centred. Where there is a conflict of interest, decisions should be made in the child's best interests;
- are rooted in child development and informed by evidence;
- are focused on action and outcomes for children;
- are holistic in approach, addressing the child's needs within their family and wider community;
- ensure equality of opportunity;
- involve children and families;
- build on strengths as well as identifying difficulties;
- are integrated in approach;
- are a continuing process not an event;
- lead to action, including the provision and review of services; and
- are transparent and open to challenge.

33. Research has shown that taking a systematic approach to enquiries using a conceptual model is the best way to deliver a comprehensive assessment for all children. A good assessment is one which investigates the following three domains, set out in the diagram on the next page:

- the child's developmental needs, including whether they are suffering or likely to suffer significant harm;
- parents' or carers' capacity to respond to those needs; and
- the impact and influence of wider family, community and environmental circumstances.

34. The interaction of these domains requires careful investigation during the assessment. The aim is to reach a judgement about the nature and level of needs and/or risks that the child may be facing within their family. It is important that:

- information is gathered and recorded systematically;
- information is checked and discussed with the child and their parents/carers where appropriate;
- differences in views about information are recorded; and
- the impact of what is happening to the child is clearly identified.



35. Assessments for some children - including young carers, children with special educational needs (who may require statements of SEN or Education Health and Care Plans subject to the passage of the Children and Families Bill), unborn children where there are concerns, asylum seeking children, children in hospital, disabled children, children with specific communication needs, children considered at risk of gang activity, children who are in the youth justice system - will require particular care.[7] Where a child has other assessments it is important that these are coordinated so that the child does not become lost between the different agencies involved and their different procedures.

Focusing on the needs and views of the child

36. Every assessment should be child centred. Where there is a conflict between the needs of the child and their parents/carers, decisions should be made in the child's best interests.

[7] Young carers are also entitled to request a separate carer's assessment under the Carers (recognition and Services) Act 1995 and, if they are over 16 years, under the Carers and Disabled Act 2000.

37. Each child who has been referred into local authority children's social care should have an individual assessment to respond to their needs and to understand the impact of any parental behaviour on them as an individual. Local authorities have to give due regard to a child's age and understanding when determining what (if any) services to provide under section 17 of the Children Act 1989, and before making decisions about action to be taken to protect individual children under section 47 of the Children Act 1989.

38. Every assessment must be informed by the views of the child as well as the family. Children should, wherever possible, be seen alone and local authority children's social care has a duty to ascertain the child's wishes and feelings regarding the provision of services to be delivered.[8] It is important to understand the resilience of the individual child when planning appropriate services.

39. Every assessment should reflect the unique characteristics of the child within their family and community context. The Children Act 1989 promotes the view that all children and their parents should be considered as individuals and that family structures, culture, religion, ethnic origins and other characteristics should be respected.

40. Every assessment should draw together relevant information gathered from the child and their family and from relevant professionals including teachers, early years workers, health professionals, the police and adult social care.

41. A high quality assessment is one in which evidence is built and revised throughout the process. A social worker may arrive at a judgement early in the case but this may need to be revised as the case progresses and further information comes to light. It is a characteristic of skilled practice that social workers revisit their assumptions in the light of new evidence and take action to revise their decisions in the best interests of the individual child.

42. The aim is to use all the information to identify difficulties and risk factors as well as developing a picture of strengths and protective factors.

Developing a clear analysis

43. The social worker should analyse all the information gathered from the enquiry stage of the assessment to decide the nature and level of the child's needs and the level of risk, if any, they may be facing. The social work manager should challenge the social worker's assumptions as part of this process. An informed decision should be taken on the nature of any action required and which services should be provided. Social workers, their managers and other professionals should be mindful of the requirement to understand the level of

[8] Section 17 of the Children Act 1989, amended by section 53 Children Act 2004

need and risk in a family from the child's perspective and ensure action or commission services which will have maximum impact on the child's life.

44. No system can fully eliminate risk. Understanding risk involves judgement and balance. To manage risks, social workers and other professionals should make decisions with the best interests of the child in mind, informed by the evidence available and underpinned by knowledge of child development.

45. Critical reflection through supervision should strengthen the analysis in each assessment.

46. Social workers, their managers and other professionals should always consider the plan from the child's perspective. A desire to think the best of adults and to hope they can overcome their difficulties should not trump the need to rescue children from chaotic, neglectful and abusive homes. Social workers and managers should always reflect the latest research on the impact of neglect and abuse when analysing the level of need and risk faced by the child. This should be reflected in the case recording.

47. Assessment is a dynamic and continuous process which should build upon the history of every individual case, responding to the impact of any previous services and analysing what further action might be needed. Social workers should build on this with help from other professionals from the moment that a need is identified.

48. Decision points and review points involving the child and family and relevant professionals should be used to keep the assessment on track. This is to ensure that help is given in a timely and appropriate way and that the impact of this help is analysed and evaluated in terms of the improved outcomes and welfare of the child.

Focusing on outcomes

49. Every assessment should be focused on outcomes, deciding which services and support to provide to deliver improved welfare for the child.

50. Where the outcome of the assessment is continued local authority children's social care involvement, the social worker and their manager should agree a plan of action with other professionals and discuss this with the child and their family. The plan should set out what services are to be delivered, and what actions are to be undertaken, by whom and for what purpose.

51. Many services provided will be for parents or carers. The plan should reflect this and set clear measurable outcomes for the child and expectations for the parents, with measurable, reviewable actions for them.

52. The plan should be reviewed regularly to analyse whether sufficient progress has been made to meet the child's needs and on the level of risk faced by the

child. This will be important for neglect cases where parents and carers can make small improvements. The test should be whether any improvements in adult behaviour are sufficient and sustained. Social workers and their managers should consider the need for further action and record their decisions. The review points should be agreed by the social worker with other professionals and with the child and family to continue evaluating the impact of any change on the welfare of the child.

53. Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family. The social worker and their manager should review the plan for the child. Together they should ask whether the help given is leading to a significant positive change for the child and whether the pace of that change is appropriate for the child. Any professional working with vulnerable children should always have access to a manager to talk through their concerns and judgements affecting the welfare of the child. Assessment should remain an ongoing process, with the impact of services informing future decisions around action.

Timeliness

54. The timeliness of an assessment is a critical element of the quality of that assessment and the outcomes for the child. The speed with which an assessment is carried out after a child's case has been referred into local authority children's social care should be determined by the needs of the individual child and the nature and level of any risk of harm faced by the child. This will require judgements to be made by the social worker in discussion with their manager on each individual case.

55. Within **one working day** of a referral being received, a local authority social worker should make a decision about the type of response that is required and acknowledge receipt to the referrer.

56. For children who are in need of immediate protection, action must be taken by the social worker, or the police or NSPCC if removal is required, as soon as possible after the referral has been made to local authority children's social care (sections 44 and 46 of the Children Act 1989).

57. The maximum timeframe for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than 45 working days from the point of referral. If, in discussion with a child and their family and other professionals, an assessment exceeds 45 working days the social worker should record the reasons for exceeding the time limit.

58. Whatever the timescale for assessment, where particular needs are identified at any stage of the assessment, social workers should not wait until the

assessment reaches a conclusion before commissioning services to support the child and their family. In some cases the needs of the child will mean that a quick assessment will be required.

59. The assessment of neglect cases can be difficult. Neglect can fluctuate both in level and duration. A child's welfare can, for example, improve following input from services or a change in circumstances and review, but then deteriorate once support is removed. Professionals should be wary of being too optimistic. Timely and decisive action is critical to ensure that children are not left in neglectful homes.

60. It is the responsibility of the social worker to make clear to children and families how the assessment will be carried out and when they can expect a decision on next steps.

61. To facilitate the shift to an assessment process which brings continuity and consistency for children and families, there will no longer be a requirement to conduct separate initial and core assessments. Local authorities should determine their local assessment processes through a local protocol.

Local protocols for assessment

62. Local authorities, with their partners, should develop and publish local protocols for assessment. A local protocol should set out clear arrangements for how cases will be managed once a child is referred into local authority children's social care and be consistent with the requirements of this statutory guidance. The detail of each protocol will be led by the local authority in discussion with their partners and agreed with the relevant LSCB.

63. The local authority is publicly accountable for this protocol and all organisations and agencies have a responsibility to understand their local protocol.

The local protocol for assessment should:

- ensure that assessments are timely, transparent and proportionate to the needs of individual children and their families;
- set out how the needs of disabled children, young carers and children involved in the youth justice system will be addressed in the assessment process;
- clarify how agencies and professionals undertaking assessments and providing services can make contributions;
- clarify how the statutory assessments will be informed by other specialist assessments, such as the assessment for children with special educational needs (Education, Health and Care Plan) and disabled children;

- ensure that any specialist assessments are coordinated so that the child and family experience a joined up assessment process and a single planning process focused on outcomes;
- set out how shared internal review points with other professionals and the child and family will be managed throughout the assessment process;
- set out the process for assessment for children who are returned from care to live with their families;
- seek to ensure that each child and family understands the type of help offered and their own responsibilities, so as to improve the child's outcomes;
- set out the process for challenge by children and families by publishing the complaints procedures; and
- require decisions to be recorded in accordance with locally agreed procedures. Recording should include information on the child's development so that progress can be monitored to ensure their outcomes are improving. This will reduce the need for repeat assessments during care proceedings, which can be a major source of delay.

Processes for managing individual cases

64. The following descriptors and flow charts set out the precise steps that professionals should take when working together to assess and provide services for children who may be in need, including those suffering harm. The flow charts cover:

    - the referral process into local authority children's social care;
    - the process for determining next steps for a child who has been assessed as being 'in need'; and
    - the essential processes for children where there is reasonable cause to suspect that the child is suffering, or likely to suffer, significant harm (this includes immediate protection for children at serious risk of harm).

Response to a referral

Once the referral has been accepted by local authority children's social care the lead professional role falls to a social worker.

The social worker should clarify with the referrer, when known, the nature of the concerns and how and why they have arisen.

Within **one working day** of a referral being received a local authority social worker should **make a decision** about the type of response that is required. This will include determining whether:

- the child requires immediate protection and urgent action is required;
- the child is in need, and should be assessed under section 17 of the Children Act 1989;
- there is reasonable cause to suspect that the child is suffering, or likely to suffer, significant harm, and whether enquires must be made and the child assessed under section 47 of the Children Act 1989;
- any services are required by the child and family and what type of services; and
- further specialist assessments are required in order to help the local authority to decide what further action to take.

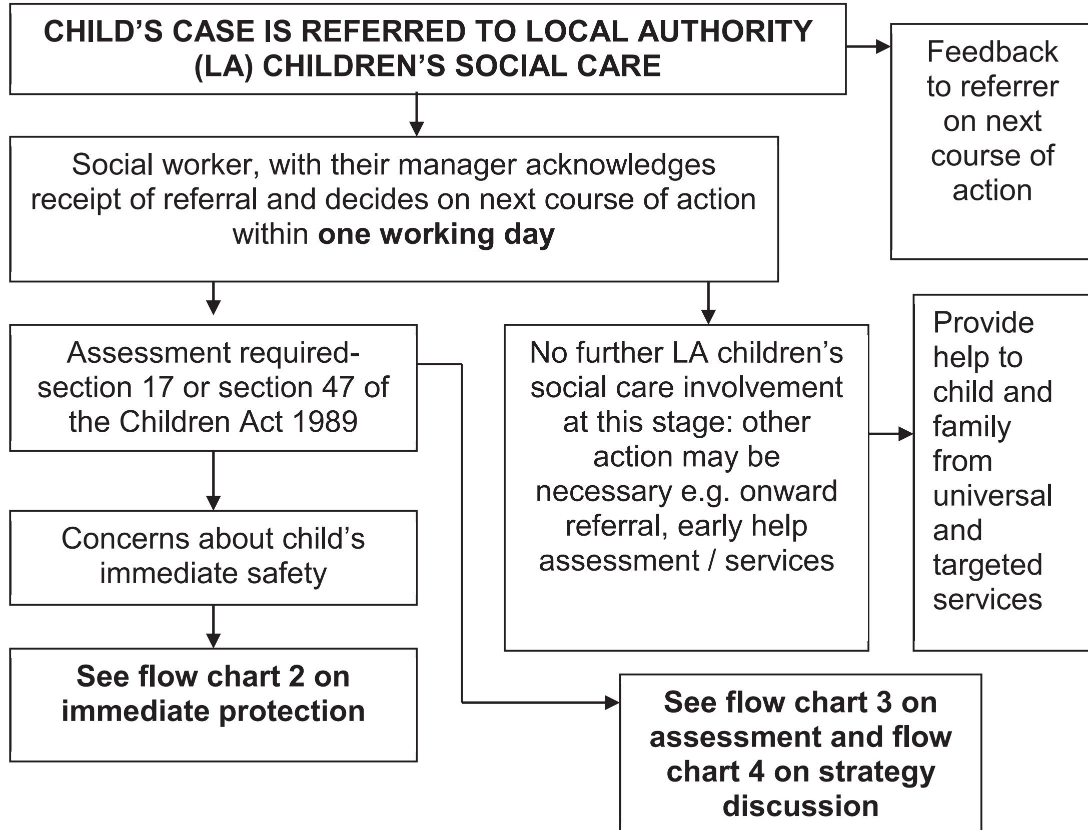
Action to be taken:

The child and family must be informed of the action to be taken.

