Children Level 3 Safeguarding Training

05/02/2025 9:30-12:30

The Primary Care Safeguarding Team

Dr Marie McVeigh

& Dr Vicky Donkin

Named GPs for Primary Care

Kirsten Bowes (South Bristol and North Somerset)

& Louise Ledgerwood-Care (South Glos & Bristol)

Named Professionals for Primary Care

Agenda

Time	Activity
09:30	Introductions, Housekeeping, Aims & objectives
09:40	Intro: Safeguarding Principles & Thresholds Principles of Safeguarding Children Key sections to protect children Continuum of need and thresholds
10:00	Safeguarding topics: ICON NAI pathways MASH outcomes
10:20	Tea break
10:30	Specialist topics & break out exercises Child Criminal Exploitation, Serious Youth Violence. Case studies/ decision Making Skills,
11:35	Tea break
11:45	Referrals, Policies, Sharing information

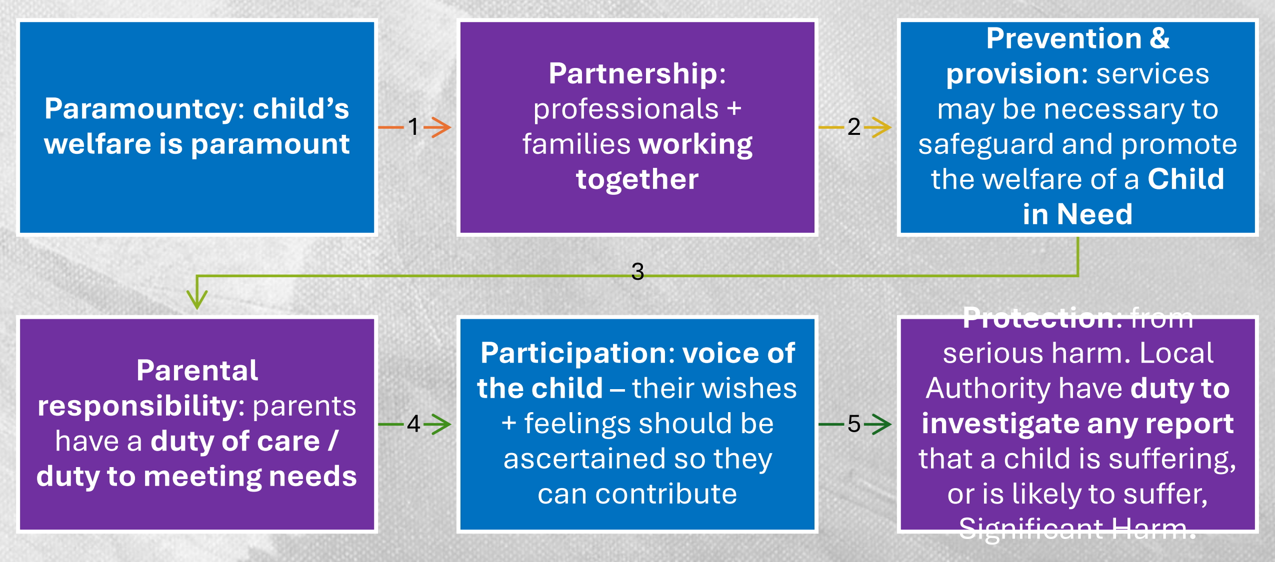
Housekeeping

- Please keep your microphone on mute when you're not speaking.
- Please turn cameras on during the break-out sessions and for case-based discussion.
- If you have any questions, please do use the chat-box or raise your virtual hand.
- No need to take notes, presentations and useful links will be sent out after the session.

Aims and Objectives

- Understand local policies and pathways around child safeguarding eg Non mobile baby policy
- Understand inter-agency frameworks and child protection processes led by the local authority / children's partnership
- Confidently document safeguarding concerns in health records, including appropriate coding and information governance
- Update on current local safeguarding activities eg Serious Youth Violence
- Confidently report concerns and initiate safeguarding referrals to children's social care, using threshold guidance and local referral pathways

