

Advanced Child Protection UPDATE Training Handout

This course is commissioned for professionals from all organisations by the South Gloucestershire Children' Partnership.

The children's partnership is the strategic body that ensures children are safeguarded with appropriate policies and procedures and ensures the children's workforce has access to multi agency training to help equip them working together effectively for children and families. Your feedback on today's course will go directly to the partnership to help ensure the training offer is the best it can be.

This package is designed to complement the trainer led facilitation of this training through discussion and activities. It is put together as a learning aid, and to signpost and encourage additional learning and further development.

Please note that safeguarding and child protection policies and practices change and are frequently updated. Some slides used in the session may not be included as the presentation is continually evolving.

It is entirely your choice whether you use this as a digital resource or print. **There is no requirement to bring a copy to the training session unless this would support your learning style and needs.**

There are additional resources available via the HRLearning & Development website/course details. These include documents relating to specific information and links to resources that you may find useful.

In addition to this training, you will benefit from regular continuous professional development specific to your role. The NSPCC Learning service has amazing resources. Sign up to their CASPAR service to be notified of the latest developments and research. [CASPAR | NSPCC Learning](https://learning.nspcc.org.uk/newsletter/caspar) (<https://learning.nspcc.org.uk/newsletter/caspar>)

Please do raise any feedback or resource support needs by email to: HRlearninganddevelopment@southglos.gov.uk



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Session Aims

- Reinforce understanding of current legislation, policies, procedures and best practice in safeguarding
- Increase confidence in utilising local tools and resources to support practice
- Encourage and signpost to opportunities to develop knowledge and understanding of emerging safeguarding themes
- Discuss and signpost to learning from local case reviews



Recommendations & Reform



Children's Social Care National Framework, published in 2023, is statutory guidance that sets out the purpose of children's social care as existing to support children and families, to protect children by **intervening decisively** when they are at **risk of harm** and to **provide care for those who need it**, so they **grow up and thrive with safety, stability, and love**



Children's Social Care National Framework

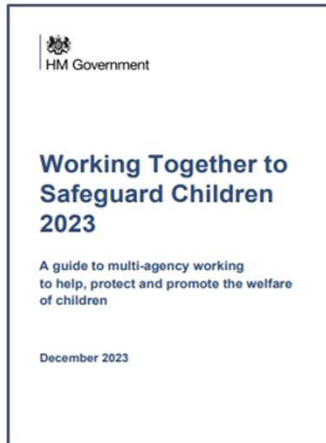
The four outcomes which children's social care should be aiming for are:

- Children, young people and families stay together and get the help they need
- Children and young people are supported by their family network
- Children and young people are safe outside their homes
- Children in care and care leavers have stable and loving homes



Updated Statutory Guidance 2023

Emphasis on:



- Strong multi-agency relationships...to offer 'tailored' support
- Early Help – Risk factors to be considered (Early Help Guide)
- Safeguarding S17 – A wider range of professionals can be the 'lead professional'
- Children with disabilities – Social Care role clarified
- Considering risks children face outside of the home



Child Safeguarding Practice Review Panel Dec 2024



Spotlight Themes

1. Safeguarding children with mental health needs
2. Safeguarding pre-school children with parents with mental health needs
3. Extrafamilial harm

The report highlights how professionals can struggle to find the best and right resources needed to help keep children safe.



Child Safeguarding Practice Review Panel Dec 2024



The Six key practice themes to make a difference:

1. Critical Thinking & Professional Challenge
2. Whole family approach
3. Racial, ethnic and cultural identity and lived experience impact
4. Vulnerability of babies
5. Domestic abuse and harm to children
6. Risks outside the family



Child Safeguarding Practice Review Panel Dec 2024



The Six emerging themes last three reports = : Still relevant

1. Parenting capacity and children with disabilities and health needs
2. Children with complex mental health needs
3. Parental mental health and parenting capacity
4. Children not in school
5. Young carers
6. Working with Gypsy, Roma and Traveller communities



**Multi Agency
Quality Assurance Audit:
Domestic Abuse
Dec 2024**

The ten children chosen for this audit were aged between unborn and 7 years old at the time of the audit.

The children have a range of needs and experiences in addition to domestic abuse including parental mental health, parental autism, traveller family, parental substance misuse, parent is a care leaver, neglect

The audit of 10th December 2024 reviewed the records of eight children where there is a Child Protection plan or Child in Need plan under the category of domestic abuse for children under 7 including unborn children. This used the criteria of the current JTAI theme.

The aim of the audit was to ascertain whether there were good multi-agency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, and the Children's Partnership policies and procedures.

What we are worried about?

- Hard to see and hear information about the children because of the complex adult issues
- Being able to see a holistic picture – tendency to focus on one issue and lose sight of other worries
- 'Start again' pattern following a Marac to Marac transfer.
- Lack of clarity about who the men are in families audited, some assumptions about adults involved being 'dad' when they are not
- Child in Need review meeting notes not visible on social care record – unclear if they have taken place, midwifery and DHI not included
- Limited evidence of co-ordinated approach taken at Child in Need level
- Escalation process not used by any agency
- Lack of use of tools by practitioners
- Voice of child missing but older siblings heard, or children as a collective recorded. Each child needs to be heard.

What Good Practice did we see?

