Title of meeting: Governing Body in Public			
Date of Meeting	09.07.19	**Paper Number**	3.2.1
Title		CCG Statutory requirements of 'working together 2018':Development of the Multi agency safeguarding arrangements and Child Death Overview Panel process	
Sponsoring Director (name and job title)		Sarah Bellars Director of Nursing	
Sponsoring Clinical / Lay Lead (name and job title)		Debbie Hartrick Designated professional	
Author(s)		Sarah Bellars/Debbie Hartrick	
Purpose		To provide assurance to the Governing Body that CCG has discharged its statutory Duty in relation to the requirements of "working together " 2018	
The Committee is required to (please tick)			

Decision		**Review**		**Discuss**		**Note**	X	**Recommend**	

Risk and Assurance (*outline the key risks / where to find mitigation plan in the attached paper and any assurances obtained)*	Due to change there is a risk that the changed arrangements will not provide sufficient assurance until the changes in arrangements have been embedded.
Legal implications/regulatory requirements	Statutory changes required as detailed in paper
Equality, Diversity and Inclusion (identify any best practice or areas of concern in regards to the Public Sector Equality Duty and the Equality Act 2010)	
Links to the NHS Constitution (relevant patient/staff rights)	
Strategic Fit	Person: working alongside individuals to empower them to take control of their own health and wellbeing Place: working in local communities, local authority areas or across a bigger geography to respond to the needs of our population Engage: engaging with staff, member practices, local people and other stakeholders so that services are informed by their

	needs, views and behaviours Integrate: breaking down the barriers of traditional organisational boundaries to deliver effective and responsive services
Commercial and Financial Implications *(Identify how the proposal impacts on existing contract arrangements and have these been incorporated?* *Include date Deputy CFO has signed off the affordability and has this been incorporated within the financial plan. Include details of funding source(s)*	Date Deputy CFO sign off ……
Quality Focus *(Identify how this proposal impacts on the quality of services received by patients and/or the achievement of key performance targets* *Include date the Director of Nursing has signed off the quality implications)*	Date Director of Nursing sign off……..
Clinical Engagement *Outline the clinical engagement that has been undertaken*	
Consultation, public engagement & partnership working implications/impact	All arrangements have been co-produced with the other two statutory organisation and the wider LCSB partners
NHS Outcomes *Please indicate (highlight) which Domain this paper sits within by highlighting or ticking below:* *Please note there may be more than one Domain.*	Domain 1 Preventing people from dying prematurely; Domain 2 Enhancing quality of life for people with long-term conditions; Domain 3 Helping people to recover from episodes of ill health or following injury; Domain 4 Ensuring that people have a positive experience of care; and Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Executive summary

The guidance in "working together" focuses on the core legal requirements for individuals, organisations and agencies must or should put in place to keep children safe.
The key actions for the CCG were to participate in the production of the Multi agency safeguarding arrangements (MASSA) and ensure that they were signed off and published by the 28th of June 2019.To review, refresh and publish the Child Death Overview Panel (CDOP) process by the 28th of

June to 2018.The CCG has complied with the requirements and the arrangements will transition between now and the end of September 2019.
Recommendation(s) New arrangements to be monitored closely to ensure early detection of any unreported or unregistered safeguarding risks across East Berkshire.

Purpose

The purpose of this paper to advise the Governing Body of the statutory changes required following the publication of Working Together 2018 and to provide assurance of compliance.

Introduction

Working Together 2018[1]

In July 2018, the Department for Education published a new edition of the statutory guidance 'Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children' (Department for Education, 2018). The new guidance followed a government consultation, launched in October 2017 which set out the changes needed to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act 2017.

The guidance sets out what organisations in England must do to safeguard all children and young people under the age of 18. Key areas of amendment and change include:

- assessing need and providing help
- organisational responsibilities
- multi-agency safeguarding arrangements
- local and national safeguarding practice reviews
- child death reviews.

Health organisation must ensure awareness of the amendments. The new legalisation directs specific responsibility for the CCG for: local multi-agency safeguarding arrangements, local and national practice reviews and child death reviews:

Multi-agency safeguarding arrangements

- Local Safeguarding Children Boards (LSCBs) will be replaced by "safeguarding partners."
- Under the new legislation, three safeguarding partners (local authorities, chief officers of police, and CCGs) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area.
- The 3 safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. These arrangements were published on 29 June 2019, and will be implemented 29 September 2019.

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

- To fulfil this role, the three safeguarding partners set out how they will work together and with any relevant agencies. The three sets of arrangements (Bracknell Forrest, Slough and RBWM) are attached to this paper.
- All 3 safeguarding partners have equal and joint responsibility for local safeguarding arrangements.

Local and national child safeguarding practice reviews

- The guidance sets out the process for new national and local reviews. The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners. The Child Safeguarding Practice Review Panel operates from 29 June 2018, and will consider all notifications of serious incidents.
- The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.
- The Panel must decide whether it is appropriate to commission a national review of a case or cases
- The Panel must set up a pool of potential reviewers who can undertake national reviews, a list of whom must be publicly available.
- Local safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area.
- A copy of the rapid review should be sent to the Panel who decide on whether it is appropriate to commission a national review of a case or cases.
- The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

Child death reviews

- The guidance replaces the requirement for LSCBs to ensure that child death reviews are undertaken by a child death overview panel (CDOP) with the requirement for "child death review partners" (consisting of local authorities and any clinical commissioning groups for the local area) to make arrangements to review child deaths.
- **The Child Death Review Statutory and Operational Guidance**[2] have been published October 2018. This guidance sets out changes to the child death review process and governance arrangements; the CCG and Local Authorities were compliant and published their arrangements on the 28 June 2019 for implementation by 29 September 2019.
- This guidance specifies there should be reviews of all deaths children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.
- This guidance specifies that reviews have "the intention of learning what happened and why, and preventing future child deaths" and that "the information gathered … may help child death review partners to identify modifiable factors that could be altered to prevent future deaths." (replacing the previous wording that set out that Child Death Overview Panels (CDOP) should look to determine "whether the death was deemed preventable")

[2] https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england