Appendix A - Working Together 2013 – Action Plan

WORKING TOGETHER 2013

Summary:
The new Working Together to Safeguard children (2013) streamlines previous guidance documents to clarify the responsibilities of professionals towards safeguarding children and strengthens the focus away from processes and onto the needs of the child.
It replaces:

- Working together to safeguard children (2010)
- 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).

Most of the responsibilities and procedures in the new 2013 Working together remain the same as the 2010 guidance, but the guidance is presented in a much more succinct and less detailed way.
There are 5 chapters in the new 2013 guidance.

Chapter 1: Assessing need and providing help

Contains guidance on:

- providing early help
- information sharing
- undertaking assessments under the Children Act 1989
- focusing on the needs and views of the child
- focusing on outcomes
- timeliness of assessments
- Commencing child protection proceedings (strategy discussion, section 47 enquiries, initial child protection conference, child protection plan, and child protection review conference).

Action	Lead	By When	Comments/Progress
LSCBs 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;	Head of Assessment & Children in Need	Completed	Published on council website and Barnet Safeguarding Board website and accessible

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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			to all agencies.
There will no longer be a requirement to conduct separate **initial and core assessments**. The maximum timeframe for the assessment to conclude should be no longer than 45 working days from the point of referral.	Head of Assessment & Children in Need	In progress	Work to review process and format of assessments in ongoing and is due to conclude by March 2014
Local authorities, with their partners, should develop and publish **local protocols for assessment**.	Head of Assessment & Children in Need		As above

Chapter 2: Organisational responsibilities

Contains guidance on:

- section 11 of the Children Act 2004 (duty to safeguard and promote the welfare of children) Separate guidance has been replaced by this chapter.
- specific safeguarding duties placed on schools and colleges, early years and childcare, health services, police, adult social care services, housing authorities, British Transport Police, Prison Service, Probation Service, secure estate for children, Youth Offending Teams, United Kingdom Border Agency, CAFCASS, armed services, voluntary and private sectors and faith organisations.

Action	Lead	By When	Comments/Progress
All agencies follow & evidence S11 responsibilities	Head of Safeguarding & Quality Assurance	Completed – in place	All named agencies have completed this year an audit using S11 guidance. A report will be presented to the BSCB.

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Chapter 3: Local Safeguarding Children Boards

Contains guidance on:

- Statutory objectives and functions of LSCBs
- LSCB membership
- LSCB chair
- Accountability and resourcing; and information sharing.

Action	Lead	By When	Comments/ Progress
Every LSCB should have an **independent chair** accountable to the Chief Executive	Head of Safeguarding & Quality Assurance	Completed – in place	The Barnet Safeguarding Children Board has an independent chair. From October 2013 the independent post will also chair the Safeguarding Adult Board

Chapter 4: Learning and improvement framework

Contains guidance on:

- serious case reviews including requirements around publication
- other case reviews
- local learning and development framework
- a national panel of independent experts on serious case reviews.

Action	Lead	By When	Comments/Progress
Local Safeguarding Children Boards (LSCBs) should maintain a local **learning and improvement**	Head of Safeguarding &	Completed – in place	Cases are referred to the Board where there are areas

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framework which is shared across local organisations who work with children and families	Quality Assurance		of poor practice and where good practice is recognised. This allows learning to be disseminated. In addition a comprehensive audit of a child's journey has been introduced to focus in depth on a case with the involvement of all relevant agencies
Reviews should be conducted regularly, not only on those cases which meet statutory requirements but also on other cases which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children.	Head of Safeguarding & Quality Assurance	Completed – in place	Regular reviews are in place using the recommended SCIE model and outcomes reported to the BSCB
A national panel of independent experts on Serious Case Reviews will advise LSCBs about the initiation and publication of SCRs	Government action	In place June 2013	
The guidance emphasises that a **Serious Case Review** should always be carried out if a child dies by suspected suicide (and abuse or neglect was believed to be a factor).	Head of Safeguarding & Quality Assurance	Completed - In place	This is incorporated into the decision making process of the Serious Case Review group that reports to the Chair of the BSCB
LSCBs may use any **learning model** which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro.	Head of Safeguarding & Quality Assurance	Completed - In place	The SCIE model as recommended by Professor Munro is in place and used by the BSCB.
Although the review process must include appropriate	Head of	Completed – in	This is incorporated into the

representation from other organisations, and these organisations may be required to submit written information about their involvement with the child who is subject to the review, there is no longer any requirement for organisations to undertake **Individual Management Reviews (IMRs**).	Safeguarding & Quality Assurance	place	decision making process of the Serious Case Review group that reports to the Chair of the BSCB
Final reports of SCRs findings must be published on the LSCB's website for a minimum of 12 months. The 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.	Head of Safeguarding & Quality Assurance	Completed – in place	Following evaluation by the national panel SCR's will be published on the council website and the BSCB website as detailed.

Chapter 5: Child death reviews

Contains guidance on:

- responsibilities of the LSCB
- responsibilities of relevant bodies in relation to child deaths
- responsibilities of Child Death Overview Panels
- definition of preventable child deaths; action by professionals when a child died unexpectedly

- involvement of the coroner and pathologist.

Action	Lead	By When	Comments/Progress
Child Death Reviews follow national statutory guidance	Head of Safeguarding & Quality Assurance	Completed – in place	Child Death Review process in place and follows national guidance. Reported to BSCB through an Annual report from Paediatrician lead for child deaths.