- Think family work undertaken by maternity
- Good information sharing, right support at the right time
- Domestic Abuse screening took place throughout pregnancy
- Clear on records about risk of Domestic Abuse
- Use of traveller network to establish trust
- Perpetrators working with Drive
- Regular contact between social care and probation
- Transition between infant and junior school, with good information sharing
- Voice of father clear in some of these audits
- Joint visit with Health visitor and social worker

Eight cases were audited by the multi agency group and six of these were discussed during the audit meeting

Themes for Learning: Start again

- Incident led responses rather than holistic review of chronology and history
- Moving in or out of area and transition is a risk time for starting again
- Pattern of non engagement/avoidant behaviour – parent engages initially and then drops away – review history to make sure patterns are identified and not seen as a one off
- Recognition of cumulative risk and impact of harm is needed
- Recurring pattern of repeat child protection plans and PLO process seen in this audit

Themes for Learning Domestic Abuse alongside other complex issues

What we found: Complex Families

- Parental mental health became focus rather than DA
- Difficult to understand who is the protective parent, who is perpetrator
- Understanding of additional risks due to cultural identity

What needs to Happen?

- Consider use of a multi agency meeting when there are complex family cases
- Ensure all those working with the family are included in multi agency work
- Work alongside the Traveller Liaison Service or other specialist provisions

Domestic Abuse Training – this is for practitioners from all agencies [Click for more](#)

What is a day in the life of each child like? It is easy to lose sight of this in complex family situations. Each child needs to be heard

Records need to be clear about who is in the room, naming the adults and their relationship to the child

Maintain respectful uncertainty rather than accepting all you are told

For escalation click here

Domestic Abuse Tools are available by clicking here

Traveller Liaison service – more information here

Organisations that audited their involvement with the ten children were: GPs, Social Care, Sirona, NBT, AWP, Next Link, Police, YJS, EDT and Preventative Services, Education.

**Multi Agency
Quality Assurance Audit:
Young Adults under 25
November 2024**

The adults reviewed for this multi agency audit are aged between 18 and 25.
3 are female and 3 are male.
3 live in supported accommodation.

The adults in the audit have a range of issues including domestic abuse, drug and alcohol misuse, being a care leaver, mental health, sexual abuse, exploitation, learning disability, Autism, ADHD.

The audit of 13th November 2024 reviewed the records of six adults who were identified through Adult Safeguarding on the theme of transition. All the adults are under 25 years of age.

The aim of the audit was to ascertain whether there were good multi-agency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, SGSAB policies and procedures and the six key principles underpinning all adult safeguarding work.

What we are worried about?

The audit group saw concerns in terms of:

- GP not aware of safeguarding for one adult
- Flags not available to show care leaver status
- Information about care and support needs not available to police
- Advocacy not included in any of the cases and all of them could have had an advocate - doesn't appear in records to have been considered
- One adult mainly known to police because of raising concerns for a sibling and in relation to domestic abuse – but not known in their own right as being at risk
- One adult not spoken to directly, and another has not had their voice heard
- Recognition of the vulnerability of adults who commit offences when they have also been identified as a victim on multiple occasions.
- Gap in information sharing with GP for one adult who would be having an annual health check so key information would not be known.

Theme: Advocacy

None of the adults in this audit had an advocate and there is no evidence that advocacy has been offered to them.

If advocacy has been considered it has not been recorded.

This has been a recurring theme throughout audits this year.

Numbers of young adults under 25 being referred to advocacy is low.

Recommendation that this becomes a priority for SAB for 2025

To make a referral for advocacy in South Gloucestershire contact Voiceability. Click this box to see the services they offer

Use of advocacy is a recurrent theme in SAB audits we would like to know more about this and make it better – please click this box to complete a short survey

What Good Practice did we see?

- Voice of the adult heard for four adults
- Good relationship with mental health practitioner
- Care leaver has a personal adviser (PA) however no evidence that other practitioners were working with the PA, or considering join up
- Good use of DASH
- Strong evidence of multi agency working for some of the adults

You can still request an advocate for someone who has capacity – always consider this

Think about language when recording – this audit found the use of the terminology 'catfished' which could minimise the impact of the abuse/deception that took place

Anyone can call a multi agency meeting – always consider if this would help

There was learning for this audit that children's services should always be included when auditing on the theme of transition

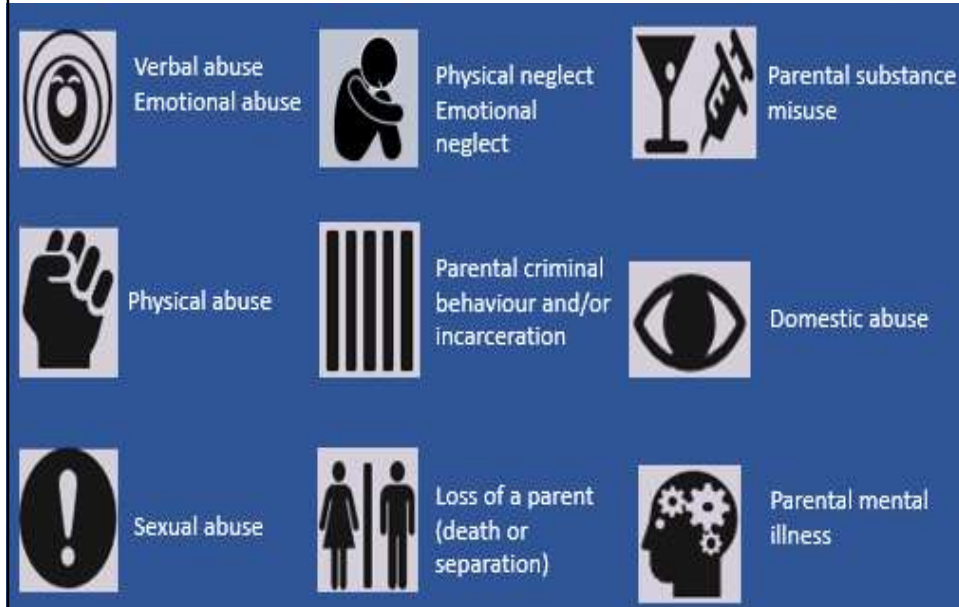
Organisations that audited their involvement with the six adults were: Adult Social Care, Sirona, Police, GPs, DHI, Bromford & Voiceability

