Review of Section 12 [MAKING A REFERRAL TO BUCKINGHAMSHIRE COUNTY COUNCIL CHILDREN & FAMILY SOCIAL CARE] Buckinghamshire Healthcare Trust Safeguarding Policy by @MandateNow

There is no law requiring alleged or even 'known' child abuse to be reported to the 'authorities.' With this at the foundation of child protection for all 'Regulated Activities' [as defined in SAFEGUARDING VULNERABLE GROUPS ACT 2006] which includes most institutional settings, we have reviewed sections 12 and 16 of the Buckinghamshire Healthcare Trust Safeguarding Policy to see if, in the absence of mandatory referral, whether the Trust has recreated a reliable staff and administration referral scheme and on that supports staff to make the most challenging of call they are ever likely to face.

The Trust's policy is on the left with @MandateNow comments on the right. Those which are highlighted are of particular concern.

Procedures need to be worded as a sequence of instructions in the form of "In circumstance A, identified person B shall take action C". This barely exists in the policy. The flow charts are cut and pasted from 'guidance' documents and need to be supplemented to make them relevant to the Trust's policy which is mostly absent of procedure.

For text and flow charts to work together effectively, what is needed is as follows

1. The text should be, but in this case sadly is not, the primary description of the procedure
2. The flow chart should be an aide-memoire summary of the text. Each box in the chart should mention a specific numbered paragraph of the text which contains the full and authoritative specification of the procedure being referred to. But none of this is present in the Trust's policy.

12. MAKING A REFERRAL TO BUCKINGHAMSHIRE COUNTY COUNCIL CHILDREN & FAMILY SOCIAL CARE	
12.1 Introduction	
12.1.1. If it is believed that a child is suffering, or may be at risk of suffering significant harm, then those concerns must be referred to Buckinghamshire County Council (BCC) First Response Team.	The referral is only made if it is "believed" that the child is suffering significant harm. And if, following a decision having been taken on the concern is believable, it 'must' then be referred to the First Response Team of the Local Authority who have experienced in these matters. This statement does not provide an assurance that **all concerns will be discussed with the Local Authority First Response Team** for independent assessment.
12.1.2. Referrals can be made 24 hours a day as there is an out of hours emergency Children and Family Social Care team. These children are often referred to as 'Children in Need of Protection 'under Section 47 of the Children Act 1989.	
BUCKINGHAMSHIRE SOCIAL SERVICES **FIRST RESPONSE TEAM** **0845 4600001** **Local rate: 01296 383962** **Out of hours – Emergency Duty Team – 0800 9997677** **Secure email: secure-cypfirstresponse@buckscc.gcsx.gov.uk**	
12.1.3. BCC Children & Family Social Care also has a responsibility towards all children whose health and development may be impaired without the provision of support and services; and this includes children who have a disability. These children are often referred to as "Children in Need" under Section 17 of the Children Act, and can also be referred to BCC Children and Family Social Care if it is felt that they can or should provide services to support the child and/or their family.	Nothing in this paragraph describes what must be done in order to discharge this responsibility. In particular there is nothing in this paragraph on the subject of "making a referral," so it is either useless or in the wrong place or both.
12.1.4. If a child is from a neighbouring local authority it will be necessary to contact the individual Social Care department to establish what systems they have in place and to whom to make a referral see appendix 8.	Which child? We haven't actually got to the point of starting a referral process yet, so it seems a premature to be describing exceptions to it.