Local authority children's social care should see the child as soon as possible if the decision is taken that the referral requires further assessment.

Where requested to do so by local authority children's social care, professionals from other parts of the local authority such as housing and those in health organisations have a duty to cooperate under section 27 of the Children Act 1989 by assisting the local authority in carrying out its children's social care functions.

Flow chart 1: Action taken when a child is referred to local authority children's social care services



Immediate Protection

Where there is a risk to the life of a child or a likelihood of serious immediate harm, local authority social workers, the police or NSPCC should use their statutory child protection powers to **act immediately to secure the safety of the child**.

If it is necessary to remove a child from their home, a local authority must, wherever possible and unless a child's safety is otherwise at immediate risk, apply for an **Emergency Protection Order (EPO)**. Police powers to remove a child in an emergency should be used only in exceptional circumstances where there is insufficient time to seek an EPO or for reasons relating to the immediate safety of the child.

An **EPO,** made by the court, gives authority to remove a child and places them under the protection of the applicant.

When considering whether emergency action is necessary an agency should always consider the needs of other children in the same household or in the household of an alleged perpetrator.

The local authority in whose area a child is found in circumstances that require emergency action (the first authority) is responsible for taking emergency action.

If the child is looked after by, or the subject of a child protection plan in another authority, the first authority must consult the authority responsible for the child. Only when the second local authority explicitly accepts responsibility (to be followed up in writing) is the first authority relieved of its responsibility to take emergency action.

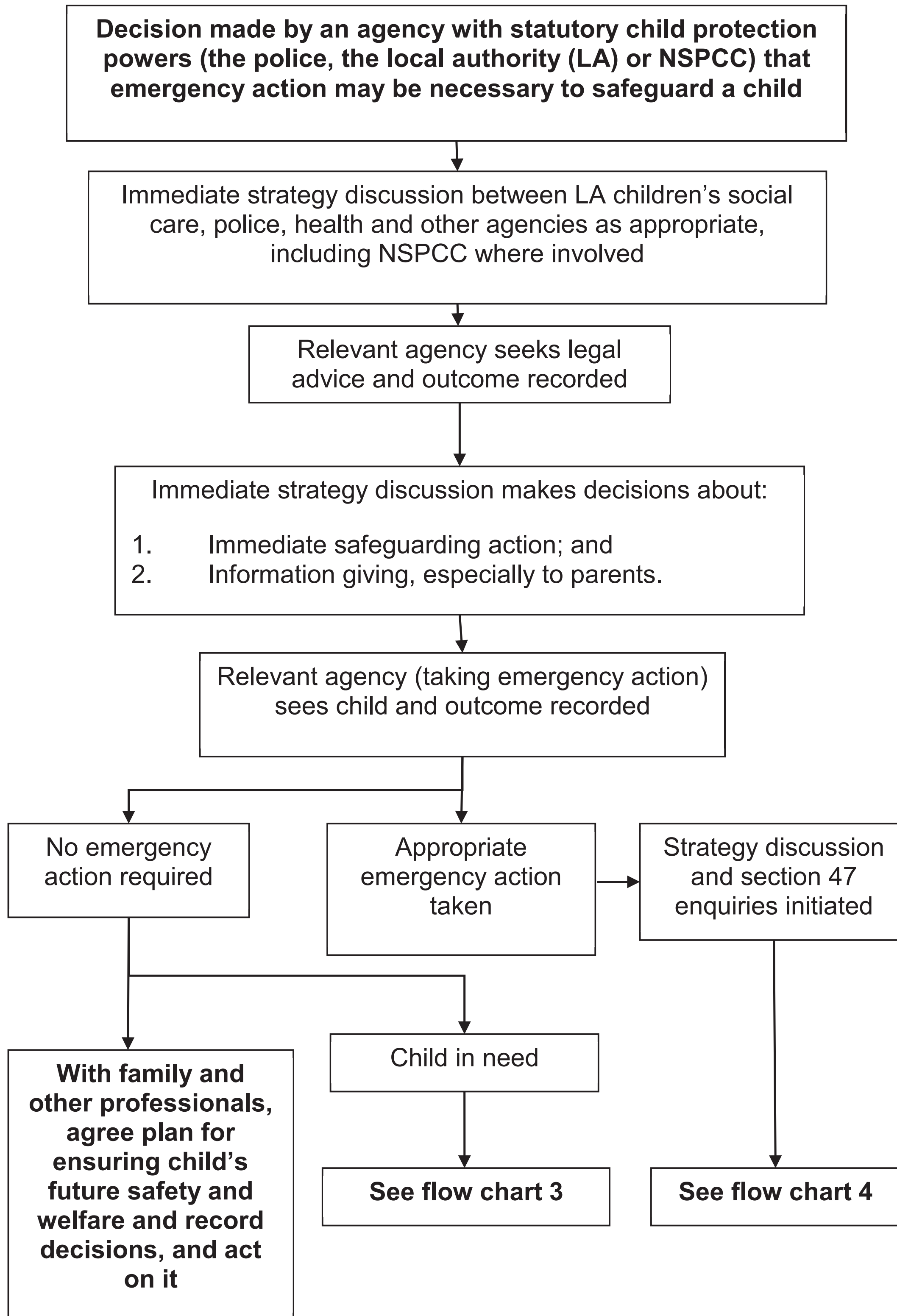
Multi-agency working

Planned emergency action will normally take place following an immediate strategy discussion. Social workers, the police or NSPCC should:

- initiate a strategy discussion to discuss planned emergency action. Where a single agency has to act immediately, a strategy discussion should take place as soon as possible after action has been taken;
- see the child (this should be done by a practitioner from the agency taking the emergency action) to decide how best to protect them and whether to seek an EPO; and
- wherever possible, obtain legal advice before initiating legal action, in particular when an EPO is being sought.

Related information: *For further guidance on EPOs see pages 55-65 of Volume 1 of the Children Act Guidance and Regulations, Court Orders.*

Flow chart 2: Immediate protection



Assessment of a child under the Children Act 1989

Following acceptance of a referral by the local authority children's social care, a social worker should lead a multi-agency assessment under section 17 of the Children Act 1989. Local authorities have a duty to ascertain the child's wishes and feelings and take account of them when planning the provision of services. Assessments should be carried out in a timely manner reflecting the needs of the individual child, as set out in this chapter.

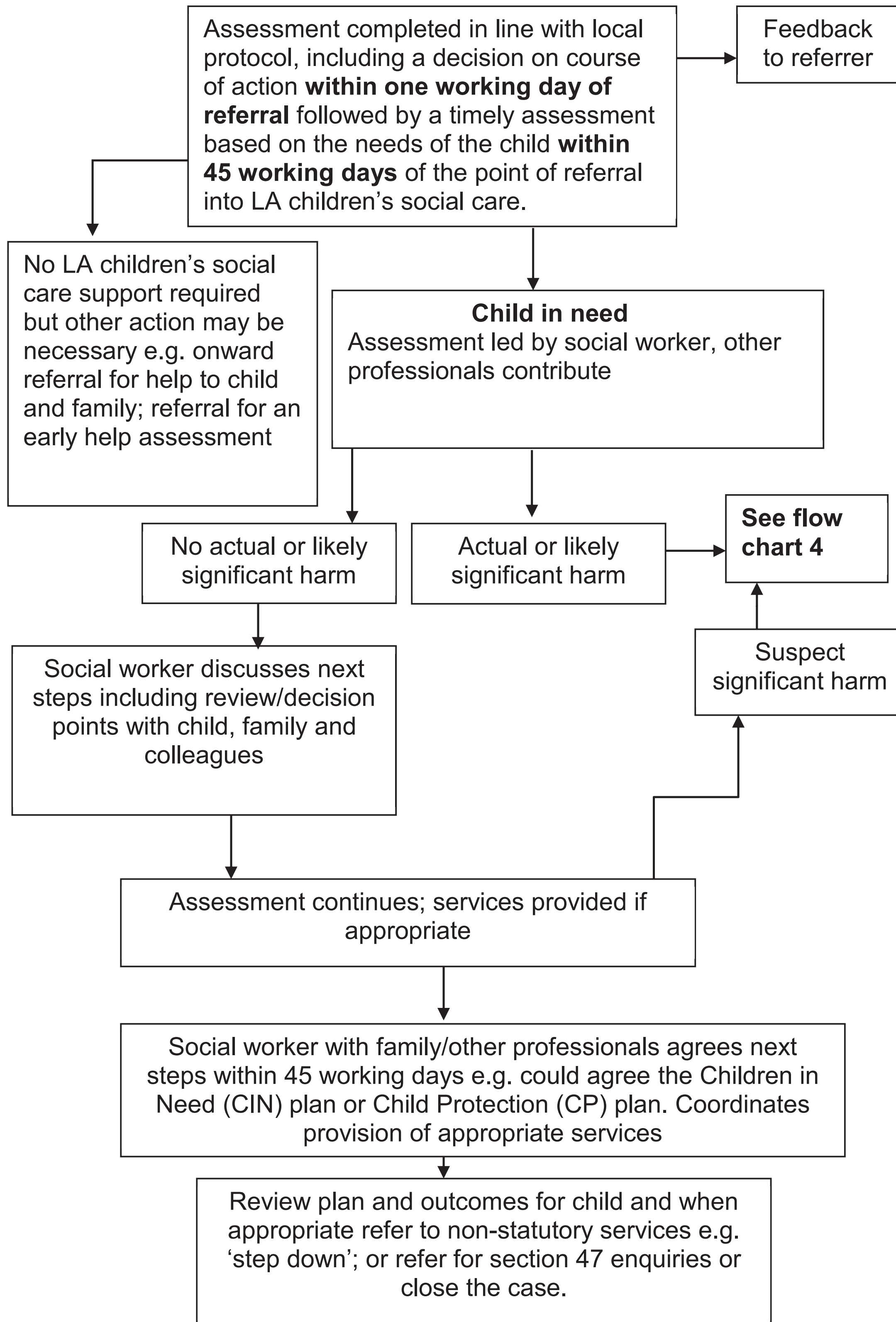
Where the local authority children's social care decides to provide services, a multi-agency child in need plan should be developed which sets out which agencies will provide which services to the child and family. The plan should set clear measurable outcomes for the child and expectations for the parents. The plan should reflect the positive aspects of the family situation as well as the weaknesses.

Where information gathered during an assessment (which may be very brief) results in the social worker suspecting that the child is suffering or likely to suffer significant harm, the local authority should hold a strategy discussion to enable it to decide, with other agencies, whether to initiate enquiries under section 47 of the Children Act 1989.