Click these circles for more information

Care Leaver Offer and information – Click here for information

Self Neglect Bitesize sessions include info about calling a multi agency meeting Click to book

Adversity & Trauma - ACEs?



Disguised Compliance?

Non engagement
or
Avoidant behaviour



Disguised Compliance?

Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993).

Important that practitioners can recognise disguised compliance, establish facts and gather evidence about what is actually happening in a child's life.



Keep an open mind!

Be Curious – Non-Engagement – Avoidant Behaviour?

The increasing ease with which the **label** 'disguised compliance' is used puts the **focus on parents as the problem**, rather than encouraging professionals to think about a **two-way relationship** and their behaviour in it.

(Forrester et al 2012 – Parental resistance and social worker skills: Towards a theory of motivational social work)



‘Concerns around caregiver engagement and patterns of behaviour can divert professional attention away from potential concerns for a child’s wellbeing. This can lead to cases drifting and risks increasing or prolonging harm’.



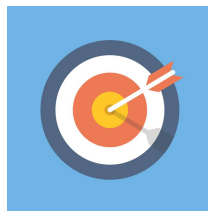
Learning from these case reviews highlights the importance of:

- maintaining professional curiosity and reflective thinking
- staying child-centred
- sharing information and working together.



Identifying Disguised Compliance?

- Conflicting accounts of family life from family members
- Conflicting accounts/evidence from different professionals
- Conflicting accounts from neighbours
 - Persistently unmet needs of children
- Presentation and behaviour of children conflicts with adult accounts
- Repeat incidents of harm/neglect to children
- Analysis of details, multi-agency chronology
- Observation of parent child interaction (convincing evidence that simulated sensitive parenting is difficult to sustain C4EO 2010)
 - Dependency
 - Closure
 - Flight





Sue Woolmore

Dealing with Disguised Compliance

VIRTUAL
COLLEGE

South Gloucestershire Children's Partnership Learning from Rapid Review April 2021 Family D

Who are Family D?

Family D are a mum and two children. It has been widely reported in the media that mum and the youngest child were murdered in Scotland, and the older child survived. This learning brief does not relate to the investigation into what happened in any way, but looks simply at learning for professionals and organisations.

Theme One: Professional Curiosity

What did we learn?

- Information taken at face value
- Process driven without looking at wider picture
- Not enough consideration given about ways to contact a parent when details are not on the system
- Lack of curiosity shown when exploring the vulnerability of an adult

What should we do differently?

- Ask further questions, be nosy, explore what is happening. Be careful not to simply accept what is happening without thinking about why it is happening
- Make sure you hear the voice of the child and all key people in the child's life, don't rely on one person's view
- Explore what a day in the life of the person you are working with is like



Be a curious practitioner

The Children's Partnership held a multi-agency rapid review to look for learning on 26th April 2021.



Professionals from 15 different agencies took part in the review

If my work comes to an end - who else needs to know what I know?

When English is not the first language, always consider use of interpreters

Seek evidence of Parental Responsibility

Theme Two: Working Together

What did we learn?

- Not all professionals knew who else was involved and didn't know about the Child in Need plan
- The professionals who saw the family most, had the least contact with other organisations
- Information was not shared as well as it could have been

What should we do differently?

- If you undertake an assessment think about who else should be told of the outcome, and who needs this noted in records
- At a transition point – for example changing school, closing a support package, change of team or service. Make sure other professionals know what is happening and share safeguarding records so that information is not lost
- Speak to families about who else they are working with

Theme Three: Parental Responsibility

What did we learn?

- Evidence was not always sought to check who does and does not have Parental Responsibility (PR) for a child

What should we do differently?

- Make sure this is routine practice, and that confirmation of PR is always seen

Evidence of Good Practice

- Speedy assessment by Social Care, and quick practical support
- Swift move to locality social work team
- Appropriate DVA coding on GP records for the family
- Good communication and relationships with education settings
- Additional resources, including a laptop, provided for home learning during covid
- Support for immigration status
- Regular contact from multiple agencies
- Good communication between agencies when unable to make contact
- Good multi agency response to missing episode

Theme Four: Children and Domestic Abuse

What did we learn?

- Two children left the home with their mother and were provided with emergency accommodation following a disclosure of domestic abuse, but there were other children in the home who remained
- The remaining children were not considered by police or subsequently by children's social care despite living in the same house and witnessing the same incident
- Lack of voice for mum in family court process

What should we do differently?