12.2. Consent/Consultation	
12.2.1. In accordance with Inter-Agency procedures and as a matter of good practice, professionals should seek to discuss any concerns with the parent/carer of the child/children. Where possible, seek their agreement to making a referral to BCC Children & Family Social Care. However, if the referrer believes that seeking consent would place the child at increased risk of significant harm it would not be appropriate to discuss or inform the parents or carers of the referral.	What is the definition of a 'professional,' where does this definition start and stop, particularly as safeguarding is apparently everyone's business? "Should", "appropriate", "where possible". In essence these are forms of word which leave the matter at the complete discretion of whoever is supposed to be following this procedure. Discretion is incompatible with a functioning child protection policy.
12.2.2. Depending on the child's age and understanding it may be appropriate to discuss the concerns with them.	"Appropriate" again. Unlimited discretion.
12.2.3. If professionals are uncertain about a situation and require advice they can contact the Named Nurse Child Protection Team or consult BCC Children & Family Social First Response Team by telephone for a discussion on a no-names basis.	"Can" Not even "should". If advice is required then you "can" contact BCC. Why not must? Clarity of language is an essential component for effective safeguarding.
12.3. Timescale for referrals	
12.3.1. When a professional makes contact with BCC First response team with concerns about a child's welfare, it is their responsibility to clarify the nature of concerns, how and why they have arisen, and what appear to be the needs of the child and family.	The policy clearly now refers to 'professionals' in the hospital – these are defined as whom? "Responsibility to clarify"? Why not just state the concerns? Written record not mentioned here.
12.3.2. If professionals identify that there is possible or actual significant harm to a child then the referral should immediately be made by telephone to the first response team, followed by the completion and sending of a Multi Agency common referral form (Appendix 3) to First Response within 24 hours. Ideally the referral form should be sent to the First response secure email address via an nhs.net email account. If professionals do not have an nhs.net account then it should be hand delivered (see appendix 9) or posted via recorded delivery. A copy should always be sent to the Named nurse for child protection team.	**Discretionary "should" is everywhere. Possible or even actual significant harm and all the Trust requires is that a referral "should" be made that might or might not be fulfilled. "*Possible* or actual significant harm" is a different threshold from 12.1.1 "it is *believed* that a child is suffering significant harm"** **Whichever of the two thresholds it is it only 'should' be reported.**

12.3.3. All other referrals should be made within 24 hours of a child being identified as being in need and requiring support/services/assessment. This should also be done by sending a Multi-Agency Referral Form to BCC Children & Family Social Care First Response Team, or by telephoning them, followed by the completion of a referral form within 24 hours as already detailed. A copy should always be sent to the Named nurse for child protection team.	Let's hope these referrals are made – because the consequences for failing to perform to this low 'expectation' set by the Trust are unexplained.
12.3.4. When making a referral it must be made clear exactly what your concerns are and you must be sure that the social worker has correctly understood your concerns.	So when the Trust employees have made their 'discretionary' decision to refer a 'must' appears in the vocabulary of this document which is pointless. This paragraph's subject matter seems to be repeating 12.3.1. Is there are reason for this duplication?
12.4. The Assessment Framework	
12.4.1. Making a Referral.	See below
All referrals to BCC Children & Family Social Care First Response Team should be made by completing a Multi-Agency Referral Form Appendix 3. This can also be down-loaded from the BHT staff intranet http://swanlive/policies-guidelines/child-protection or BSCB web-site. www.bucks-lscb.org.uk	This appears in subject matter to duplicate part of 12.3.2 and 12.3.3, with the website added.
12.4.2. The following points should be observed when making a referral:	"Should;" indicates the discretionary nature of reporting known or alleged abuses.
• All indicated sections of the referral form must be completed. If information is not known, this must be recorded accordingly.	We only "should" fill in the form, but we "must" fill in all parts of it if we do decide to complete it.
• The form must clarify whether it is a new referral or confirmation of a telephone call.	
• The form must be legible and completed in accordance with the relevant Trust's record keeping policy. Typing of the forms is preferable; however, if the form is hand-written, care should be taken to ensure that all of the information is readable.	Why is this not completed electronically?