Principles of safeguarding – 6 Ps



Children Act 1989 - Key Sections

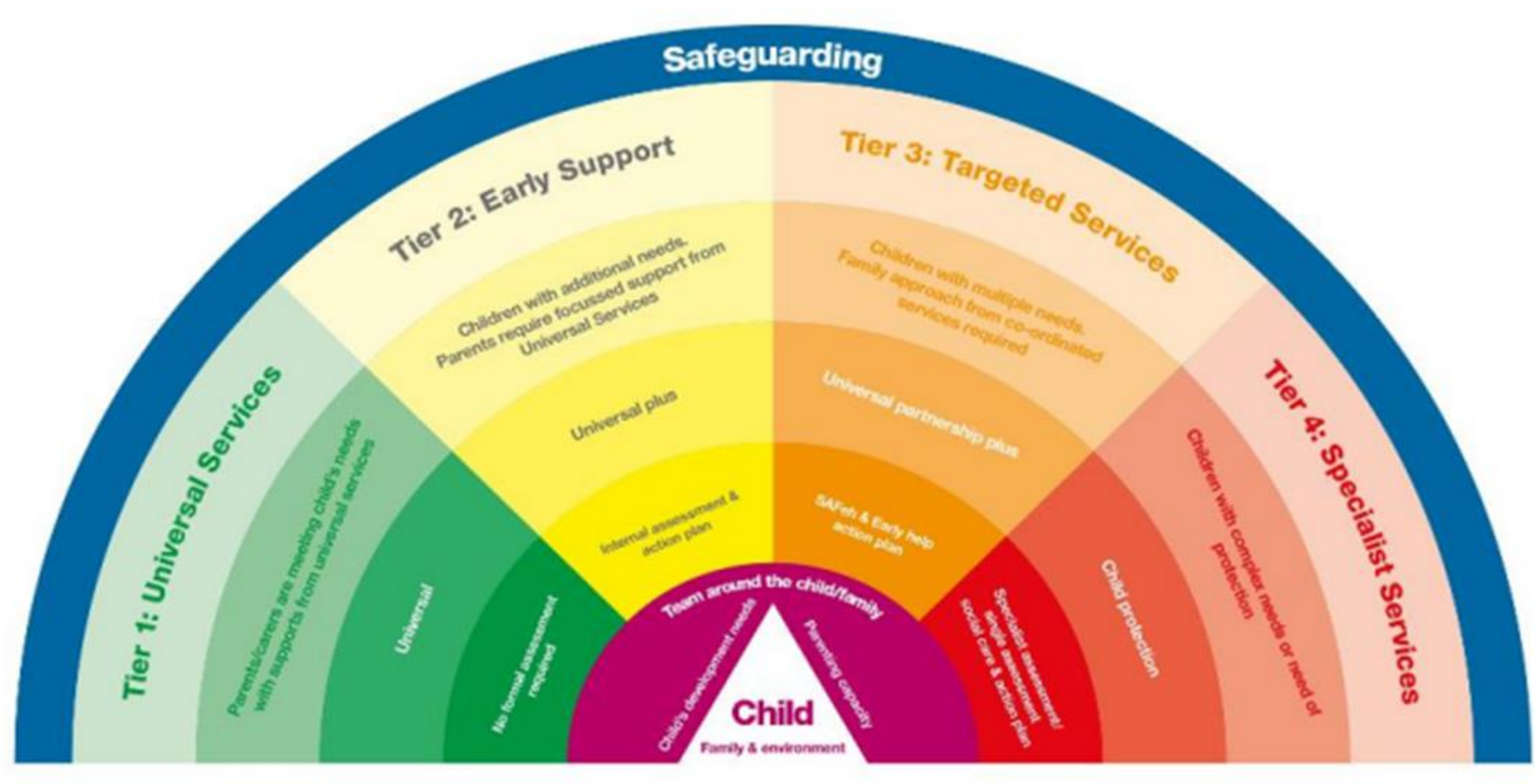
- Section 47: Child at Risk of Harm – This could be within the family or extra-familial harm (risks outside the home).

- Section 17: Child in Need – When a child needs support from services. This includes Early Help for families, Children with additional needs/disabilities.

- Section 20: Voluntary – The Local Authority can provide accommodation for a child within their area, if that child is in need of it due to the child being lost/abandoned or there is no person with parental responsibility for that child