Purpose:	Assessments should determine whether the child is in need, the nature of any services required and whether any specialist assessments should be undertaken to assist the local authority in its decision making.
Social workers should:	▪ lead on an assessment and complete it in line with the locally agreed protocol according to the child's needs and within **45 working days** from the point of referral into local authority children's social care; ▪ see the child within a timescale that is appropriate to the nature of the concerns expressed at referral, according to an agreed plan; ▪ conduct interviews with the child and family members, separately and together as appropriate. Initial discussions with the child should be conducted in a way that minimises distress to them and maximises the likelihood that they will provide accurate and complete information, avoiding leading or suggestive questions; ▪ record the assessment findings and decisions and next steps following the assessment; ▪ inform, in writing, all the relevant agencies and the family of their decisions and, if the child is a child in need, of the plan for providing support; and

	▪ inform the referrer of what action has been or will be taken.
The police should:	▪ assist other agencies to carry out their responsibilities where there are concerns about the child's welfare, whether or not a crime has been committed. If a crime has been committed, the police should be informed by the local authority children's social care.
All involved professionals should:	▪ be involved in the assessment and provide further information about the child and family; and ▪ agree further action including what services would help the child and family and inform local authority children's social care if any immediate action is required.

Flow chart 3: Action taken for an assessment of a child under the Children Act 1989.



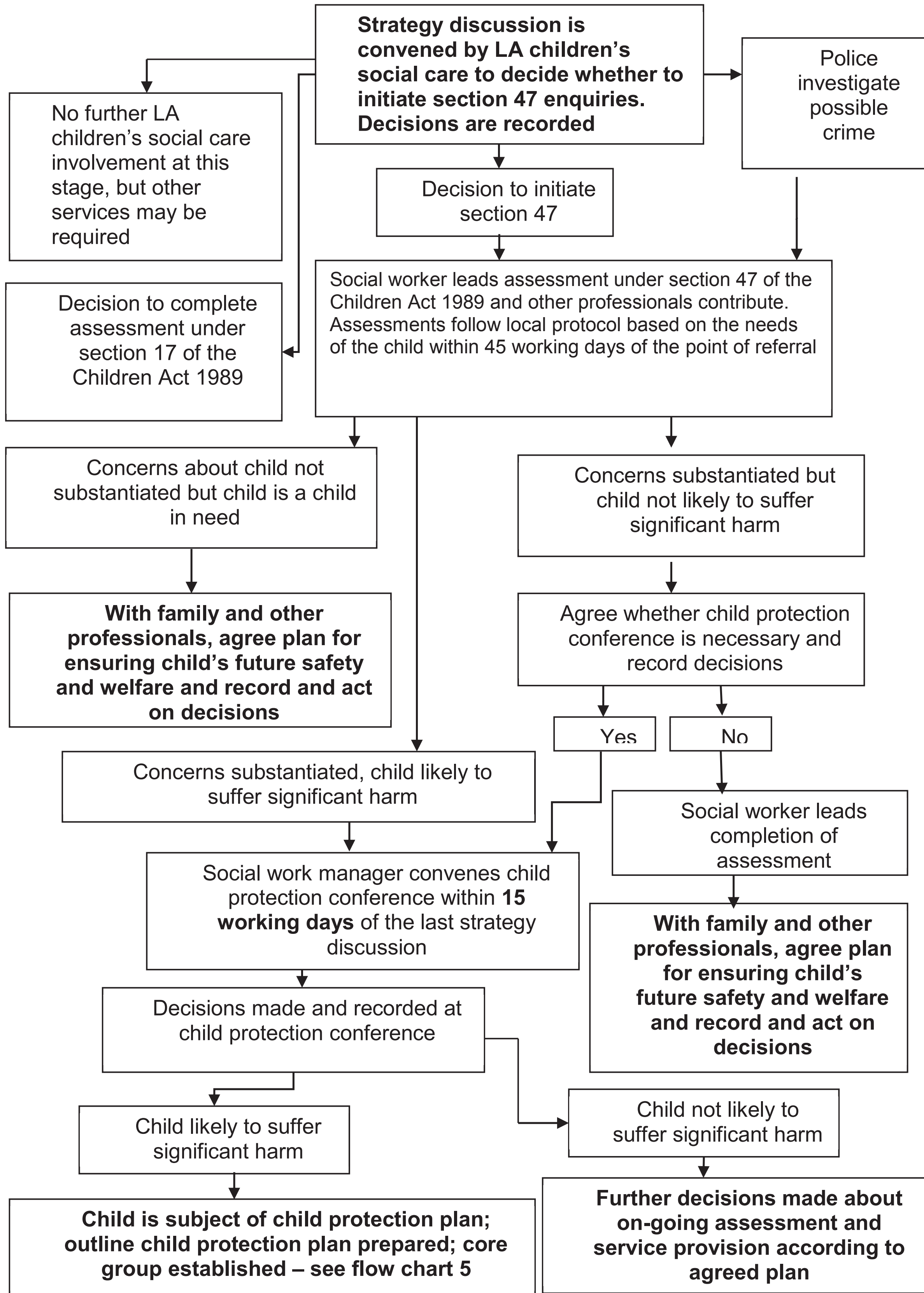
Strategy discussion

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care, the police, health and other bodies such as the referring agency. This might take the form of a multi-agency meeting or phone calls and more than one discussion may be necessary. A strategy discussion can take place following a referral or at any other time, including during the assessment process.

Purpose:	Local authority children's social care should convene a strategy discussion to determine the child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering, or is likely to suffer, significant harm.
Strategy discussion attendees:	A local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion. Other relevant professionals will depend on the nature of the individual case but may include: ▪ the professional or agency which made the referral; ▪ the child's school or nursery; and ▪ any health services the child or family members are receiving. All attendees should be sufficiently senior to make decisions on behalf of their agencies.
Strategy discussion tasks:	The discussion should be used to: ▪ share available information; ▪ agree the conduct and timing of any criminal investigation; and ▪ decide whether enquiries under section 47 of the Children Act 1989 should be undertaken. Where there are grounds to initiate a section 47 of the Children Act 1989 enquiry, decisions should be made as to: ▪ what further information is needed if an assessment is already underway and how it will be obtained and recorded; ▪ what immediate and short term action is required to support the child, and who will do what by when; and ▪ whether legal action is required. The timescale for the assessment to reach a decision on next steps should

	be based upon the needs of the individual child, consistent with the local protocol and certainly no longer than **45 working days** from the point of referral into local authority children's social care. The principles and parameters for the assessment of children in need at chapter 1 paragraph 32 should be followed for assessments undertaken under section 47 of the Children Act 1989.
Social workers with their managers should:	▪ convene the strategy discussion and make sure it: ▪ considers the child's welfare and safety, and identifies the level of risk faced by the child; ▪ decides what information should be shared with the child and family (on the basis that information is not shared if this may jeopardise a police investigation or place the child at risk of significant harm); ▪ agrees what further action is required, and who will do what by when, where an EPO is in place or the child is the subject of police powers of protection; ▪ records agreed decisions in accordance with local recording procedures; and ▪ follows up actions to make sure what was agreed gets done.
The police should:	▪ discuss the basis for any criminal investigation and any relevant processes that other agencies might need to know about, including the timing and methods of evidence gathering; and ▪ lead the criminal investigation (local authority children's social care have the lead for the section 47 enquires and assessment of the child's welfare) where joint enquiries take place.

Flow chart 4: Action following a strategy discussion



Initiating section 47 enquiries A section 47 enquiry is carried out by undertaking or continuing with an assessment in accordance with the guidance set out in this chapter and following the principles and parameters of a good assessment. Local authority social workers have a statutory duty to lead assessments under section 47 of the Children Act 1989. The police, health professionals, teachers and other relevant professionals should help the local authority in undertaking its enquiries.	
Purpose:	A section 47 enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.
Social workers with their managers should:	▪ lead the assessment in accordance with this guidance; ▪ carry out enquiries in a way that minimises distress for the child and family; ▪ see the child who is the subject of concern to ascertain their wishes and feelings; assess their understanding of their situation; assess their relationships and circumstances more broadly; ▪ interview parents and/or caregivers and determine the wider social and environmental factors that might impact on them and their child; ▪ systematically gather information about the child's and family's history; ▪ analyse the findings of the assessment and evidence about what interventions are likely to be most effective with other relevant professionals to determine the child's needs and the level of risk of harm faced by the child to inform what help should be provided and act to provide that help; and ▪ follow the guidance set out in *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures*, where a decision has been made to undertake a joint interview of the child as part of any criminal investigation.[9]
The police should:	▪ help other agencies understand the reasons for concerns about the child's safety and welfare;

[9] Ministry of Justice *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures*.

	▪ decide whether or not police investigations reveal grounds for instigating criminal proceedings; ▪ make available to other professionals any evidence gathered to inform discussions about the child's welfare; and ▪ follow the guidance set out in *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures*, where a decision has been made to undertake a joint interview of the child as part of the criminal investigations.[10]
Health professionals should:	▪ undertake appropriate medical tests, examinations or observations, to determine how the child's health or development may be being impaired; ▪ provide any of a range of specialist assessments. For example, physiotherapists, occupational therapists, speech and language therapists and child psychologists may be involved in specific assessments relating to the child's developmental progress. The lead health practitioner (probably a consultant pediatrician, or possibly the child's GP) may need to request and coordinate these assessments; and ▪ ensure appropriate treatment and follow up health concerns.
All involved professionals should:	▪ contribute to the assessment as required, providing information about the child and family; and ▪ consider whether a joint enquiry/investigation team may need to speak to a child victim without the knowledge of the parent or caregiver.

[10] Ministry of Justice *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures*.

Outcome of section 47 enquiries Local authority social workers are responsible for deciding what action to take and how to proceed following section 47 enquiries. If local authority children's social care decides not to proceed with a child protection conference then other professionals involved with the child and family have the right to request that local authority children's social care convene a conference, if they have serious concerns that a child's welfare may not be adequately safeguarded. As a last resort, the LSCB should have in place a quick and straightforward means of resolving differences of opinion.	
Where concerns of significant harm are not substantiated:	
Social workers with their managers should:	▪ discuss the case with the child, parents and other professionals; ▪ determine whether support from any services may be helpful and help secure it; and ▪ consider whether the child's health and development should be re-assessed regularly against specific objectives and decide who has responsibility for doing this.
All involved professionals should:	▪ participate in further discussions as necessary; ▪ contribute to the development of any plan as appropriate; ▪ provide services as specified in the plan for the child; and ▪ review the impact of services delivered as agreed in the plan.
Where concerns of significant harm are substantiated and the child is judged to be suffering, or likely to suffer, significant harm:	
Social workers with their managers should:	▪ convene an initial child protection conference (see next section for details). The timing of this conference should depend on the urgency of the case and respond to the needs of the child and the nature and severity of the harm they may be facing. The initial child protection conference should take place within **15 working days** of a strategy discussion, or the strategy discussion at which section 47 enquiries were initiated if more than one has been held; ▪ consider whether any professionals with specialist knowledge should be invited to participate; ▪ ensure that the child and their parents understand the purpose of the conference and who will attend; and ▪ help prepare the child if he or she is attending or making representations through a third party to the conference. Give information about advocacy agencies and explain that the family may bring an advocate, friend or supporter.
All involved	▪ contribute to the information their agency provides ahead of the conference, setting out the nature of the agency's

professionals should:	involvement with the child and family; ▪ consider, in conjunction with the police and the appointed conference Chair, whether the report can and should be shared with the parents and if so when; and ▪ attend the conference and take part in decision making when invited.