• It should be identified whether the family is aware of the referral and if they are not, the reasons why.	Once more merely an 'expectation' rather than a requirement.
• Section 1, Box 11 is the most crucial. The reason for the referral needs to be identified here in a clear, concise and relevant manner. A separate sheet of paper can be used to provide this if necessary, which should be stapled to the form if hand delivered. You should not presume that information previously provided or known to Children & Family Social Care has been re-read. Include a summary or reference to any previous concerns or referrals.	Why not say 'must be identified'? 'Needs to be' is a grey phrase hovering partway between the discretion of "should" and the authority of "must". It is stating as a fact that a clear reason is needed on the form, but doesn't quite require the professional to supply the reason.
• The information should be presented in a logical format by considering and including information you have regarding the child's developmental needs; their parents/carers' ability to meet their needs; and wider family and environmental factors as identified in the Assessment Framework	Another expectation, but not a requirement.
• **Referral forms and other information must only be faxed to Children & Family Social Care, if in an urgent situation, the faxing of information is necessary in order to protect a child. In such circumstances, the Trust guideline on faxing should be followed.**	
Ref: BHT - Protocol for the Transfer of Personal Data by Facsimile (fax)	
12.4.3. A copy of the referral form should be sent to the Named Nurse for the relevant area and a copy filed in the notes.	"Should" – once more merely an expectation not an instruction.
12.5. Response from BCC Children & Family Social Care to a Referral	
Referrals are assessed by the First Response Team to check the seriousness and urgency of the concerns. The First response team aim to act on the referral: Within 3 hours if the decision is that the information indicates high risk. Within 24 hours if the decision is that the information indicates medium risk. Within 72 hours if the decision is that the information indicates low risk. The referrer will be informed of the outcome of their referral. However, if an outcome is not forthcoming, the referrer is required to contact the First Response Team within 3 days (or earlier if the referral was more urgent) to clarify the outcome.	This describes what the Trust understands the Local Authority First Response Team actually do. It doesn't specify what the LA 'must' do. Is this part of the Trust procedure specification or is it informative text describing a procedure actually specified elsewhere? Moreover, what the First Response team does with the information is outside the control of Bucks NHS Trust and therefore arguably has no place in these procedures except as an informative note.

12.5.2. Referrals to BCC Children & Family Social Care First Response Team may have 5 outcomes: - No further action - Signposting or referral to another agency such as the Family resilience service for early help - Transfer to CIN unit for assessment and the provision of services under section17 (Children Act 1989) - If there reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm a Section 47 (Children Act 1989) inquiry is initiated and transfer to CIN unit for further assessment and the provision of services - Or emergency action to safeguard and promote the welfare of the child	
12.5.3. It may be appropriate to challenge a decision made by BCC Children & Family Social First Response Team in response to a referral, as stated in the Inquiry into the Death of Victoria Climbie (DH 2003), especially if it is to clarify that they have understood the nature of the concerns. The named child protection professionals can support staff with this if necessary.	
Ref: BSCB Procedure - Conflict Resolution between Practitioners or Agencies.	Where can this document be found? Which version is applicable? Which clauses relate to this issue?
12.6. Assessment	
12.6.1. Under the children Act 1989 for each referral that is accepted, social care will analyse the nature and level of risk and harm, undertake an assessment of the needs of the individual children to determine what services to provide and action to take. Since April 2013 there is no longer a requirement to conduct separate initial and core assessments; this is to facilitate a shift to an assessment process which brings continuity and consistency for children and families.	

12.6.2. Assessment is undertaken in accordance with the Framework for the Assessment of Children in Need and their Families (DH 2000) (Appendix 2). Information is gathered and analysed within the 3 domains of the Assessment Framework. All relevant information will be taken into account, including seeking information from relevant services, e.g. health.	Descriptive text again. Is this part of the procedure?
12.6.3. The speed with which an assessment is carried out after referral is determined by the level of risk and the needs identified. 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. Where particular needs are identified at any stage of the assessment social care should not wait for the assessment to reach conclusion before commissioning or providing the services.	
12.7. Early Help	
12.7.1. Providing early help is more effective in promoting the welfare of children and sustaining positive outcomes than reacting at a later date when the child is at increased risk. Health based services such as health visiting; school nursing and the family nurse partnership provide early intervention and prevention work. Children's centres are a particular effective source of early help for families with children under the age of 5 years. There is a range of other services within Buckinghamshire and the Family information service is the key information bank to obtain knowledge of these services; http://www.bucksfamilyinfo.org/kb5/buckinghamshire/fsd/home.page	This is descriptive text. What is the procedure?
12.7.2. Where there are multiple issues, low level additional support through a multi-agency coordinated approach is appropriate. In Buckinghamshire this is now provided by the Family Resilience service. It is a consent based service and referrals are taken over the phone; 08454 600 300 (Monday – Friday 9.00 – 16.30).	This is descriptive text. What is the procedure?
12.7.3. Professionals should be alert to the potential need for early help and refer to appropriate services as necessary. Social care may sign post professionals to make a referral to the Family resilience team or they make a referral to the team themselves if they assess that it doesn't meet social care threshold.	More "should"