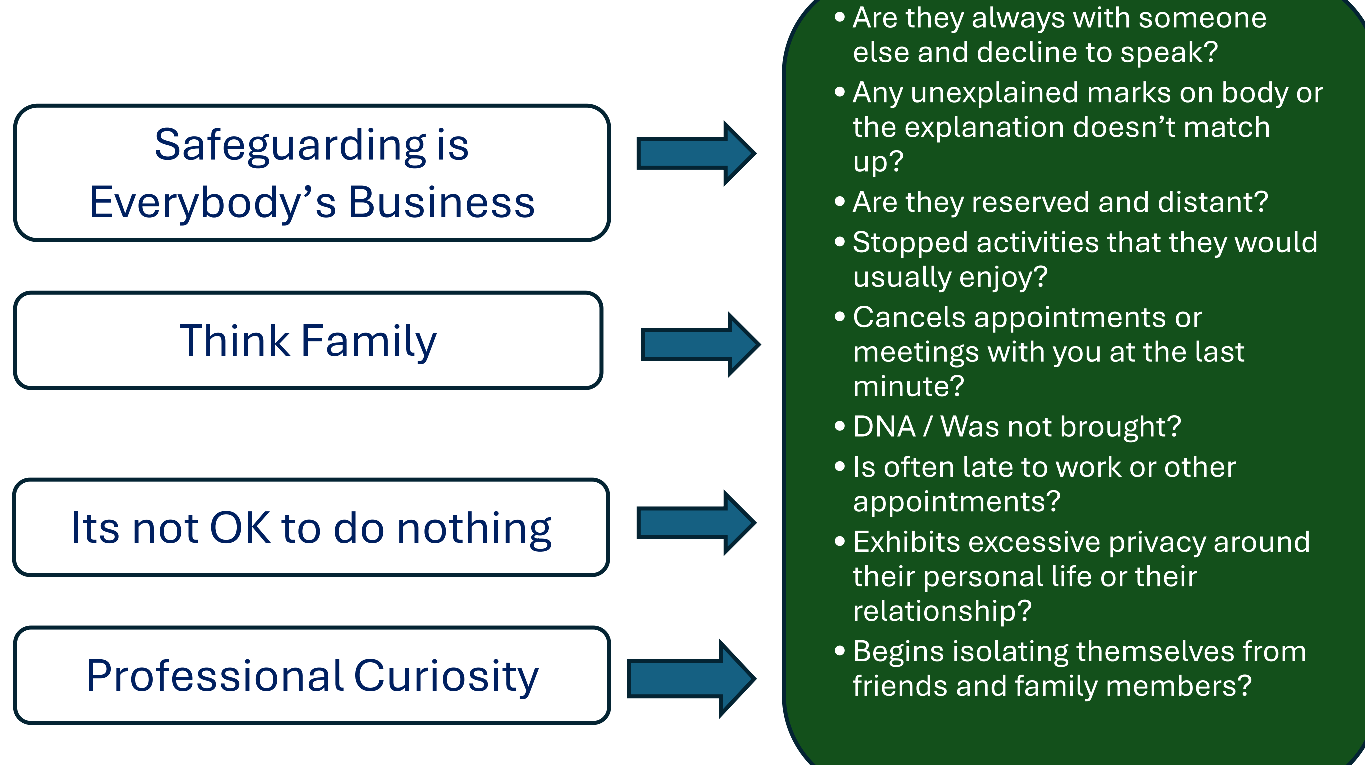
Understanding Section 31 Care Orders: A Comprehensive Guide | Looked After Child

Effective Support: A Continuum of Need



Any significant concerns should be taken straight to the Access & Response Team

Making every contact count



Think Family Approach

'Think Family' isn't a new or complicated idea. It is, however, a theme that we see raised repeatedly in both national and local reviews concerning children and adults.

- **The Think Family agenda** recognises and promotes the importance of a whole-family approach. A holistic view of **all members** of the household - Remember: children, young people and adults do not exist or live in isolation.
- **No wrong door:** all services should offer an 'open door' into a system of joined-up support. This is based on more coordination between adult and children's services.
- **Looking at the whole family:** services working with both adults and children take into account family circumstances and responsibilities.
- **Building on family strengths:** practitioners work in partnership with families recognising what is going well, collaborating and building skills to encourage self sufficiency.

What is Professional Curiosity?

It is using your skills to explore and understand what is happening for an individual or family, rather than making assumptions or accepting things at face va“Thinking the unthinkable”. This is not about

assuming the worst, but about keeping an open mind for all possible explanations. Practitioners need to think ‘outside the box’, and respond using respectful uncertainty rather than

Curious professionals engage with individuals and families through visits, conversations, observations and asking relevant questions to gather historical and current information. This involves triangulation of information from different sources and participating in wider

Why is Professional Curiosity important?

A lack of Professional Curiosity can lead to:

- **Missed opportunities** to identify subtle signs of vulnerability or harm.
- **Incorrect assumptions** made leading to inaccurate risk assessment and inappropriate interventions.
- **Silo working resulting in missing the big picture.** Silo working could mean dealing with problems in isolation and/or working in isolation from colleagues.

Being respectfully nosey

It is common to feel awkward, worried and uncomfortable when asking additional questions or seeking alternative explanations.
Professionals need to be brave, understand why they are asking difficult questions and explore further with compassion.
It is our professional responsibility to build the skills and competence to do this confidently.

What are ACEs?

Examples of ACEs:

Verbal abuse

Physical abuse

Sexual abuse

Parental separation

Household domestic violence

Household mental illness

Household alcohol abuse

Household drug use

Household member incarcerated

Individuals reporting at least one ACE

47%

Individuals reporting 4 ACEs or more

9%

A trauma informed approach can help to support patients with ACEs.

Video link:
https://youtu.be/zg8ahtHIRxU?si=WP4io2mHlVRR-1sv

Definition of a Child In Care
(Looked After Children)

- This term is used to describe any child who is in the care of the local authority or who is provided with accommodation by the local authority social services department for a continuous period of more than 24 hours.
- This covers children in respect of whom a compulsory care order or other court order has been made, including those on an adoption pathway.
- It also refers to children that are accommodated voluntarily, including under an agreed series of short-term placements which may be called short breaks, family link placements or respite care, as well as those who are on remand.