- Consider the impact of domestic abuse on all children within the family
- Remain curious even when another agency has already made an assessment of risk
- Ensure all appropriate information is available to court, especially relevant while case are being heard in a virtual space and ensure parents are aware when the case is happening

What is happening Now?

There is a single agency and a multi agency action plan to ensure the learning identified throughout this process is acted on in a timely manner. This is being monitored by the Child Safeguarding Practice Review Sub group on behalf of the Executive of the Children's Partnership.

Top Tips – Professional Curiosity



See It



Hear It



Explore
It



Check It



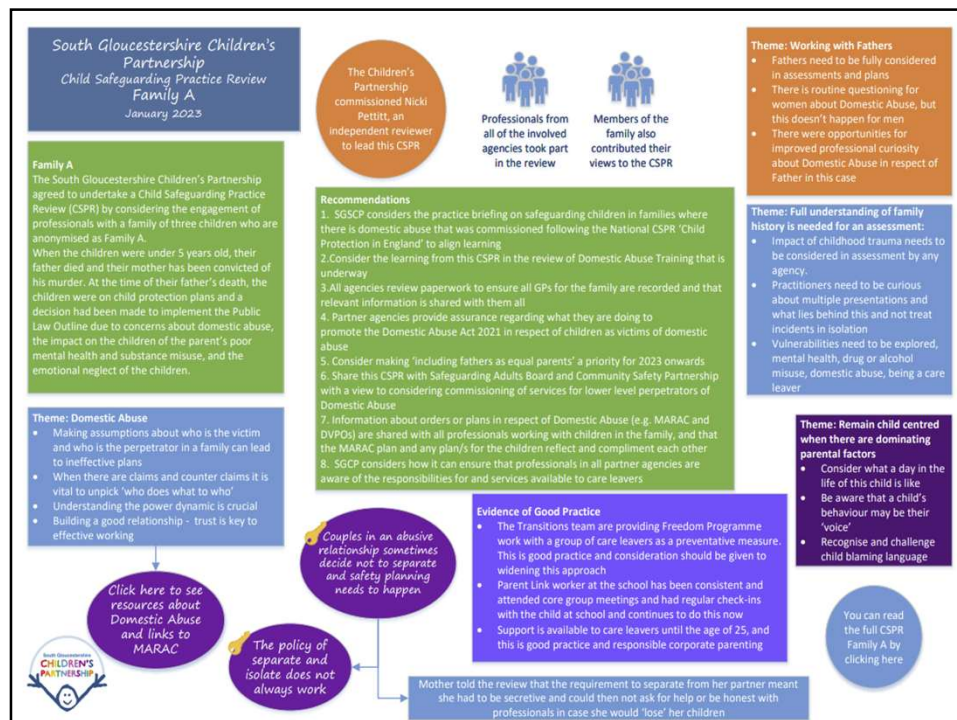
Professional Curiosity, Challenge & Courage

What
?

Why?

How?





Unseen Men – Learning From Case Reviews



- A lack of professional engagement and curiosity
- An over-focus on the quality-of-care children receive from their mothers
- Inadequate information sharing between services





South Gloucestershire Children's Partnership

Safeguarding is everyone's business

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Working with Fathers



Including Fathers – Self Assessment Checklist

This guide provides the key descriptors of evidence-based ways of working with fathers/male caregivers. This can include partners, stepparents, males in same sex partnerships and any male with caring responsibilities in the child's life. It is a self-assessment and planning tool, the outcome of which should lead to a clearer and shared understanding of the current ways of working with fathers within an organisation or service and what steps need to be taken to progress.

This tool is available [here](#).

There is also a video to support this which is available [here](#).

Downloads

[Working with Fathers](#)

Concerned about a child?

01454 866000 - Monday to Friday
01454 615165 - Out of hours/Weekends
 In an emergency please ring **999**

www.southglos.gov.uk


Bath & North East Somerset Community Safety & Safeguarding Partnership and South Gloucestershire Children's Partnership Child Safeguarding Practice Review

Baby M
April 2023

The two Partnerships commissioned Sarah Holtam, an independent reviewer to lead this CSPR

Professionals from all of the involved agencies took part in the review

Members of the family also contributed their views to the CSPR

Recommendations

There are four main recommendations each with a series of actions relating to each theme.

1. Health Recording Systems include a holistic assessment of a child's needs which includes contextual maternal and paternal family factors
2. The ICON Programme & Increasing awareness of Non Accidental Injury in Babies
3. Effective Transfer of Information between areas and services
4. Safeguarding Supervision arrangements for community health professionals which ensures there is a safe space for critical thinking in practice, promotes professional curiosity, and is a trauma informed approach to the family's needs when working with pre and post birth situations

Theme: Identifying and Responding to the vulnerability of babies

- Increasing awareness of the ICON programme to all practitioners including those outside of health providers
- Ensure physical health needs for a baby are balanced with understanding of wider factors, including parental needs, past trauma to gain a comprehensive picture

Theme: Keeping a focus on the child when they move between areas

- It was not clear where Baby M lived, agencies were reliant on what and when parents told them
- There wasn't enough curiosity about where Baby M was
- Information sharing was too variable between areas and health services and with housing providers. More collaboration was needed
- Practitioners should ensure housing providers are kept in the loop with key information and included in multi agency discussions

Theme: Critical thinking in Practice

'On the face of things' all appeared well for Baby M

- It is vital to understand the narrative of a baby's lived experience. What is the day in the life of a child like?
- Inquisitive, open minded practice ensures a holistic view of day to day life
- Lack of multi agency information sharing and decision making contributed to Baby M remaining at a universal support level

Theme: Recording systems

- Different pieces of information were seen in isolation, language and behaviours of parents and information about the past were not joined together
- Record keeping was poor at times with limited details
- Language used to describe situations was factually incorrect at times and did not distinguish fact from opinion or was not specific enough to describe what was being seen.