12.8. Child in Need	
12.8.1. A child in need is defined under Section17 of 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 with significantly impaired, without the provision of services; or a child who is disabled. When assessing children in need and providing services, social care may need to provide specialist assessments and should coordinate care so that the child and family experience a coherent process and a single plan of action.	"May need to provide". Descriptive, or discretionary. Not clear which. Certainly not a clear procedure.
12.9. Strategy discussion	
12.9.1. At any point in the process when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm, a strategy discussion involving Children's Social Care, the police and other agencies such as health will take place. This may be as soon as a referral has been made. As a health professional you may be invited to a strategy meeting, your role is to share relevant information about your involvement and the health and development of the child in question. The purpose of the strategy meeting is to decide whether Section 47 enquiries will be initiated or continued and plan how these will be handled, including action required immediately to safeguard the child.	"a strategy discussion … will take place" however nothing is specified as to who will call it, or when or where or why.
12.10. Suspected actual or likely significant harm	
12.10.1. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life, in the best interests of children. It gives local authorities a duty under section 47 to make enquiries when they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or likely to suffer, significant harm, to enable them to decide whether they should take action to safeguard or promote the child's welfare.	Informative text concerning the legislation. Contains no procedures.

12.10.2.This statutory guidance adopts specifically the legislative terminology of 'significant harm' in preference to the use of the word —risk, given the need both to reflect the legislative requirements and to avoid confusion with the wide variety of contexts and associated tools and methodologies associated with risk assessment/analysis. When assessing whether a child is suffering, or likely to suffer, significant harm, local authority children's social care will, of course, draw on a wide variety of information, including the outcomes of relevant risk assessments or judgments provided by other agencies and professionals, to inform their own evidence based assessment.	This child protection policy document is NOT statutory guidance. This text is copied and pasted from the guidance document 'Working Together to Safeguard children 2010' paragraph 5.49. The definition of 'significant harm' is contained in the Children Act 1989 Section 31(9) and it should be engrossed into this policy document. Statutory guidance is guidance as to how procedures should be designed. This document is *supposed* to be the result of that guidance and therefore procedural.
12.10.3 Where a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by Section 47 of the Children Act (1989) to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child.	**It is understood that "the local authority is required", but what is the procedure by which the LA fulfils this requirement?** Also, Bucks healthcare NHS Trust has no control over what the LA does. The child protection procedure should be dealing with what employees of the Trust must be doing.
12.10.4 Where there is a risk to the life of a child or a likelihood of serious immediate harm, police or social care should act to secure the immediate safety of the child. This emergency action should then be followed by Section 47 enquiries.	
12.11. Section 47 enquiries	
12.11.1 When a child is suspected to be suffering or likely to suffer significant harm, Children's Social Care are required to make enquires to decide what action they should take to safeguard and promote the child's welfare. These are known as Section 47 enquiries. The Children Act places a statutory duty on other agencies, including health, to help Children's Social Care with these enquiries. Section 47 enquiries may have three outcomes: - Concerns are not substantiated, although they may still require support as a child in need,	Informative text. What is the procedure?