Initial child protection conferences Following section 47 enquiries, an initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.	
Purpose:	▪ To bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child. It is the responsibility of the conference to make recommendations on how agencies work together to safeguard the child in future. Conference tasks include: ▪ appointing a lead statutory body (either local authority children's social care or NSPCC) and a lead social worker, who should be a qualified, experienced social worker and an employee of the lead statutory body; ▪ identifying membership of the core group of professionals and family members who will develop and implement the child protection plan; ▪ establishing timescales for meetings of the core group, production of a child protection plan and for child protection review meetings; and ▪ agreeing an outline child protection plan, with clear actions and timescales, including a clear sense of how much improvement is needed, by when, so that success can be judged clearly.
The Conference Chair:	▪ is accountable to the Director of Children's Services. Where possible the same person should chair subsequent child protection reviews; ▪ should be a professional, independent of operational and/or line management responsibilities for the case; and ▪ should meet the child and parents in advance to ensure they understand the purpose and the process.
Social workers with their managers should:	▪ convene, attend and present information about the reason for the conference, their understanding of the child's needs, parental capacity and family and environmental context and evidence of how the child has been abused or neglected and its impact on their health and development; ▪ analyse the information to enable informed decisions about what action is necessary to safeguard and promote the welfare of the child who is the subject of the conference; ▪ share the conference information with the child and family beforehand (where appropriate); ▪ prepare a report for the conference on the child and family which sets out and analyses what is known about the child and family and the local authority's recommendation; and

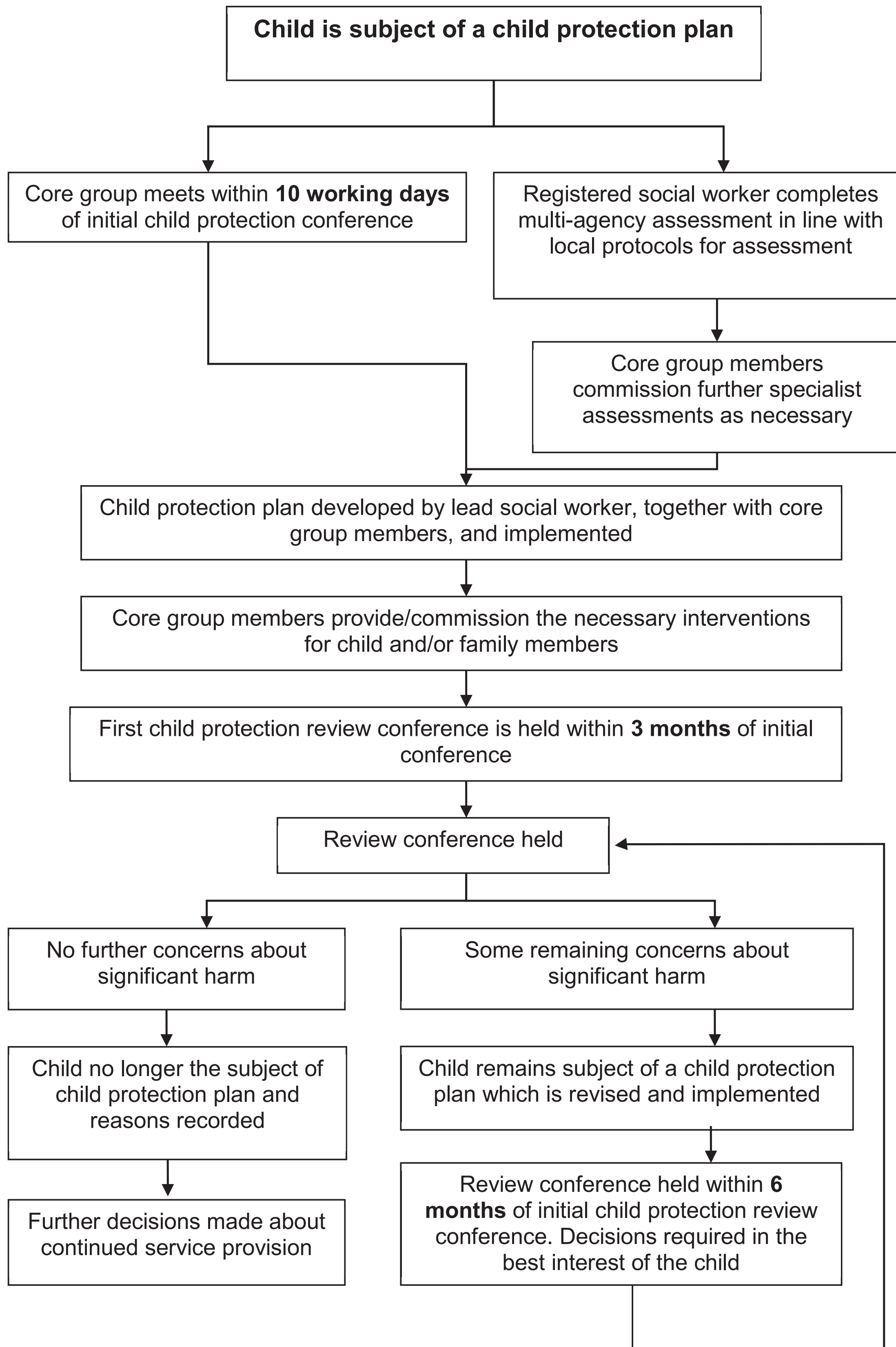
	▪ record conference decisions and recommendations and ensure action follows.
All involved professionals should:	▪ work together to safeguard the child from harm in the future, taking timely, effective action according to the plan agreed.
LSCBs should:	▪ monitor the effectiveness of these arrangements.

The child protection plan **Actions and responsibilities following the initial child protection conference**	
Purpose:	The aim of the child protection plan is to: ▪ ensure the child is safe from harm and prevent him or her from suffering further harm; ▪ promote the child's health and development; and ▪ support the family and wider family members to safeguard and promote the welfare of their child, provided it is in the best interests of the child.
Local authority children's social care should:	▪ designate a social worker to be the lead professional as they carry statutory responsibility for the child's welfare; ▪ consider the evidence and decide what legal action to take if any, where a child has suffered, or is likely to suffer, significant harm; and ▪ define the local protocol for timeliness of circulating plans after the child protection conference.
Social workers with their managers should:	▪ be the lead professional for inter-agency work with the child and family, coordinating the contribution of family members and professionals into putting the child protection plan into effect; ▪ develop the outline child protection plan into a more detailed inter-agency plan and circulate to relevant professionals (and family where appropriate); ▪ undertake direct work with the child and family in accordance with the child protection plan, taking into account the child's wishes and feelings and the views of the parents in so far as they are consistent with the child's welfare; ▪ complete the child's and family's in-depth assessment, securing contributions from core group members and others as necessary; ▪ explain the plan to the child in a manner which is in accordance with their age and understanding and agree the plan with the child; ▪ coordinate reviews of progress against the planned outcomes set out in the plan, updating as required. The first review should be held within 3 months of the initial conference and further reviews at intervals of no more than 6 months for as long as the child remains subject of a child protection plan; ▪ record decisions and actions agreed at core group meetings as well as the written views of those who were not able to attend, and follow up those actions to ensure they take place. The child protection plan should be updated as necessary; and ▪ lead core group activity.

The core group should:	- meet within 10 working days from the initial child protection conference if the child is the subject of a child protection plan; - develop the outline child protection plan, based on assessment findings, and set out what needs to change, by how much, and by when in order for the child to be safe and have their needs met; - decide what steps need to be taken, and by whom, to complete the in-depth assessment to inform decisions about the child's safety and welfare; and - implement the child protection plan and take joint responsibility for carrying out the agreed tasks, monitoring progress and outcomes, and refining the plan as needed.

Child protection review conference **The review conference procedures for preparation, decision-making and other procedures should be the same as those for an initial child protection conference.**	
Purpose:	To review whether the child is continuing to suffer, or is likely to suffer, significant harm, and review developmental progress against child protection plan outcomes. To consider whether the child protection plan should continue or should be changed.
Social workers with their managers should:	▪ attend and lead the organisation of the conference; ▪ determine when the review conference should be held within 3 months of the initial conference, and thereafter at maximum intervals of 6 months; ▪ provide information to enable informed decisions about what action is necessary to safeguard and promote the welfare of the child who is the subject of the child protection plan, and about the effectiveness and impact of action taken so far; ▪ share the conference information with the child and family beforehand, where appropriate; ▪ record conference outcomes; and ▪ decide whether to initiate family court proceedings (all the children in the household should be considered, even if concerns are only expressed about one child) if the child is considered to be suffering significant harm.
All involved professionals should:	▪ attend, when invited, and provide details of their involvement with the child and family; and ▪ produce reports for the child protection review. This information will provide an overview of work undertaken by family members and professionals, and evaluate the impact on the child's welfare against the planned outcomes set out in the child protection plan.

Flow chart 5: What happens after the child protection conference, including the review?



Discontinuing the Child Protection Plan	
A child should no longer be the subject of a child protection plan if: ▪ it is judged that the child is no longer continuing to, or is likely to, suffer significant harm and therefore no longer requires safeguarding by means of a child protection plan; ▪ the child and family have moved permanently to another local authority area. In such cases, the receiving local authority should convene a child protection conference within 15 working days of being notified of the move. Only after this event may the original local authority discontinue its child protection plan; or ▪ the child has reached 18 years of age (to end the child protection plan, the local authority should have a review around the child's birthday and this should be planned in advance), has died or has permanently left the United Kingdom.	
Social workers with their managers should:	▪ notify, as a minimum, all agency representatives who were invited to attend the initial child protection conference that led to the plan; and ▪ consider whether support services are still required and discuss with the child and family what might be needed, based on a re-assessment of the child's needs.

Chapter 2: Organisational responsibilities

1. The previous chapter set out the need for organisations, working together, to take a coordinated approach to ensure effective safeguarding arrangements. This is supported by the duty on local authorities under section 10 of the Children Act 2004 to make arrangements to promote cooperation to improve the wellbeing of all children in the authority's area.
2. In addition, a range of individual organisations and professionals working with children and families have specific statutory duties to promote the welfare of children and ensure they are protected from harm.

Section 11 of the Children Act 2004

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.

Various other statutory duties apply to other specific organisations working with children and families and are set out in this chapter.

3. Section 11 places a duty on:
   - 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.
4. 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:
  - behaved in a way that has harmed a child, or may have harmed a child;
  - possibly committed a criminal offence against or related to a child; or
  - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

In addition:

- county level and unitary local authorities should have a Local Authority Designated Officer (LADO) to be involved in the management and oversight of individual cases. The LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other

agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process;

- any allegation should be reported immediately to a senior manager within the organisation. The LADO should also be informed within one working day of all allegations that come to an employer's attention or that are made directly to the police; and
- if an organisation removes an individual (paid worker or unpaid volunteer) from work such as looking after children (or would have, had the person not left first) because the person poses a risk of harm to children, the organisation must make a referral to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.

Individual organisational responsibilities

5. In addition to these section 11 duties, which apply to a number of named organisations, further safeguarding duties are also placed on individual organisations through other statutes. The key duties that fall on each individual organisation are set out below.

Schools and colleges

6. Section 175 of the 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 institutions. 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.
7. In order to fulfil their duty under sections 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 paragraph 4 of this chapter. In addition schools should have regard to specific guidance given by the Secretary of State under sections 157 and 175 of the Education Act 2002 namely, *Safeguarding Children and Safer Recruitment in Education and Dealing with allegations of abuse against teachers and other staff.*[11,12]

[11] DfE *Safeguarding Children and Safer Recruitment in Education.*
[12] DfE *Dealing with allegations of abuse against teachers and other staff.*

Early Years and Childcare

8. Early years providers have a duty under section 40 of the Childcare Act 2006 to comply with the welfare requirements of the Early Years Foundation Stage.[13] Early years providers should ensure that:

    - staff complete safeguarding training that enables them to recognise signs of potential abuse and neglect; and
    - they have a practitioner who is designated to take lead responsibility for safeguarding children within each early years setting and who should liaise with local statutory children's services agencies as appropriate. This lead should also complete child protection training.