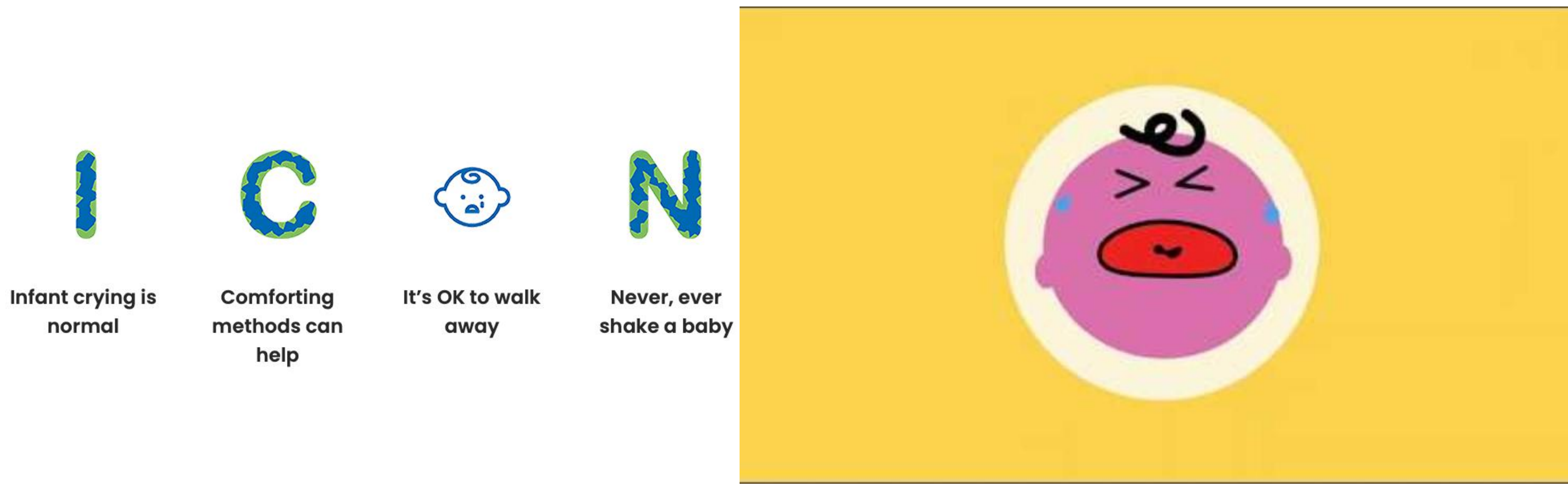
https://remedy.bnssg.icb.nhs.uk/children-young-people/safeguarding-children/children-in-care-and-care-leavers-also-known-as-looked-after-children/

Definition of 'Care Leaver'

- Those children and young people formerly in care before the age of 18 years of age.
- Such care could be in foster care, residential care (mainly children's homes), or other arrangements outside the immediate or extended family.
- A child ceases to be looked after when they are adopted, return home without a care order in place or turn 18 years old.
- However local authorities in all nations of the UK are required to support children leaving care at 18 until they are at least 21 (or 25 if in full time education or if the young person has a disability). This may involve them continuing to live with their foster family.
- Local authorities should have a published care leavers offer detailing support available.

Safeguarding Topics

- ICON
- Non-Accidental Injuries
- Was Not Brought
- MASH outcomes



Many serious events + rapid reviews arise from 'shaken baby' NAI incidents.

ICON teaches parents/carers it is ok to leave baby in safe place & walk away, buying time to regulate their own emotions and behaviours to prevent an avoidable incident.

- Are you discussing ICON at routine immunisations appointments and baby-checks?
- How is this discussion evidenced in the medical records?
- Have you considered sending ICON info as a text message?
- How can the message be shared with all adults caring for the baby, not just the parent/carer who can to this appointment?

ICON resources link + 3-minute video

NAI: injuries in non-mobile babies

A BNSSG-wide policy is been published on REMEDY:

This policy was produced following a Serious Case Review (SCR) into the death of a baby in South Gloucestershire and should be used when **any injury is identified in a baby who cannot move independently**.

- Please remember it is not the responsibility of the primary care practitioner to determine causality.

A Keeping Babies Safe leaflet explaining the process should be downloaded and printed and given to the parents/carers. This leaflet is also available in EASY READ format.