- Concerns are substantiated but the child is not judged to be at continuing risk of significant harm, for example if the perpetrator no longer has contact with the child or it is judged that those involved are willing and able to co-operate with actions to ensure the child's safety and well-being. - Concerns are substantiated and child is judged to be at continuing risk of significant harm. In this case a child protection conference should be convened. - A strategy discussion/meeting will decide if a Child Protection Investigation is to be single agency – social care or will run concurrently with the Police investigation concerning possible associated crimes. Some cases will also be police single agency investigations these include: allegations of childhood abuse made by adults and where the alleged abuser is not known to the child or the child's family.	Nothing is stated as to who calls the strategy meeting, when the meeting will be called, and once again its passive voice.
12.12. Initial Child Protection Conference	
12.12.1.An initial child protection conference brings together family members, the child (where appropriate) and those professionals most involved with the child and family following Section 47 enquiries, which have concluded that a child is at continuing risk of significant harm.	Informative text. What is the procedure?
12.12.2 Its purpose is to: - Bring together and analyse in inter-agency setting information about the child's health and development, and the parents' capacity to ensure the child's safety and to promote their child's health and development. - Make judgments about the likelihood of the child suffering significant harm in the future, - Decide and plan future action needed to safeguard and promote the welfare of the child, along with intended outcomes.	Informative text. What is the procedure?

12.12.3 Any health professional that has a (significant) contribution to make to the conference will be invited to attend. Attendance at conference needs to be considered as high priority and a written report provided (see report writing guidelines and template in Appendix 4A & 4B). It is advisable for health professionals to start a chronology of significant events to be kept in the child's records. This will aid practitioners in identifying and analysing events that impact the child's health and development give indications of any emerging patterns and will help in any further report writing. Guidance on Chronologies is included in Appendix 5A.	Who makes that decision about invitations & on what basis? **"It is advisable to start a chronology." The wording suggests people are free to ignore this advice, yet a chronology frequently becomes a key document for the agencies, yet in this policy it is merely a suggestion.**
12.12.4. If the decision of the conference is taken that the child is at continuing risk of significant harm then the child will become subject to a child protection plan under one or more of the following categories: physical abuse; sexual abuse; emotional abuse or neglect.	Informative text – or is this supposed to be a procedure? If it is a procedure, it is a procedure applicable to LA social care, not the local NHS Trust
12.12.5. A range of tasks including appointing a key worker, the lead professional and identifying membership of the core group will be agreed. Identifying further assessments, outlining the child protection plan and a contingency plan, if agreed actions are not completed, or circumstances change, will be undertaken, and the date for the first review child protection conference, usually 3 months later, will also be agreed.	Informative text – or is this supposed to be a procedure?
12.12.6. Discontinuing the Child Protection Plan should never lead to an automatic withdrawal of services	"Should" again, even though it is followed by "never."

12.13.1. Flow Chart 1: What to do if you are worried a child is being abused	In the body of the text, clauses 12.1.1 and 12.3.2 describe the initial reporting procedure. This flowchart doesn't resemble either clause. The flowchart starts from "trust employee has concerns about a child's welfare" which is different from either "believed that a child is suffering, or may be at risk of suffering significant harm" (clause 12.1.1) or "possible or actual significant harm" (clause 12.3.2). the reporting arrangements are different depending on the level of concern and whether the staff member with that concern is on the Hospital staff or the Community staff. Having two different procedures covering the same subject matter is a likely cause of confusion and error. **A flow chart itself is not an adequate description of a reporting procedure because there is insufficient space in the boxes for a full explanation of the actions to be taken. Procedure needs to be in accompanying test where it is missing.**
12.14.2 Flow chart 1a: Action taken when a child is referred to local authority children's social care services (Working Together 2013)	
12.14.3 Flow chart 2: Immediate protection (Working Together 2013)	
12.14.4 Flow chart 3: Action taken for an assessment of a child (Working Together 2013)	Last 2 boxes vague as to what "could" be done or just examples given.
12.14.5 Flow chart 4: Action following a strategy discussion (Working Together2013)	
12.14.6 Flow chart 5: After child protection conference (Working Together2013)	

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