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**Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children** was published on 4<sup>th</sup> July 2018 following changes brought about by the Children and Social Work Act 2017. The new guidance replaces Working Together 2015. Changes include:

**Updates to the following:** *Introduction, Chapter 1 - Assessing need and providing help and Chapter 2 - Organisational responsibilities*  
**Significant revision of the following:** *Chapter 3 - Multi-agency safeguarding arrangements, Chapter 4 - Improving child protection and safeguarding practice and Chapter 5 - Child death reviews*



## Working Together to Safeguard Children 2018



2

In the new guidance, “safeguarding partners” have replaced Local Safeguarding Children Boards (LSCBs). The three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area.

‘Relevant agencies’ are those organisations whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children.

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The full Statutory Guidance for Working Together 2018 can be found at: <https://www.rbscb.org/professionals/>

The NSPCC have also provided a [summary of changes](#)

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The guidance includes a new section on “people in positions of trust” highlighting that “organisations and agencies working with children and families should have clear policies for dealing with allegations against people who work with children”.

Other changes relate to specific organisations.- details at [www.rbscb.org](http://www.rbscb.org)

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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.

Information on the rapid review process and criteria, and guidance safeguarding partners must consider is also included

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The guidance highlights that practitioners should be alert to the potential need for early help for children in particular circumstances  
The guidance also includes:

- 1) a new section on referral highlighting that anyone with a concern about a child’s welfare should make a referral to local authority children’s social care.
- 2) a myth busting guide to information sharing
- 3) a new section on assessment of disabled children and their carers; young carers; children in secure youth establishments;
- 4) a new section on [contextual safeguarding](#).

4

The guidance sets out the process for new national and local reviews which replace Serious Case 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.

Details of the new ‘rapid review’ process, whereby the safeguarding partners must gather the facts about the case in order to decide if a review is appropriate, is included within the guidance and within [transitional guidance](#).