Health Services

9. NHS organisations are subject to the section 11 duties set out in paragraph 4 of this chapter. Health professionals are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating effectively with children and families, liaising with other agencies, assessing needs and capacity, responding to those needs and contributing to multi-agency assessments and reviews.
10. A wide range of health professionals have a critical role to play in safeguarding and promoting the welfare of children including: GPs, primary care professionals, paediatricians, nurses, health visitors, midwives, school nurses, those working in maternity, child and adolescent mental health, adult mental health, alcohol and drug services, unscheduled and emergency care settings and secondary and tertiary care.
11. All staff working in healthcare settings - including those who predominantly treat adults - should receive training to ensure they attain the competences appropriate to their role and follow the relevant professional guidance. [14,15,16]
12. Within the NHS:[17]

    - the **NHS Commissioning Board** will be responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It will also be

[13] DfE guidance on the welfare requirements of the Early Years Foundation Stage.
[14] Safeguarding Children and Young People: roles and competences for health care staff, RCPCH (2010).
[15] Looked after children: Knowledge, skills and competences of health care staff, RCN and RCPCH, (2012).
[16] For example, Protecting children and young people: the responsibilities of all doctors, GMC (2012).
[17] Further guidance on accountabilities for safeguarding children in the NHS is available in the NHS Commissioning Board document http://www.commissioningboard.nhs.uk

accountable for the services it directly commissions. The NHS Commissioning Board will also lead and define improvement in safeguarding practice and outcomes and should also ensure that there are effective mechanisms for LSCBs and health and wellbeing boards to raise concerns about the engagement and leadership of the local NHS;

- **clinical commissioning groups (CCGs)** will be the major commissioners of local health services and will be responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. CCGs should employ, or have in place, a contractual agreement to secure the expertise of designated professionals, i.e. designated doctors and nurses for safeguarding children and for looked after children (and designated paediatricians for unexpected deaths in childhood). In some areas there will be more than one CCG per local authority and LSCB area, and CCGs may want to consider developing 'lead' or 'hosting' arrangements for their designated professional team, or a clinical network arrangement. Designated professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, the NHS Commissioning Board, the local authority and the LSCB, and of advice and support to other health professionals; and
- all **providers of NHS funded health services** including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a named doctor and a named nurse (and a named midwife if the organisation provides maternity services) for safeguarding. In the case of NHS Direct, ambulance trusts and independent providers, this should be a named professional. GP practices should have a lead and deputy lead for safeguarding, who should work closely with named GPs. Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, designated professionals and the LSCB.[18]

Police

13. The police are subject to the section 11 duties set out in paragraph 4 of this chapter. Under section 1(8)(h) of the Police Reform and Social Responsibility Act 2011 the police and crime commissioner must hold the Chief Constable to

[18]Model job descriptions for designated and named professional roles can be found in the intercollegiate document *Safeguarding Children and Young People: roles and competences for health care staff*.

account for the exercise of the latter's duties in relation to safeguarding children under sections 10 and 11 of the Children Act 2004.

14. All police officers, and other police employees such as Police Community Support Officers, are well placed to identify early when a child's welfare is at risk and when a child may need protection from harm. Children have the right to the full protection offered by the criminal law. In addition to identifying when a child may be a victim of a crime, police officers should be aware of the effect of other incidents which might pose safeguarding risks to children and where officers should pay particular attention. For example, an officer attending a domestic abuse incident should be aware of the effect of such behaviour on any children in the household. Children who are encountered as offenders, or alleged offenders, are entitled to the same safeguards and protection as any other child and due regard should be given to their welfare at all times.

15. The police can hold important information about children who may be suffering, or likely to suffer, significant harm, as well as those who cause such harm. They should always share this information with other organisations where this is necessary to protect children. Similarly, they can expect other organisations to share information to enable the police to carry out their duties. Offences committed against children can be particularly sensitive and usually require the police to work with other organisations such as local authority children's social care. All police forces should have officers trained in child abuse investigation.

16. The police have emergency powers under section 46 of the Children Act 1989 to enter premises and remove a child to ensure their immediate protection. This power can be used if the police have reasonable cause to believe a child is suffering or is likely to suffer significant harm. Police emergency powers can help in emergency situations but should be used only when necessary. Wherever possible, the decision to remove a child from a parent or carer should be made by a court.

Adult social care services

17. Local authorities provide services to adults who are responsible for children who may be in need. These services are subject to the section 11 duties set out in paragraph 4 of this chapter. When staff are providing services to adults they should ask whether there are children in the family and consider whether the children need help or protection from harm. Children may be at greater risk of harm or be in need of additional help in families where the adults have mental health problems, misuse substances or alcohol, are in a violent relationship or have complex needs or have learning difficulties.

18. Adults with parental responsibilities for disabled children have a right to a separate carer's assessment under the Carers (Recognition and Services) Act

1995 and the Carers and Disabled Children Act 2000. The results of this assessment should be taken into account when deciding what services, if any, will be provided under the Children Act 1989.

Housing authorities

19. Housing and homelessness services in local authorities and others at the front line such as environmental health organisations are subject to the section 11 duties set out in paragraph 4 of this chapter. Professionals working in these services may become aware of conditions that could have an adverse impact on children. Under Part 1 of the Housing Act 2004, authorities must take account of the impact of health and safety hazards in housing on vulnerable occupants, including children, when deciding on the action to be taken by landlords to improve conditions. Housing authorities also have an important role to play in safeguarding vulnerable young people, including young people who are pregnant or leaving care.

British Transport Police

20. The British Transport Police (BTP) is subject to the section 11 duties set out in paragraph 4 of this chapter. In its role as the national police for the railways, the BTP can play an important role in safeguarding and promoting the welfare of children, especially in identifying and supporting children who have run away or who are truanting from school.

21. The BTP should carry out its duties in accordance with its legislative powers. This includes removing a child to a suitable place using their police protection powers under the Children Act 1989 and the protection of children who are truanting from school using powers under the Crime and Disorder Act 1998. This involves, for example, the appointment of a designated independent officer in the instance of a child taken into police protection.

Prison Service

22. The Prison Service is subject to the section 11 duties set out in paragraph 4 of this chapter. It also has a responsibility to identify prisoners who pose a risk of harm to children. [19] Where an individual has been identified as presenting a risk of harm to children, the relevant prison establishment:

    - should inform the local authority children's social care services of the offender's reception to prison and subsequent transfers and of the release address of the offender;

[19] HMP Public Protection Manual http://www.justice.gov.uk/offenders/public-protection-manual.

- should notify the relevant Probation Trust in the case of offenders who have been sentenced to twelve months or more. The police should also be notified of the release address; and [20]
- may prevent or restrict a prisoner's contact with children. Decisions on the level of contact, if any, should be based on a multi-agency risk assessment. The assessment should draw on relevant information held by police, probation, prison and local authority children's social care.[21]

23. A prison is also able to monitor an individual's communication (including letters and telephone calls) to protect children where proportionate and necessary to the risk presented.

24. Governors/Directors of women's establishments which have Mother and Baby Units should ensure that:

- there is at all times a member of staff on duty in the unit who is proficient in child protection, health and safety and first aid/child resuscitation; and
- each baby has a child care plan setting out how the best interests of the child will be maintained and promoted during the child's residence in the unit.

Probation Service

25. Probation Trusts are subject to the section 11 duties set out in paragraph 4 of this chapter. They are primarily responsible for providing reports for courts and working with adult offenders both in the community and in the transition from custody to community to reduce their reoffending. They are, therefore, well placed to identify offenders who pose a risk of harm to children as well as 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).

26. Where an adult offender is assessed as presenting a risk of serious harm to children, the offender manager should develop a risk management plan and supervision plan that contains a specific objective to manage and reduce the risk of harm to children.

27. In preparing a sentence plan, offender managers should consider how planned interventions might bear on parental responsibilities and whether the planned interventions could contribute to improved outcomes for children known to be in an existing relationship with the offender.

[20] The management of an individual who presents a risk of harm to children will often be through a multi-disciplinary Interdepartmental Risk Management Team (IRMT).
[21] Ministry of Justice Chapter 2, Section 2 of HM Prison Service Public Protection Manual.

The secure estate for children

28. Governors, managers and directors of the following secure establishments are subject to the section 11 duties set out in paragraph 4 of this chapter :
    - a secure training centre;
    - a young offender institution;
    - accommodation provided by or on behalf of a local authority for the purpose of restricting the liberty of children and young people;
    - accommodation provided for that purpose under subsection (5) of section 82 of the Children Act 1989; and
    - such other accommodation or descriptions of accommodation as the Secretary of State may by order specify.
29. Each centre holding those aged under 18 should have in place an annually reviewed safeguarding children policy. The policy is designed to promote and safeguard the welfare of children and should cover issues such as child protection, risk of harm, restraint, recruitment and information sharing. A safeguarding children manager should be appointed and will be responsible for implementation of this policy.[22]

Youth Offending Teams

30. Youth Offending Teams (YOTs) are subject to the section 11 duties set out in paragraph 4 of this chapter. YOTs are multi-agency teams responsible for the supervision of children and young people subject to pre-court interventions and statutory court disposals. [23] They are therefore well placed to identify children known to relevant organisations as being most at risk of offending and to undertake work to prevent them offending. YOTs should have a lead officer responsible for ensuring safeguarding is at the forefront of their business.
31. Under section 38 of the Crime and Disorder Act 1998, local authorities must, within the delivery of youth justice services, ensure the 'provision of persons to act as appropriate adults to safeguard the interests of children and young persons detained or questioned by police officers'.

The United Kingdom Border Agency

32. Section 55 of the Borders, Citizenship and Immigration Act 2009 places upon the United Kingdom Border Agency (UKBA) a duty to take account of the need

[22] Detailed guidance on the safeguarding children policy, the roles of the safeguarding children manager and the safeguarding children committee, and the role of the establishment in relation to the LSCB can be found in Prison Service Instruction (PSI) 08/2012 'Care and Management of Young People'.

[23] The statutory membership of YOTs is set out in section 39 (5) of the Crime and Disorder Act 1998.

to safeguard and promote the welfare of children in discharging its functions. Statutory guidance *Arrangements to Safeguard and Promote Children's Welfare in the United Kingdom Border Agency* sets out the agency's responsibilities. [24]

Children and Family Court Advisory and Support Service

33. The responsibility of the Children and Family Court Advisory and Support Service (Cafcass), as set out in the Children Act 1989, is to safeguard and promote the welfare of individual children who are the subject of family court proceedings. It achieves this by providing independent social work advice to the court.

34. A Cafcass officer has a statutory right in public law cases to access local authority records relating to the child concerned and any application under the Children Act 1989. That power also extends to other records that relate to the child and the wider functions of the local authority, or records held by an authorised body that relate to that child.

35. Where a Cafcass officer has been appointed by the court as a child's guardian and the matter before the court relates to specified proceedings, they should be invited to all formal planning meetings convened by the local authority in respect of the child. This includes statutory reviews of children who are accommodated or looked after, child protection conferences and relevant Adoption Panel meetings.

Armed Services

36. Local authorities have the statutory responsibility for safeguarding and promoting the welfare of the children of service families in the UK.[25] In discharging these responsibilities:

    - local authorities should ensure that the Soldiers, Sailors, Airmen, and Families Association Forces Help, the British Forces Social Work Service or the Naval Personal and Family Service is made aware of any service child who is the subject of a child protection plan and whose family is about to move overseas; and[26]
    - each local authority with a United States base in its area should establish liaison arrangements with the base commander and relevant staff. The requirements of English child welfare legislation should be

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[24] UK Border Agency *Arrangements to Safeguard and Promote Children's Welfare in the United Kingdom Border Agency*.

[25] When service families or civilians working with the armed forces are based overseas the responsibility for safeguarding and promoting the welfare of their children is vested in the Ministry of Defence.

[26] A single point of contact for British Forces Social Work Service will be introduced in late 2013.

explained clearly to the US authorities, so that the local authority can fulfil its statutory duties.

Voluntary and private sectors

37. Voluntary organisations and private sector providers play an important role in delivering services to children. They should have the arrangements described in paragraph 4 of this chapter in place in the same way as organisations in the public sector, and need to work effectively with the LSCB. Paid and volunteer staff need to be aware of their responsibilities for safeguarding and promoting the welfare of children, how they should respond to child protection concerns and make a referral to local authority children's social care or the police if necessary.

Faith Organisations

38. Churches, other places of worship and faith-based organisations provide a wide range of activities for children and have an important role in safeguarding children and supporting families. Like other organisations who work with children they need to have appropriate arrangements in place to safeguard and promote the welfare of children, as described in paragraph 4 of this chapter.

Chapter 3: Local Safeguarding Children Boards

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

Statutory objectives and functions of LSCBs

1. An LSCB must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are described in the two boxes below/over.

Statutory objectives and functions of LSCBs

Section 14 of the Children Act 2004 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.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

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;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(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;

(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;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of this guidance.

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

2. In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

   - assess the effectiveness of the help being provided to children and families, including early help;
   - assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
   - quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
   - monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children. [27,28]

3. LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

LSCB membership

4. LSCB membership is set out in the box on page 61.

[27] The Children's Safeguarding Performance Information Framework provides a mechanism to help do this by setting out some of the questions a LSCB should consider. Download the framework from DfE.