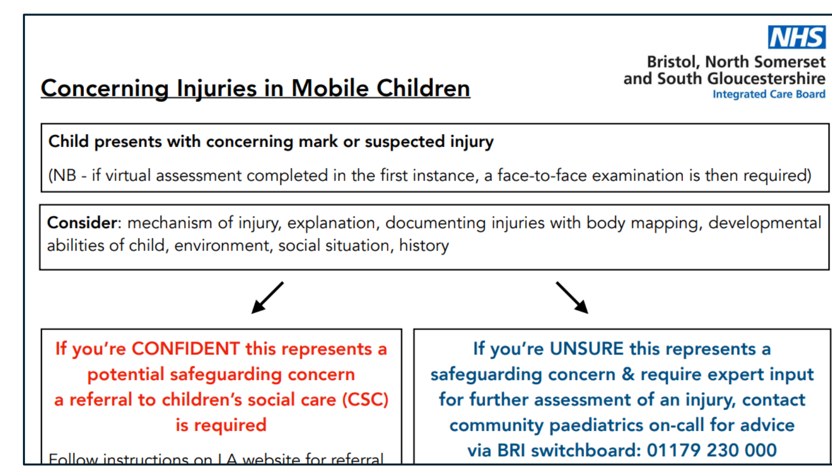
Multi-Agency Guidance for
Injuries in NON-MOBILE Babies
2023

NAI: injuries in mobile children

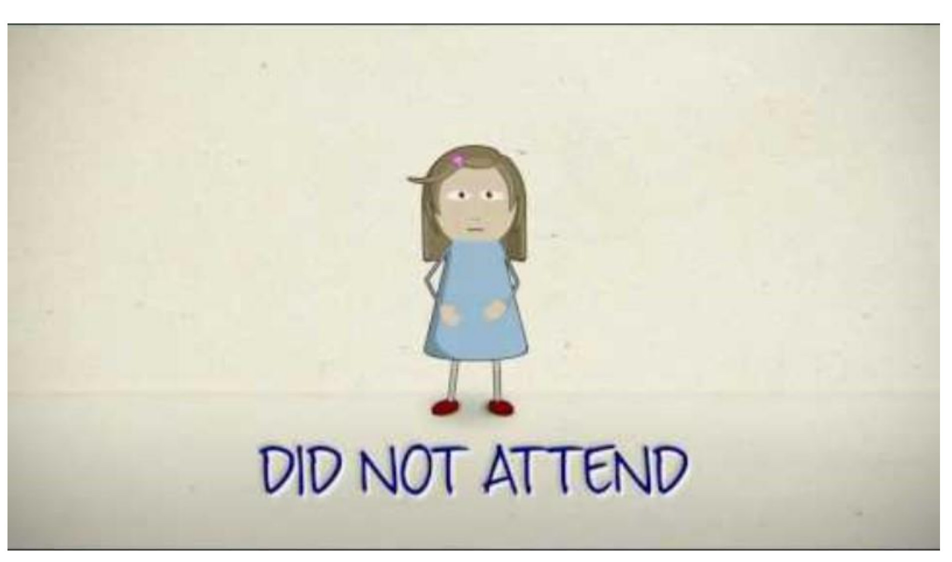
A BNSSG-wide policy is been published on REMEDY:

This policy was produced following a Single Agency Review into the case of a mobile toddler who'd presented to primary care with ear bruising, later admitted with extensive injuries and subsequently taken into care. This policy should be used when **an injury is identified in a child who is able to mobilise independently**.

- Please remember it is not the role of the primary care practitioner to determine causality.



Rethinking ~~Did Not Attend~~ = **Was Not Brought**



Recent statutory review highlights cases where poor engagement with health and social care services was evident.

Non-engagement or non-compliance may be a parent or carer's choice, but it is not the choice of the vulnerable adult or child.

Practice admin and clinical staff should treat repeated cancellations and/or rescheduling of appointments with professional curiosity and the same degree of concern as repeated non-attendance.

Changing language from the term DNA to WNB helps maintain a focus on vulnerability and dependence, and the carers' responsibilities to prioritise the individual's needs.

2-minute WNB video:
https://youtu.be/dAdNL6d4lpk?si=OdusrkoWkQtU87Ew

Children's WNB policy

A new BNSSG-wide policy has been published on REMEDY:

- Children rely on adults to attend their health appointments. When a child fails to attend an appointment, the 'did not attend' (DNA) terminology is potentially both incorrect and punitive.
- Across BNSSG the phrase 'was not brought' (WNB) is being promoted and missed appointments should be coded as such.
- A WNB event should trigger a review of the child's health and care needs, with an appropriate response required from clinicians.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Safeguarding Children

Was Not Brought Guidance for Primary Care

Author:	BNSSG ICB Safeguarding in Primary Care Team
Version:	Final – January 2025
Review Date:	Annually – January 2026

Introduction/Background

Rapid Reviews (RR) and Child Safeguarding Practice Reviews (CSPRs) have evidenced that repeated missed appointments and/or lack of response to practice communications *can* be an indicator of neglect or abuse. It is therefore important that all health care providers can recognise patterns in missed appointments and/or lack of response to practice communications to identify safeguarding concerns, so that appropriate action can be taken.