Understanding Wider Context in a Family

- One of Baby M's parents was a care leaver and the impact of this wasn't explored
- Family dynamics were not explored, including coercion and control that had been witnessed
- Housing vulnerabilities were not considered

Records need to be clear, accurate and specific so that when information is shared it is understood correctly


ICON Resources are available by clicking here

You can read the full CSPR Baby M by clicking here



Child L

Learning identified at a multi agency event
12th July 2023



Child L is a baby under one who has suffered injuries thought to be due to physical abuse with concerns about faltering growth

Theme: Faltering Growth

What is working well?

- Multi agency working between health visitor and social care strong with almost daily contact
- All South Glos professionals identifying concerns
- Curiosity and tenacity shown by professionals and information not taken on face value

What are we worried about?

- Clarity about who can weigh and measure babies. There is confusion about who is qualified/commissioned to undertake this and who should analyse this
- Child in Need meeting given a diagnosis from a consultant that there was a medical cause for Child L's growth, but there were differing views from medical professionals. Professionals felt unable to challenge
- Incorrect information sharing and missing information from other area about the child and whether Child L had a CP plan
- Rapid Access Clinic referral turned down
- Confusion about which teams would undertake assessments, across two regions
- Continuity interrupted due to complaints by family and also family attending appointments in different places

What needs to happen?

- Pathway for children with faltering growth requiring regular weights to be clarified, including who is their lead health professional, and a resource and pathway established for weighing those children where there are high level concerns.
- Single point of contact/voice needed for social care

Theme: Multi Agency Working

What is Working Well?

- Unwavering focus on the child
- Engaged and consistent GP
- Maintained working relationships through challenge
- Evidence of professional curiosity
- Evidence based practice drawing on learning from previous CSPP, and use of tools

What are we worried about?

- Change in decision about whether to have a strategy discussion
- Escalation within timescales
- Cross border information sharing between areas

What needs to happen?

GP and other professionals can seek advice from Community Paediatrician, reminder needs to be given

Theme: Attempts to mislead professionals/Not following advice

What is Working Well?

- Tenacity of professionals, appropriate challenge
- Professional triangulation of information
- Housing officer asked to see Child L

What are we worried about?

- Unclear of impact of parental learning needs, and possible coercive control to Mum
- Parents refusal to accept support
- Over optimism about parenting abilities
- Parental avoidance of all professionals and lying to professionals at times

What needs to happen?

- Professionals need to ensure they link up with others who are working with the family, consider joint visits
- Remain curious and don't accept information on face value

Theme: Response to Bruising in Non-Mobile Babies

What is working well?

- Bruise identified and CP medical took place
- Non mobile baby checks took place, Child L followed the protocol
- Assessment went ahead by children's social care

What are we worried about?

- NSPCC referrals happened prior to medical but not showing on all records
- Gap in information that was shared with the referrer
- Differing accounts given about what happened to cause the bruise

What needs to happen?

When information is shared as part of non mobile baby checks each agency to clearly record what is shared and their analysis around this

Theme: Locations, Cross Border Work

What is working well?


- Escalation used correctly
- Kept sight of the child when he could have been transferred

What are we worried about?




- Incorrect information sharing
- Housing had concerns in the other local authority, but hard to get the concerns shared in multi agency meetings
- Response to escalations

What needs to happen?

- Ensure the voice of practitioners who know the child/family well is heard to minimise risk of incorrect information



Injuries in NON-MOBILE Babies - 2023

Multi-Agency Guidance for
Injuries in NON-MOBILE Babies
2023

South Glos and Bristol multi agency working group
(Chair Dr Emma Bradley, Designated Doctor)


Ratified by: South Gloucestershire Children's Partnership
 Approved on: January 2023
 Ratified by: Bristol Keeping Children Safe Partnership
 Approved on: May 2023
 Ratified by: North Somerset Safeguarding Children's Partnership
 Approved on: June 2023
 Date for Review: January 2026