[28] Research has shown that multi-agency training in particular is useful and valued by professionals in developing a shared understanding of child protection and decision making. Carpenter et al (2009). *The Organisation, Outcomes and Costs of Inter-agency Training to safeguard and promote the welfare of children*. London: Department for Children, Schools and Families.

Statutory Board partners and relevant persons and bodies

Section 13 of the Children Act 2004, as amended, sets out that an LSCB must include at least one representative of the local authority and each of the other Board partners set out below (although two or more Board partners may be represented by the same person). Board partners who must be included in the LSCB are:

- district councils in local government areas which have them;
- the chief officer of police;
- the Local Probation Trust;
- the Youth Offending Team;
- the NHS Commissioning Board and clinical commissioning groups;
- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;
- Cafcass;
- the governor or director of any secure training centre in the area of the authority; and
- the governor or director of any prison in the area of the authority which ordinarily detains children.

The Apprenticeships, Skills, Children and Learning Act 2009 amended sections 13 and 14 of the Children Act 2004 and provided that the local authority must take reasonable steps to ensure that the LSCB includes two lay members representing the local community.

Section 13(4) of the Children Act 2004, as amended, provides that the local authority must take reasonable steps to ensure the LSCB includes representatives of relevant persons and bodies of such descriptions as may be prescribed. Regulation 3A of the LSCB Regulations prescribes the following persons and bodies:

- the governing body of a maintained school;
- the proprietor of a non-maintained special school;
- the proprietor of a city technology college, a city college for the technology of the arts or an Academy; and
- the governing body of a further education institution the main site of which is situated in the authority's area.

5. All schools (including independent schools, Academies and free schools) have duties in relation to safeguarding children and promoting their welfare and these are covered in chapter 2. Local authorities should take reasonable steps to ensure that the LSCB includes representatives from of all types of school in their area. A system of representation should be identified to enable all schools to receive information and feed back comments to their representatives on the LSCB.
6. The LSCB should work with the Local Family Justice Board. They should also work with the health and wellbeing board, informing and drawing on the Joint Strategic Needs Assessment.
7. In exceptional circumstances an LSCB can cover more than one local authority. Where boundaries between LSCBs and their partner organisations are not coterminous, such as with health organisations and police authorities, LSCBs should collaborate as necessary on establishing common policies and procedures and joint ways of working.
8. Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to:
   - speak for their organisation with authority;
   - commit their organisation on policy and practice matters; and
   - hold their own organisation to account and hold others to account.
9. The LSCB should either include on its Board, or be able to draw on appropriate expertise and advice from, frontline professionals from all the relevant sectors. This includes a designated doctor and nurse, the Director of Public Health, Principal Child and Family Social Worker and the voluntary and community sector.
10. Lay members will operate as full members of the LSCB, participating as appropriate on the Board itself and on relevant committees. Lay members should help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work. A local authority may pay lay members.
11. The Lead Member for Children should be a participating observer of the LSCB. In practice this means routinely attending meetings as an observer and receiving all its written reports.

LSCB Chair, accountability and resourcing

12. In order to provide effective scrutiny, the LSCB should be independent. It should not be subordinate to, nor subsumed within, other local structures.
13. Every LSCB should have an independent chair who can hold all agencies to account.
14. It is the responsibility of the Chief Executive (Head of Paid Service) to appoint or remove the LSCB chair with the agreement of a panel including LSCB partners and lay members. The Chief Executive, drawing on other LSCB partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the LSCB.
15. The LSCB Chair should work closely with all LSCB partners and particularly with the Director of Children's Services. The Director of Children's Services has the responsibility within the local authority, under section 18 of the Children Act 2004, for improving outcomes for children, local authority children's social care functions and local cooperation arrangements for children's services.[29]
16. The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.[30] The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and wellbeing board.
17. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period (see chapters 4 and 5).
18. The report should also list the contributions made to the LSCB by partner agencies and details of what the LSCB has spent, including on Child Death Reviews, Serious Case Reviews and other specific expenditure such as learning events or training. All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies.

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[29] Department for Education statutory guidance on *The roles and responsibilities of the Director of Children's Services and Lead Member for Children's Services* which expands on this role.

[30] This is a statutory requirement under section 14A of the Children Act 2004

19. All LSCB Chairs should have access to training and development opportunities, including peer networking. They should also have an LSCB business manager and other discrete support as is necessary for them, and the LSCB, to perform effectively.

Information sharing

20. Chapter 1 sets out how effective sharing of information between professionals and local agencies is essential for effective service provision. Every LSCB should play a strong role in supporting information sharing between and within organisations and addressing any barriers to information sharing. This should include ensuring that a culture of information sharing is developed and supported as necessary by multi-agency training.

21. In addition, the LSCB can require a person or body to comply with a request for information.[31] This can only take place where the information is essential to carrying out LSCB statutory functions. Any request for information about individuals must be 'necessary' and 'proportionate' to the reasons for the request. LSCBs should be mindful of the burden of requests and should explain why the information is needed.

[31] Section 14A of the Children Act 2004 which was inserted by section 8 of the Children, Schools and Families Act 2010.

Chapter 4: Learning and improvement framework

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;
   - 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.

6. LSCBs should also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute these reviews are important for highlighting good

practice as well as identifying improvements which need to be made to local services. Such reviews may be conducted either by a single organisation or by a number of organisations working together. LSCBs should follow the principles in this guidance when conducting these reviews.

7. Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

8. The different types of review include:

    - Serious Case Review (see page 69): 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;
    - child death review (see Chapter 5): a review of all child deaths up to the age of 18;
    - review of a child protection incident which falls below the threshold for an SCR; and
    - review or audit of practice in one or more agencies.

Principles for learning and improvement

9. The following principles should be applied by LSCBs and their partner organisations to all reviews:

    - there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
    - the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
    - reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
    - professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
    - families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

This is important for ensuring that the child is at the centre of the process;[32]

- final reports of SCRs **must be published,** including the LSCB's response to the review findings, in order to achieve **transparency.** The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

10. SCRs and other case reviews should be conducted in a way which:
    - recognises the complex circumstances in which professionals work together to safeguard children;
    - seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
    - seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
    - is transparent about the way data is collected and analysed; and
    - makes use of relevant research and case evidence to inform the findings.
11. LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro.[33]

[32] British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN, further information on involving families in reviews
[33] Department for Education The Munro Review of Child Protection: Final Report: A Child Centred System, Cm 8062, May 2011

Serious Case Reviews

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

12. Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) above) **must always** trigger an SCR. In addition, 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, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.
13. Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.
14. LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. They will also want to review instances of good practice and consider how these can be shared and embedded. LSCBs are free to decide how best to conduct these reviews. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

National panel of independent experts on Serious Case Reviews

15. From 2013 there will be a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The role of the panel will be to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The panel will also report to the Government their views of how the SCR system is working.

16. The panel's remit will include advising LSCBs about:

    - application of the SCR criteria;
    - appointment of reviewers; and
    - publication of SCR reports.

17. LSCBs should have regard to the panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings. [34]

18. The text which follows provides a checklist for LSCBs on how to manage the SCR process.

[34] In doing so LSCBs will be exercising their powers under Regulation 5(3) of the Local Safeguarding Children Board Regulations 2006 which states that 'an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objective'.

Serious Case Review checklist

Decisions whether to initiate an SCR

The LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be made within one month of notification of the incident. The final decision rests with the Chair of the LSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

The LSCB must let Ofsted and the national panel of independent experts know their decision.

If the LSCB decides not to initiate an SCR, their decision may be subject to scrutiny by the national panel. The LSCB should provide information to the panel on request to inform its deliberations and the LSCB Chair should be prepared to attend in person to give evidence to the panel.

Appointing reviewers

The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case. The LSCB should provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers.

Engagement of organisations

The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

Timescale for SCR completion

The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

Agreeing improvement action

The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings.

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. Thereafter 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 very 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.

Final SCR reports should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders.

LSCBs should send copies of all SCR reports to the national panel of independent experts at least one week before publication. If an LSCB considers that an SCR report should not be published, it should inform the panel which will provide advice to the LSCB. The LSCB should provide all relevant information to the panel on request, to inform its deliberations.

Chapter 5: Child death reviews

The Regulations relating to child death reviews

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying—

> *(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);*
>
> *(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;*
>
> *(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and*

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

1. Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons. The Review will help to prevent further such child deaths.[35]
2. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).

Responsibilities of Local Safeguarding Children Boards (LSCBs)

3. The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP). The Panel will have a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. The Panel should include a professional from public health as well as child health. It

[35] Department for Education leaflet that can be given to parents, carers and family members to explain the child death review process.

should be chaired by the LSCB Chair's representative. That individual should not be involved directly in providing services to children and families in the area. One or more LSCBs can choose to share a CDOP. CDOPs responsible for reviewing deaths from larger populations are better able to identify significant recurrent contributory factors.

4. LSCBs should be informed of the deaths of all children normally resident in their geographical area. The LSCB Chair should decide who will be the designated person to whom the death notification and other data on each death should be sent.[36] LSCBs should use sources available, such as professional contacts or the media, to find out about cases when a child who is normally resident in their area dies abroad. The LSCB should inform the CDOP of such cases so that the deaths of these children can be reviewed.
5. In cases where organisations in more than one LSCB area have known about or have had contact with the child, lead responsibility should sit with the LSCB for the area in which the child was normally resident at the time of death. Other LSCBs or local organisations which have had involvement in the case should cooperate in jointly planning and undertaking the child death review. In the case of a looked after child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCBs with an interest or whose lead agencies have had involvement as appropriate.

[36] Department for Education: list of people designated by the CDOP to receive notifications of child death information.

Specific responsibilities of relevant bodies in relation to child deaths	
Registrars of Births and Deaths (Children & Young Persons Act 2008)	Requirement to supply the LSCB with information which they have about the death of persons under 18 they have registered or re-registered. Notify LSCBs if they issue a *Certificate of No Liability to Register* where it appears that the deceased was or may have been under the age of 18 at the time of death. Requirement to send the information to the appropriate LSCB (the one which covers the sub-district in which the register is kept) no later than seven days from the date of registration.
Coroners (Coroners Rules 1984 (as amended by the Coroners (Amendment) Rules 2008)	Duty to inquire and may require evidence. Duty to inform the LSCB for the area in which the child died within three working days of the fact of an inquest or post mortem. Powers to share information with LSCBs for the purposes of carrying out their functions, including reviewing child deaths and undertaking SCRs.
Registrar General (section 32 of the Children and Young Persons Act 2008)	Power to share child death information with the Secretary of State, including about children who die abroad.

Medical Examiners (Coroners and Justice Act 2009)	It is anticipated that from 2014 Medical Examiners will be required to share information with LSCBs about child deaths that are not investigated by a coroner.
Clinical Commissioning Groups (Health and Social Care Act 2012)	Employ, or have arrangements in place to secure the expertise of, consultant paediatricians whose designated responsibilities are to provide advice on: ▪ commissioning paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood, and from medical investigative services; and ▪ the organisation of such services.

6. A summary of the child death processes to be followed when reviewing all child deaths is set out in Flowchart 6 on page 83.. The processes for undertaking a rapid response when a child dies unexpectedly are set out in Flowchart 7 on page 84.

Providing information to the Department for Education

7. Every LSCB is required to supply anonymised information on child deaths to the Department for Education. This is so that the Department can commission research and publish nationally comparable analyses of these deaths.[37]

[37] Department for Education detailed guidance on how to supply the information on child deaths

Specific responsibilities of relevant professionals - When responding rapidly to the unexpected death of a child	
Designated Paediatrician for unexpected deaths in childhood (designated paediatrician)	Ensure that relevant professionals (i.e. coroner, police and local authority social care) are informed of the death; coordinate the team of professionals (involved before and/or after the death) which is convened when a child who dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team). Convene multi-agency discussions after the initial and final initial post mortem results are available.