There are many legitimate reasons for children missing appointments. However, in order to ensure causes for concern are not missed there should be a process in place to identify and act on cases of a missed appointments.
It is recommended that practices have procedures to identify and follow children and adults at risk who do not attend scheduled appointments in the practice. Missed appointments with other providers should also be considered if the practice becomes aware of this.

Referral outcomes - MASH Outcome Forms

MASH (Multi-Agency Safeguarding Hub) is now live across BNSSG.
Safeguarding referrals to social care at triaged and if appropriate, sent to MASH.
Specialist Nurses from Sirona participate in the MASH and attend Strategy meetings on behalf of 'Health partners', incl Primary Care.
They present information from GP records via connecting care.
They feedback outcomes and actions to Primary Care, via MASH outcome forms.

The MASH Outcome form is a *brief overview* to let you know that a child has been discussed, share any relevant info, actions and sometimes a task for the GP.

If an action has been allocated to the GP, this will be clear, with details provided regarding who to liaise with.
The form includes details of allocated social workers.

Further MASH information is added to Sirona view of EMIS, use the "all records".

The form should be processed & coded just like other safeguarding forms received into the practice, following coding guidance on REMEDY.

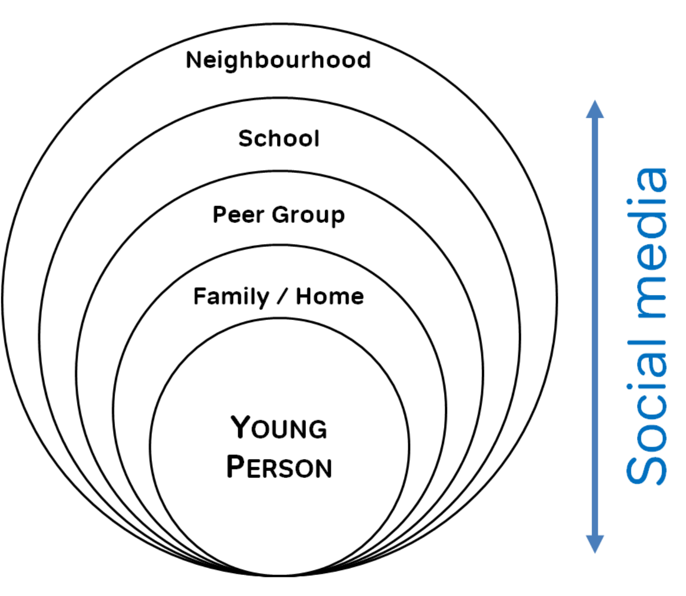
Tea Break (10 mins)

Safeguarding Topics

- Contextual Safeguarding
- Child Criminal Exploitation
- County Lines
- Serious Youth Violence (SYV)

.

Contextual Safeguarding
Risk outside the home (ROTH)
Extra-familial harm



- Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families.
- Contextual safeguarding seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or other young people.
- Beware that intra- and extra-familial harm often co-exist.

Child Exploitation

Forms of exploitation include:

- Sexual exploitation (CSE); a form of sexual abuse, this can include grooming and trauma-bonding - Spotting the signs
- Debt bondage; where children are manipulated into having debts they must 'work off' – Spotting the signs
- Criminal exploitation (CEE); where children are coerced or manipulated into committing crimes, such as drug trafficking, theft, or violence – Spotting the signs
- Modern slavery; where children are deprived of their freedom and forced to work or provide services for others.
- Early or forced marriage, where children are married off without their consent or against their will.

County Lines

County Lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas [within the UK], using dedicated mobile phone lines or other form of "deal line".

A common feature in county lines drug supply is the exploitation of young and vulnerable people.

Avon and Somerset Police:

280 Lines, Bristol, WSM, Bath, Taunton, Bridgwater.

Lines within the villages and cities.

Child T – South Glos review 2024

- Child T had dual diagnoses of **ADHD and anxiety**; this made him more reactive and impulsive, therefore more **vulnerable** than his peers
- He had been a history of carrying **weapons**; found carrying a baseball bat aged 9, then a knife aged 13
- He had previously been on a **Child Protection Plan**
- He had been **excluded** from mainstream school but was doing well in a referral unit and remained in **contact with his social worker**
- Feb 2022 Child T's 'Child In Need' **support ended**; he was risk assessed using a well-established risk assessment tool, deemed to be **low** risk
- Nov 2022 Child T was involved in an incident in Bristol, however details were not shared with South Glos Children's Social Care
- Child T was a well-known **Drill** artist; added risks of this were not recognised
- He died of a knife stab wound late on a Saturday night in 2023 in a neighbouring local authority.

Children Exposed to **Serious Youth Violence –** a learning brief

BBC iPlayer – 'a house party murder' documentary

Serious Youth Violence

What is Serious Youth Violence (SYV)

The threat, and intentional use, of violence towards children under 18 years old.

SYV usually occurs in a public place, may involve the use of weapons and can result in serious physical injury or death.