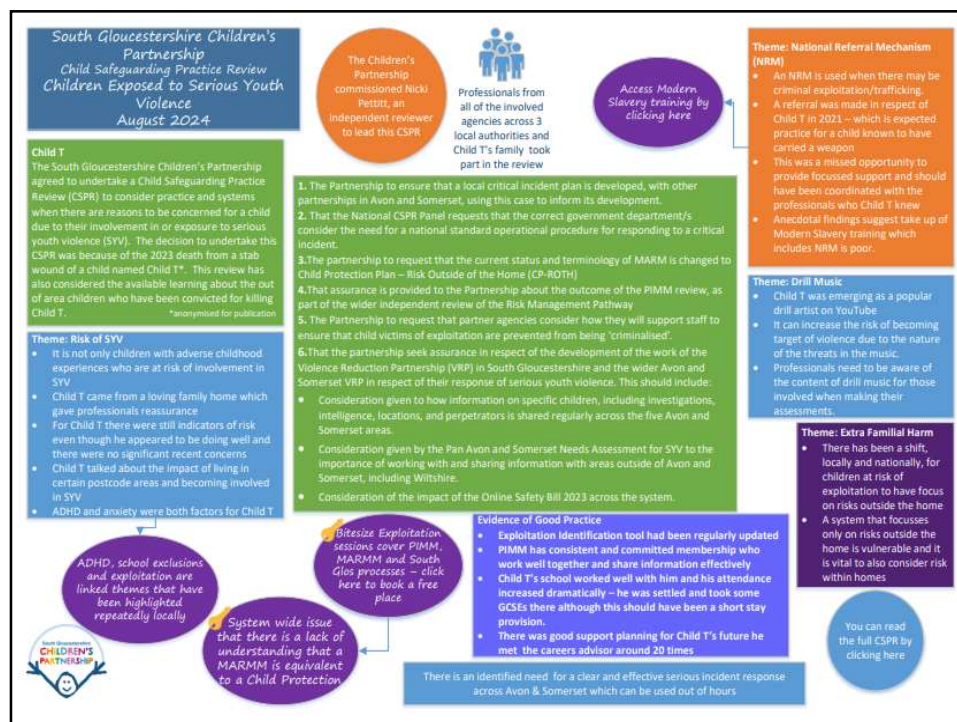
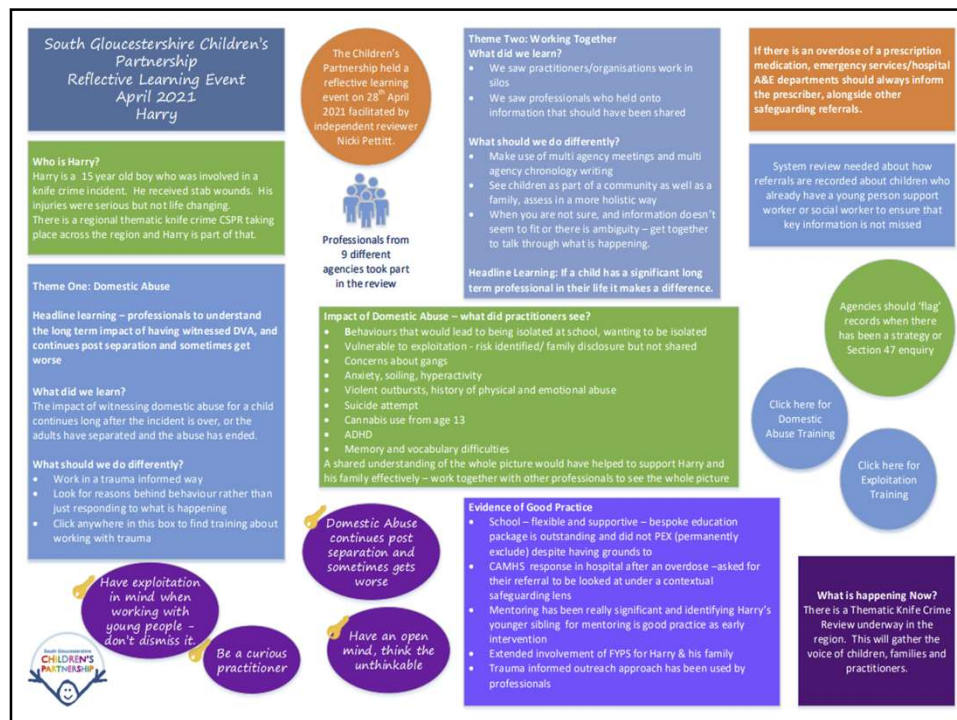
Aim of guidance to ensure professionals

- Are aware that even minor injuries could be a pointer to serious abuse in non-mobile babies
- Know that such injuries, however plausible, MUST routinely lead to multi-agency information sharing
- Support professionals to identify potential concerns and make referrals as appropriate

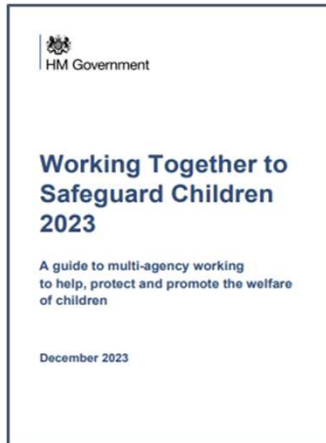
Also read

- Guidance – Congenital dermal melanocytosis (blue spot marks)
- Addendum for Early years settings and Child Minders
- Parent leaflet + accessible version





Updated Statutory Guidance 2023



Emphasis on:

- Strong multi-agency relationships...to offer 'tailored' support
- Early Help – Risk factors to be considered (Early Help Guide)
- Safeguarding S17 – A wider range of professionals can be the 'lead professional'
- Children with disabilities – Social Care role clarified
- Considering risks children face outside of the home



Safeguarding Definition 2023

Providing help and support to meet the needs of children as soon as problems emerge

Protecting children from maltreatment, whether that is within or outside the home, including online

Preventing impairment of children's mental & physical health or development

Ensuring that children grow up in circumstances consistent with the provision of **safe & effective care**

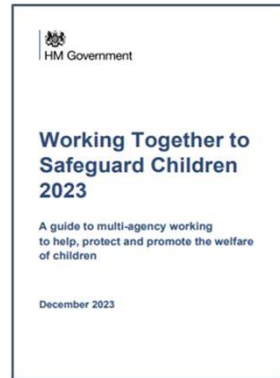
Promoting family & kinship upbringing where that is in the best interests of the children

Taking action to enable all children to have the **best outcomes** in line with the Children's Social Care National Framework



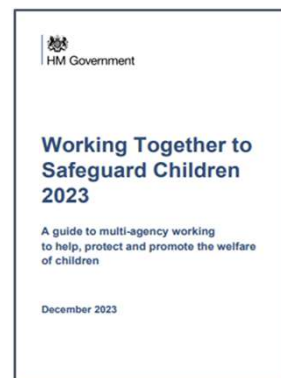
Responsibilities ?