Responsibilities of Child Death Overview Panels

8. The functions of the CDOP include:

   - reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
   - collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
   - discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
   - determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
   - making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
   - identifying patterns or trends in local data and reporting these to the LSCB;
   - where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
   - agreeing local procedures for responding to unexpected deaths of children; and
   - cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

9. The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report.

Definition of preventable child deaths

10. For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

11. In reviewing the death of each child, the CDOP should consider modifiable factors, for example in the family and environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

Action by professionals when a child dies unexpectedly

Definition of an unexpected death of a child

12. In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

13. The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

14. As set out the Local Safeguarding Children Boards Regulations 2006, LSCBs are responsible for putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

15. When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the local designated paediatrician with responsibility for unexpected child deaths at the same time as informing the coroner and police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. A paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it. The joint responsibilities of the professionals involved with the child include:

    - responding quickly to the child's death in accordance with the locally agreed procedures;
    - maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the Association of Chief Police Officers;[38]

[38] PJ. Fleming, P.S. Blair, C. Bacon, and P.J. Berry (2000) Sudden Unexpected Death In Infancy. The CESDI SUDI Studies 1993-1996. The Stationery Office. London. ISBN 0 11 3222 9988; Royal College of

- making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- liaising with the coroner and the pathologist;
- undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;
- collecting information about the death;[39]
- providing support to the bereaved family, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and
- gaining consent early from the family for the examination of their medical notes.

16. If the child dies suddenly or unexpectedly at home or in the community, the child should normally be taken to an Emergency Department rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to immediately move the child's body, for example because forensic examinations are needed.

17. As soon as possible after arrival at a hospital, the child should be examined by a consultant paediatrician and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it. In all cases when a child dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.

18. If the child has died at home or in the community, the lead police investigator and senior health care professional should decide whether there should be a visit to the place where the child died, how soon (ideally within 24 hours) and who should attend. This should almost always take place for cases of sudden infant death.[40] After this visit the senior investigator, visiting health care professional, GP, health visitor or school nurse and local authority children's social care representative should consider whether there is any information to raise concerns that neglect or abuse contributed to the child's death.

19. Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user **– but NHS providers may discharge this duty by notifying the National Health Service Commissioning Board.** [41] Where a young person dies at work, the

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Pathologists and the Royal College of Paediatrics and Child Health (2004) Sudden unexpected death in infancy. A multi-agency protocol for care and investigation. The Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Royal College of Pathologists and the Royal College of Paediatrics and Child Health, London. www.rcpath.org

[39] See Footnote 32.

[40] See footnote 33.

[41] Regulation 16 of the Care Quality Commission (Registration) Regulations 2009

Health and Safety Executive should be informed. Youth Offending Teams' reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP child death processes.

20. If there is a criminal investigation, the team of professionals must consult the lead police investigator and the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. If the child dies in custody, there will be an investigation by the Prisons and Probation Ombudsman (or by the Independent Police Complaints Commission in the case of police custody). Organisations who worked with the child will be required to cooperate with that investigation.

Involvement of the coroner and pathologist

21. If a doctor is not able to issue a medical certificate of the cause of death, the lead professional or investigator must report the child's death to the coroner in accordance with a protocol agreed with the local coronial service. The coroner must investigate violent or unnatural death, or death of no known cause, and all deaths where a person is in custody at the time of death. The coroner will then have jurisdiction over the child's body at all times. Unless the death is natural a public inquest will be held.[42]

22. The coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The designated paediatrician will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

23. If the death is unnatural or the cause of death cannot be confirmed, the coroner will hold an inquest. Professionals and organisations who are involved in the child death review process must cooperate with the coroner and provide him/her with a joint report about the circumstances of the child's death. This report should include a review of all medical, local authority social care and educational records on the child. The report should be delivered to the coroner within 28 days of the death unless crucial information is not yet available.

Action after the post mortem

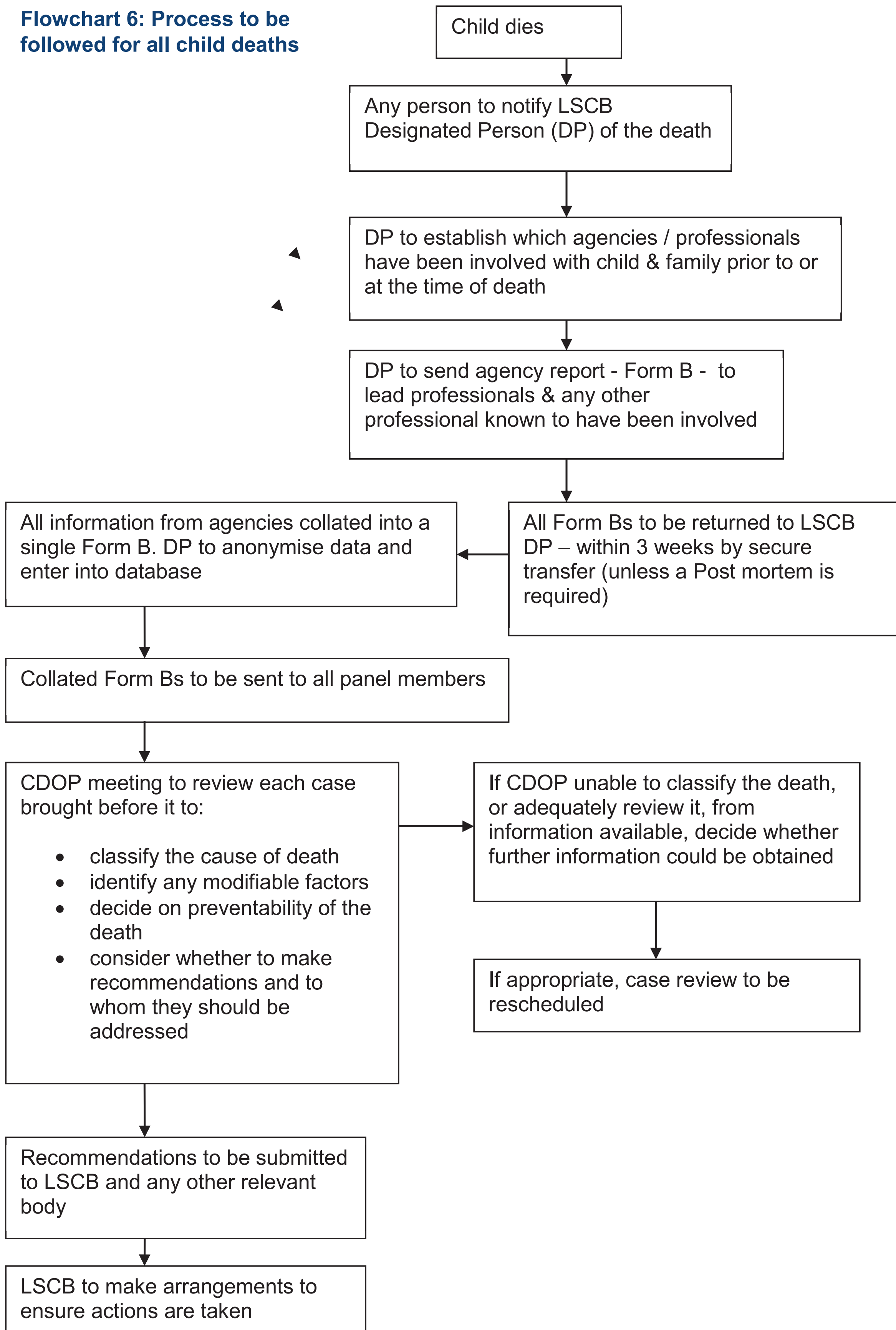
24. Although the results of the post mortem belong to the coroner, it should be possible for the paediatrician, pathologist, and the lead police investigator to

[42] Ministry of Justice guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children.

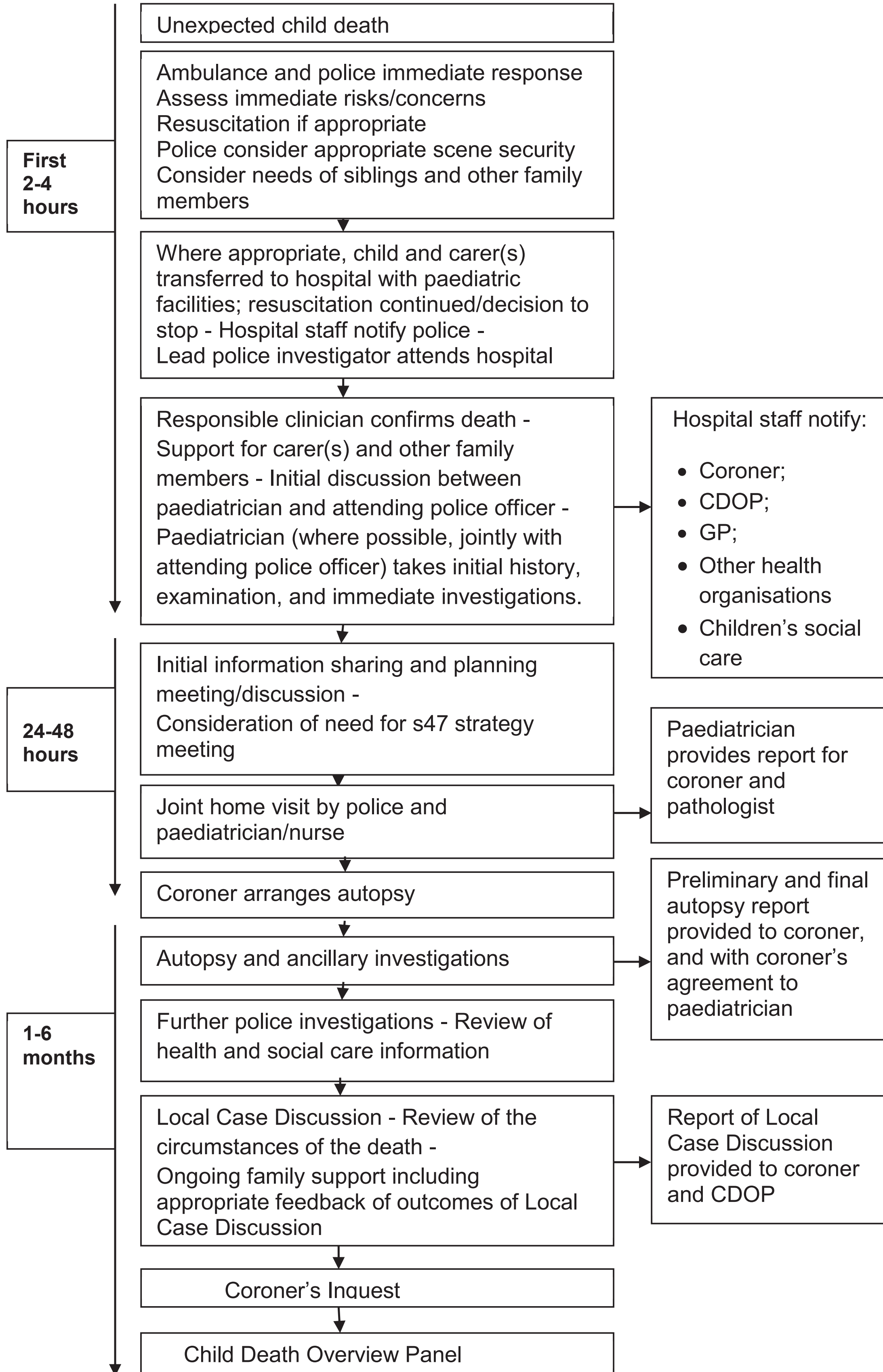
discuss the findings as soon as possible, and the coroner should be informed immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death, the paediatrician should inform the police and local authority children's social care immediately. He or she should also inform the LSCB Chair so that they can consider whether the criteria are met for initiating an SCR.

25. Shortly after the initial post mortem results become available, the designated paediatrician for unexpected child deaths should convene a multi-agency case discussion, including all those who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues. A further multi-agency case discussion should be convened by the designated paediatrician, or a paediatrician acting as their deputy, as soon as the final post mortem result is available. This is in order to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family. The designated paediatrician should arrange for a record of the discussion to be sent to the coroner, to inform the inquest and cause of death, and to the relevant CDOP, to inform the child death review. At the case discussion, it should be agreed how detailed information about the cause of the child's death will be shared, and by whom, with the parents, and who will offer the parents on-going support.