Perpetrators of SYV may also be victims of exploitation in their own right; they could be being pressured or threatened or in debt to drug dealers. SYV does not always happen in the context of gang activity.

Exclusion from mainstream education is known to be a risk factor for involvement in Serious Youth Violence

Indicators for SYV:

- Non-accidental or unexplained injuries - Bruising, Fractures, Fresh scars or minor cuts, Internal injuries with inconsistent explanation about how the injury was obtained
- Attempting to hide the injury by wearing long clothing on a hot day
- Requesting medication or treatment (bandages or plasters) for unseen injuries
- Refusing to be referred to a hospital for further examination/ Becoming defensive when explore/angry when questioned about injury and sequence of events
- Unwillingness to talk, or fearfulness, in the presence of another person.
- Victim of a recent theft, mugging, bullying, assault, or weapon related offence
- Regular missing episodes and/or exclusion from school

SYV - Information Sharing in BNSSG

- The ICB Safeguarding team represent Primary Care at weekly multiagency meetings (Bristol).
- System partners deliberate on young people suspected or known to be involved in SYV.
- Relevant info/contact details for key professionals working with the young person are then shared with the GP to promote Professional Curiosity around SYV.

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Highly Confidential Information

Please hide from general and patient view.

GP Practice codes for this document:
6881000000105 - Child is cause for safeguarding concern
1188261000000103 - At risk of criminal exploitation

NHS Bristol, North Somerset and South Gloucestershire ICB
Floor 2, North Wing, 100 Temple Street,
Bristol, BS1 6AG

Email: bnssg.safeguardingadmin@nhs.net

Date of meeting:

CONFIDENTIALITY STATEMENT
Information contained in this schedule is confidential police information and should not be disclosed without consent or robust justification to any other party.

There are regular tactical meetings convened where system partners collaborate to deliberate on children, young individuals, and adults who are suspected or known to be

Questions for Young People suspected to be involved in SYV

Do you feel safe to leave here today?

Who is making you feel unsafe? How do you know them?

Have they threatened to hurt you or anyone else you care about (including animals, property)?

Is there someone else that knows about what is happening to you or you have talked to?

Have they physically hurt you in any way?

Do they have access to materials/weapons to carry out their threats?

Do they know where you live or what personal information do they know about you?

HEADSSS assessment Tool

UHBW / Bristol Children's Hospital use as a tool for assessing young people, to help clinicians remember things we ought to consider asking all young people. This tool can be used in Primary Care to prompt Professional Curiosity about the experiences of children/Young People.

- Home
- Education & Employment
- Activities
- Drugs/Drinking
- Sex
- Self-harm, depression & suicide
- Safety (including inside and outside the home + social media/online)

HEADSSS tool | Paediatric Pearls

Break out rooms: Cases

Task

- Read the case, consider what else you might like to know.
- What guidelines/resources exist to help you?
- Who else could you speak with for advice?
- In what circumstances would this trigger you to make a safeguarding referral? Are there any other agencies that you need to refer to / involve?
- Can you identify any (potential) barriers to safeguarding these children?

Sasha

Three month old Sasha has attended for routine imms, a small bruise, the size of a 5 pence coin on her forehead is noted and a colleague approaches you for advice. Dad says that Sasha fell off the changing table and bumped her head on a toy on the floor.

Sam

Sam attends with his mother at the request of school who have noticed a change in him, he is 9 years old. He has Down's syndrome. The school have emailed the practice, they state:

"Sam works hard and has support at school from a 1:1. He is known for his enthusiasm and cheerfulness and is popular with staff. Recently they have noticed that he is subdued. He is not completing homework for school and often turns up without the required equipment. On several occasions he has said that he cannot find his bag. He has attended with a plaster on his cheek his Mum said he tripped into a doorframe. Sam has been seen arguing with another young person but when asked about it shouted and kicked over a chair. When the school have asked is everything ok, he says yes, they wonder if he is depressed?"

Mum says she has no concerns and is simply acting on school's request to bring him in as they've been 'nagging her'. Sam sits silently and won't engage with you.

Dren

Dren is 16 and has booked an emergency phone call via 111, he is complaining of headaches. A note on Dren's record tells you that he is on a Child Protection Plan, Dren entered the UK unaccompanied, seeking asylum, he travelled from Albania where the rest of his family remain and is currently in a foster placement with a family who are all registered at your surgery.

Lorna, Ed, Jackson and Daisy

Lorna has 3 children, she says she booked an emergency appointment because she is feeling very stressed and doesn't know how to get help. Ed is 17 years old, Jackson is 14 years old and Daisy is 5 years old. Lorna tells you that she is really worried about Ed and Jackson. They are often fighting at home, the fights are physical and she is scared that one of them will get hurt. Daisy is getting upset, and recently she ran out of the house whilst Ed and Jackson were fighting.