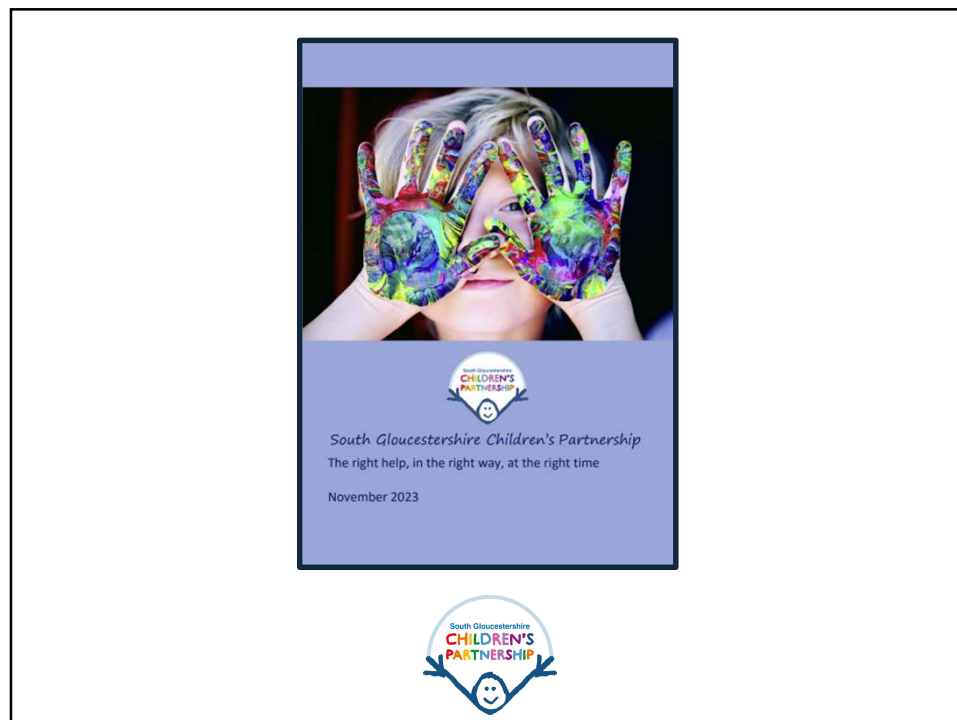
3 Statutory Partners + Relevant Agencies



What have children said they need from us?

- Vigilance
- Understanding & Action
- Stability
- Respect
- Information & Engagement
- Explanation
- Support
- Advocacy
- Protection





Guidance



Right Help, Right Way,
Right Time....

Graduated tiers of
help and support.

**'Response to
Levels of Need'**

Referral Form – Updated Jan 2025



Request for Help Form

South Gloucestershire
Council

This form needs to be completed in order to request support from all Local Authority services, including Preventative Services and Social Care. If you have an immediate safeguarding concern, please call the Access and Response Team (ART) on 01454 866000.

Before completing the form, please ensure that you have consent from the parents and Young People over 11 years and that they are aware of the information being shared in the referral and what is being requested. You also need to gather the thoughts and views of the parents and children/young people. Best Practice would be to show a copy of this referral to parents so they are clear about the information you are sharing unless to do so would place a child at risk.

When requesting support from Early Help or Preventative Services, **please consider the questions below** before completing the Request for Help form:

- Have you spoken with Compass before making this referral? email Compass@southglos.gov.uk
- Is there an EHAP (Early Help Assessment and Plan) open for this family? If not, please discuss with Compass prior to making this referral
- Have universal services/support been tried in the first instance?
- Have you referred to the SEND Local Offer?
- <https://find-information-for-adults-children-families.southglos.gov.uk/kb5/southglos/directory/localoffer.page?localofferchannel=0&channel=localoffer>
- Have you looked at the South Gloucestershire Children's partnership: The Right Help in the Right Way at the Right Time (Threshold Document)? <http://sites.southglos.gov.uk/safeguarding>

Referral Information –

| | | | |
|---------------|--|---------------|--|
| Referral Date | | Referrer Name | |
| Organisation | | Phone: | |
| | | Email: | |

MASH Partners



BRAG Rating & MASH Explained

| RAG Rating | Outcome | Response Time Target | MASH |
|--|----------------------------------|----------------------|--|
| Red (Priority) Acute Child Protection Requires intensive support. | Section 47 / Child Protection | 4 hours – 0 day | No |
| Amber Complex / Child In Need complex needs likely to lead to longer term intervention. | Child In Need Assessment | 1 working day | Do we need more than one professional opinion to make a decision? If no, progress through normal channels If yes, progress to MASH |
| Green Vulnerable Universal support and early help services | Early Help Assessment | 3 working days | Could do, do we need more than one professional opinion, evidence is it is low level. If so, progress to MASH , if no progress through normal channels. |



Early Help Assessment & Plan

Priority 1 – Early understanding of the diverse needs of children, young people, and families

Priority 2 – Access to information , advice, guidance, opportunities, support and signposting within the local community.