Flowchart 6: Process to be followed for all child deaths



Flowchart 7: Process for rapid response to the unexpected death of a child



Appendix A: Glossary

Children	Anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate, does not change his/her status or entitlements to services or protection.
Safeguarding and promoting the welfare of children	Defined for the purposes of this guidance as: ▪ protecting children from maltreatment; ▪ preventing impairment of children's health or development; ▪ ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and ▪ taking action to enable all children to have the best life chances.
Child protection	Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.
Abuse	A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.
Physical abuse	A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Emotional abuse	The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is

	involved in all types of maltreatment of a child, though it may occur alone.
Sexual abuse	Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
Neglect	The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: ▪ provide adequate food, clothing and shelter (including exclusion from home or abandonment); ▪ protect a child from physical and emotional harm or danger; ▪ ensure adequate supervision (including the use of inadequate care-givers); or ▪ ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.
Young carers	Are children and young people who assume important caring responsibilities for parents or siblings, who are disabled, have physical or mental ill health problems, or misuse drugs or alcohol.

Appendix B: Statutory framework

The legislation relevant to safeguarding and promoting the welfare of children is set out below.

Children Act 2004

Section 10 requires each local authority to make arrangements to promote cooperation between the authority, each of the authority's relevant partners (see Table A) and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes.

Section 11 places duties on a range of organisations and individuals (see Table A) to ensure their functions, and any services that they contract out to others, are discharged with regard to the need to safeguard and promote the welfare of children.

Section 13 requires each local authority to establish a Local Safeguarding Children Board (LSCB) 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.

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 of the local authority, *and*
>
> (b) to ensure the effectiveness of what is done by each such person or body for the purposes of safeguarding and promoting the welfare of children.

The LSCB Regulations 2006[43] made under section 13 set out the functions of LSCBs, which include undertaking reviews of the deaths of all children in their areas and undertaking Serious Case Reviews in certain circumstances.

Under section 55 of the Borders, Citizenship and Immigration Act 2009, the Secretary of State (in practice, the UK Border Agency or 'UKBA') has a duty to ensure that functions relating to immigration and customs are discharged with regard to the need to safeguard and promote the welfare of children. Section 55 is intended to have the same effect as section 11 of the Children Act 2004.

[43] Local Safeguarding Children Boards Regulations 2006

Education Act 2002

Section 175 places a duty on local authorities in relation to their education functions, the governing bodies of maintained schools and the governing bodies of 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 either pupils at a school or who are students under 18 years of age attending further education institutions.

The same duty applies to independent schools (which include Academies/free schools) by virtue of regulations made under section 157 of this Act.

Children Act 1989

The Children Act 1989 places a duty on local authorities to promote and safeguard the welfare of children in need in their area.

Section 17(1) of the Children Act 1989 states that it shall be the general duty of every local authority:

> *(a) to safeguard and promote the welfare of children within their area who are in need; and*
>
> *(b) so far as is consistent with that duty, to promote the upbringing of such children by their families.*

by providing a range and level of services appropriate to those children's needs.

Section 17(5) enables the local authority to make arrangements with others to provide services on their behalf and states that every local authority:

> *(a) shall facilitate the provision by others (including in particular voluntary organisations) of services which it is a function of the authority to provide by virtue of this section, or section 18, 20, 22A to 22C, 23B to 23D, 24A or 24B; and*
>
> *(b) may make such arrangements as they see fit for any person to act on their behalf in the provision of any such service.*

Section 17(10) states that a child shall be taken to be in need if:

> *(a) the child is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority under Part III of the Children Act 1989;*
>
> *(b) the child's health or development is likely to be significantly impaired, or further impaired, without the provision of such services; or*
>
> *(c) the child is disabled.*

Under section 17, local authorities have responsibility for determining what services should be provided to a child in need. This does not necessarily require local authorities themselves to be the provider of such services.

Section 27 of the Children Act 1989 imposes a duty on other local authorities, local authority housing services and health bodies to cooperate with a local authority in the exercise of that authority's duties under Part 3 of the Act which relate to local authority support for children and families. Where it appears to a local authority that any authority or body mentioned in section 27(3) could, by taking any specified action, help in the exercise of any of their functions under this Part, they may request the help of that other authority or body, specifying the action in question. An authority or body whose help is so requested shall comply with the request if it is compatible with their own statutory or other duties and obligations and does not unduly prejudice the discharge of any of their functions. The authorities are:

(a) any local authority;

(b) any local housing authority;

(c) any Local Health Board, Special Health Authority, Primary Care Trust, (National Health Service Trust or NHS Foundation Trust; and

d) any person authorised by the Secretary of State for the purpose of section 27.

Section 47(1) of the Children Act 1989 states that:

Where a local authority:

(a) are informed that a child who lives, or is found, in their area (i) is the subject of a emergency protection order, or (ii) is in police protection; and

(b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:

the authority shall make, or cause to be made, such enquires as they consider necessary to enable them to decide whether they should take any action to safeguard and promote the child's welfare.

Section 53 of the Children Act 2004 amends both section 17 and section 47 of the Children Act 1989, to require in each case that before determining what services to provide or what action to take, the local authority shall, so far as is reasonably practicable and consistent with the child's welfare:

(a) ascertain the child's wishes and feelings regarding the provision of those services or the action to be taken; and

(b) give due consideration (with regard to the child's age and understanding) to such wishes and feelings of the child as they have been able to ascertain.

Emergency protection powers

The court may make an emergency protection order under section 44 of the Children Act 1989, if it is satisfied that there is reasonable cause to believe that a child is likely to suffer significant harm if the child:

- is not removed to different accommodation; or
- does not remain in the place in which the child is then being accommodated.

An emergency protection order may also be made if enquires (for example, made under section 47) are being frustrated by access to the child being unreasonably refused to a person authorised to seek access, and the applicant has reasonable cause to believe that access is needed as a matter of urgency.

An emergency protection order gives authority to remove a child, and place the child under the protection of the applicant.

Exclusion requirement

The court may include an exclusion requirement in an interim care order or emergency protection order (section 38A and 44A of the Children Act 1989). This allows a perpetrator to be removed from the home instead of having to remove the child. The court must be satisfied that:

- there is reasonable cause to believe that if the person is excluded from the home in which the child lives, the child will cease to suffer, or cease to be likely to suffer, significant harm, or that enquires will cease to be frustrated; and
- another person living in the home is able and willing to give the child the care that it would be reasonable to expect a parent to give, and consents to the exclusion requirement.

Police protection powers

Under section 46 of the Children Act 1989, where a police officer has reasonable cause to believe that a child could otherwise be likely to suffer significant harm, the officer may:

- remove the child to suitable accommodation; or
- take reasonable steps to ensure that the child's removal from any hospital, or other place in which the child is then being accommodated is prevented.

No child may be kept in police protection for more than 72 hours.

Police Reform and Social Responsibility Act 2011

Section 1 (8)(h) requires the police and crime commissioner to hold the chief constable to account for the exercise of the latter's duties in relation to safeguarding children under section 10 and 11 of the Children Act 2004.

Childcare Act 2006

Section 40 requires early years providers to comply with the welfare requirements of the Early Years Foundation Stage.

Crime and Disorder Act 1998

Section 38 requires local authorities, within the delivery of youth justice services, to ensure the provision of persons to act as appropriate adults to safeguard the interests of children and young persons detained or questioned by police officers.

Housing Act 1996

Section 213A of the Housing Act 1996 (inserted by section 12 of the Homelessness Act 2002), housing authorities are required to refer to adult social care services homeless persons with dependent children who are ineligible for homelessness assistance, or are intentionally homeless, as long as the person consents. If homelessness persists, any child in the family could be in need. In such cases, if social services decide the child's needs would be best met by helping the family to obtain accommodation, they can ask the housing authority for reasonable advice and assistance in this, and the housing authority must give reasonable advice and assistance.

Table A: Bodies and individuals covered by key duties

Body	CA 2004 Section 10 - duty to cooperate	CA 2004 Section 11 - duty to safeguard & promote welfare	Ed Act 2002 Section 175 - duty to safeguard & promote welfare and regulations	CA 2004 Section 13 - statutory partners in LSCBs	CA 1989 Section 27 - help with children in need	CA 1989 Section 47 - help with enquiries about significant harm
Local Authorities and District councils	X	X	In relation to their education functions.	X	X	X
Local policing body	X	X				X
Chief officer of police	X	X		X		X
Local probation board	X	X		X		
SoS re probation services' functions under s2 and 3 of the Offender Management Act (OMA) 2007	X	X		X		
Providers of probation services required under s3(2) OMA 2007 to act as relevant partner of a local authority	X	X		X		
British Transport Police		X				
United Kingdom Border Agency		x under section 55 of the Borders, Citizenship and Immigration Act 2009				
Prison or secure training centre		X		X (which ordinarily detains children)		

Youth offending services	X	X		X		
NHS Commissioning Board	X	X		X	X	X
Clinical commissioning groups	X	X		X	X	X
NHS Trusts and NHS Foundation Trusts		X		X	X	X
Cafcass				X		
Maintained schools	X (includes non-maintained special schools)		X			
FE colleges	X		X			
Independent schools	X		X Via regulations made under section 157 of the Education Act 2002			
Academies and Free Schools	X		X Via regulations made under section 157 of the Education Act 2002			
Contracted services including those provided by voluntary organisations		X				

Appendix C: Further sources of information

Supplementary guidance on particular safeguarding issues

Department for Education guidance

Safeguarding children who may have been trafficked

Safeguarding children and young people who may have been affected by gang activity

Safeguarding children from female genital mutilation

Forced marriage

Safeguarding children from abuse linked to faith or belief

Use of reasonable force

Safeguarding children and young people from sexual exploitation

Safeguarding Children in whom illness is fabricated or induced

Preventing and tackling bullying

Safeguarding children and safer recruitment in education

Information sharing

Recruiting safely: Safer recruitment guidance helping to keep children and young people safe

Safeguarding Disabled Children: Practice guidance

Department of Health / Department for Education: National Service Framework for Children, Young People and Maternity Services

DfE: What to do if you're worried a child is being abused

Department of Health: The Framework for the Assessment of Children in Need and their Families 2000

Guidance issued by other government departments and agencies

Foreign and Commonwealth Office / Home Office: Forced marriage

Ministry of Justice: Guidance on forced marriage

Home Office: What is domestic violence?

Department of Health: Responding to domestic abuse: A handbook for health professionals

NHS National Treatment Agency: Guidance on development of Local Protocols between

drug and Alcohol Treatment Services and Local Safeguarding and Family Services

Home Office: Guidance on teenage relationship abuse

Youth Justice Board: Guidance on people who present a risk to children

Department of Health: Violence against Women and Children

UK Border Agency: Arrangements to Safeguard and Promote Children's Welfare in UKBA

Department of Health: Good practice guidance on working with parents with a learning disability

Home Office: Circular 16/2005 - Guidance on offences against children

Home Office: Disclosure and Barring Services

Child protection and the Dental Team – an introduction to safeguarding children in dental practice

Ministry of Justice: Multi Agency Public Protection Arrangements guidance

Ministry of Justice: HM Prison Service Public Protection Manual

Ministry of Justice: Probation service guidance on conducting serious further offence reviews Framework.

Missing Children and Adults - a cross Government strategy

Department of Health: Recognised, valued and supported: next steps for the Carers Strategy

Department of Health: Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children

Guidance issued by external organisations

BAAF: Private fostering

Royal College of Paediatrics and Child Health: Safeguarding Children and Young people: roles and competencies for health care staff - Intercollegiate document, September 2010

General Medical Council: Protecting children and young people - The responsibilities of all doctors

Royal College of Nursing: Looked after children - Knowledge, skills and competences of health care staff (Intercollegiate role framework)

NICE: Guidance on when to suspect child maltreatment

Supplementary guidance to support assessing the needs of children

DfE: What to do if you're worried a child is being abused

DfE: Childhood neglect - Improving outcomes for children

NICE: When to suspect child maltreatment

Supplementary guidance to support the Learning and Improvement Framework

DfE: Training in relation to the child death review processes and Serious Case Reviews

NPIA / ACPO: Guidance on Investigating Child Abuse and Safeguarding Children

Prison and Probation Ombudsman's fatal incidents investigation

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