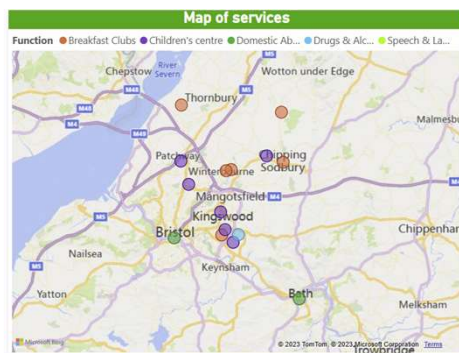
Priority 3 – Effective partnership responsibility, response and accountability.

Priority 4 – Co-ordinated planning and provision of support

Priority 5 – Demonstrate a positive impact on the lives of children, young people and families.



South Gloucestershire Council Mapping Tool – Early Help



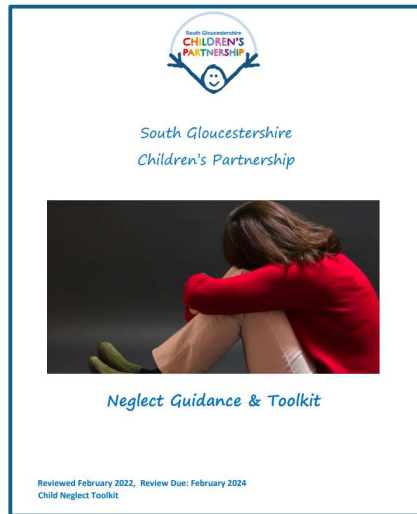
Service Function

- Search
- ☐ Select all
 - ☐ (Blank)
 - ☐ Borrow Items
 - ☒ Breakfast Clubs
 - ☐ Breastfeeding Support
 - ☐ Childminder
 - ☐ Children's centre
 - ☐ Community Centre
 - ☐ Community Welcome Spaces
 - ☐ Dentist
 - ☒ Domestic Abuse
 - ☒ Drugs & Alcohol support
 - ☐ Education (not schools)
 - ☐ Financial Services and Advice
 - ☐ Food Support & Food Banks
 - ☐ Full Day Care
 - ☐ GP Surgery
 - ☐ Health & Medical
 - ☐ Holiday Scheme
 - ☐ Home Childcarer

South Gloucestershire Council

- Town Search
- ☒ Select all
 - ☒ Kingswood
 - ☒ Bath
 - ☒ Bristol
 - ☒ Cadbury Heath
 - ☒ Chipping Sodbury
 - ☒ Filton
 - ☒ Frampton Cotterell
 - ☒ Patchway
 - ☒ Staple Hill
 - ☒ Thornbury
 - ☒ Warmley
 - ☒ Wickwar
- Cluster
- ☒ Select all
 - ☒ 1 (Thornbu...
 - ☒ 2 (Patchwa...
 - ☒ 3 (Winterb...
 - ☒ 4.5 (Kingsw...
 - ☒ 6 (Staple H...
 - ☒ Service sup...

| Service Name | Function | Contact number | Email | Website | Address Line 1 | Postcode |
|--|-------------------------|-----------------------------|--------------------------|---|--|----------|
| Cadbury Heath Children's Centre | Children's centre | 01454 862974 | | Link | Parfwall Primary School | BS30 |
| Developing Health and Independence (DHI) | Drugs & Alcohol support | 01454 868750 or 08000733011 | info@dhisouthglos.org.uk | https://www.dhi-online.org.uk/get-help/adult-drug-alcohol-treatment/south-gloucestershire-drug-and-alcohol-service | Developing Health and Independence (DHI) | BS30 |



Aims to:

- highlight difficulties experienced when working to combat neglect
- suggest ways to avoid or resolve them
- support the use of professional judgment at all stages during interventions with families



Information Sharing

The Data Protection Act 2018 & GDPR supports the sharing of relevant information for the purposes of keeping children safe

‘Legal Obligation’ or ‘Public Task’ (Public Interest)

Data Protection Act - processing condition that allows practitioners to share

Special Category Personal Data

(Sensitive = More protection needed GDPR Article 6 & Article 9)

when

‘Safeguarding children and individuals at risk’

This allows sharing without consent, where consent cannot be reasonably gained or if to gain consent would place a child at risk



**Necessary
Proportionate
Relevant
Accurate
Adequate
Timely
Secure**



Information Sharing

Advice for practitioners providing safeguarding services for children, young people, parents and carers

April 2024



Professional Differences ? What if I don't agree?

South Gloucestershire Children's Partnership

Resolution of Professional Differences

(Escalation Policy)

The aim of this policy is to provide a clear mechanism for the resolution of professional differences in order to ensure a timely resolution that ensures that the needs of the child or young person are met.

It provides a local process to be followed. SGCP see challenge as a key part of effective and healthy inter-agency working cultures and partner organisations should therefore view and respond to challenges brought under this procedure in a positive manner.

Professional Courage – Professional Curiosity – Professional Challenge





Learning and Development
Training Evaluation Form 2025