When Lorna was changing Jackson's bed she found a sharp kitchen knife under the pillow – Jackson said that he gets scared and keeps it to protect himself.

Danika

Sophie 42 (Mum) attends with Danika who is 9 years old at 10:30 on a Tuesday. Sophie has attended for a medication review, metformin (for diabetes) and sertraline (antidepressant).

Danika walks in happily, smiling and sits in the chair closest to you and asks your name. Sophie snaps at her to move out of the way. Danika moves to the other chair, in the corner and sits quietly for the rest of the appointment. As part of your mental health review you ask how family life is, Sophie tells you Danika "was born stupid, there is no point trying anything with that girl, she can't do anything right and she will probably get herself pregnant and waste her life away."

Sophie's diabetes is well controlled, and you feel that her mental health is stable. You flick to Danika's notes and notice a recent DNA for imms.

Becky & Chantelle

Becky is 15 years old, she attends with her Mum. Mum is concerned that she has been low and anxious, not wanting to go out and has self harmed on occasions. You ask to see Becky alone and she agrees.

Becky tells you that until recently she was best friends with Chantelle, another 15 year old who attends the same school. Becky is of dual heritage. Becky tells you Chantelle has not been spending as much time with Becky, and she started to talk about a new group of friends that she met online. Becky has overheard Chantelle telling a group of other girls that Becky wasn't her friend because she isn't "English" enough. Becky thinks that Chantelle has drawn the number 88 on her arm several times. Chantelle has also talked about going to a meeting with her new friends at the weekend.

Decision-making barriers

- Disguised compliance
- Professional curiosity
- Confirmation bias
- Rule of optimism
- Poor multi-agency working
- Cultural sensitivity
- Attitudes and values

What makes a good referral?

- Consent
- No medical jargon
- Child Focussed
- What do YOU think should happen?
- Contact details
- Liaise with MDT
- Don’t be vague
- Clear record keeping

Making a safeguarding referral

CHILDREN'S SOCIAL CARE REFERRALS

https://remedy.bnssg.icb.nhs.uk/children-young-people/safeguarding-children/referrals-procedures/

If you have concerns about a child/family, please refer to the relevant local authority in which they live

The decision whether to refer a child or young person to social care depends on whether a threshold has been met. This involves assessing the impact of the family situation on the child, considering the child's lived experience and voice.

Each LA has issued their own threshold guidance, to assist decision-making when considering the level of concern and expected level of response.

ADULT SOCIAL CARE REFERRALS

https://remedy.bnssg.icb.nhs.uk/adults/safeguarding/adult-safeguarding/

If you have concerns about an adult at risk of harm, please refer to the relevant local authority in which the adult lives

BRISTOL – Care Direct 0117 922 2700

SOUTH GLOS – Adult Social Care 01454 868007

NORTH SOMERSET – Care Connect 01275 888801

Professional advice and case discussion is possible via telephone; however, a written referral is always required following a telephone discussion.

Golden Rules for Information Sharing

- Data protection is not a barrier
- Be open and honest about what you will do with the information
- Seek advice from appropriate professionals
- Share with consent but don't let a lack of consent prevent sharing
- Always consider child's safety and wellbeing (e.g. will telling parents put child at further risk)
- Necessary, proportionate, relevant, accurate, timely and secure
- Keep a record

Practice policies + regional policies

- Every GP surgery must have an adults and children's safeguarding policy for all staff to access and review on an annual basis

- Regional clinical + referrals pathways are shared on the REMEDY website – adults and children's safeguarding pages

- A new BNSSG ICB safeguarding self-assessment audit is available on REMEDY to support practices to review their safeguarding standards and evidence this for CQC and QIP on an annual basis.

RCGP safeguarding standards 2024

- Adults and Children merged into one set of all-age standards
- Competence based, not hours-based training
- Focus on learning and impact on practice
- Focus on general practice being an MDT team
- Engagement with local safeguarding partners and relevant authorities
- Standards arranged into 5 areas of knowledge + capabilities:
  - Responsibilities
  - Identification of abuse and neglect
  - Responding to abuse and neglect
  - Documentation
  - Information sharing and multiagency working

Safeguarding training requirements – new RCGP standards (Oct'24)

Summary of changes and key principles:

- ☑ Adults and Children merged into one set of all-age standards
- ☑ Competence based, not hours-based training
- ☑ Focus on learning and impact on practice
- ☑ Focus on general practice being an MDT team
- ☑ Engagement with local safeguarding partners and relevant authorities
- ☑ Standards arranged into 5 areas of knowledge + capabilities:
  - ➢ Responsibilities
  - ➢ Identification of abuse and neglect
  - ➢ Responding to abuse and neglect
  - ➢ Documentation
  - ➢ Information sharing and multiagency working

New RCGP standards vs Old ICD requirements

The **RCGP** expect all staff working in GP setting to comply with their **new all-age safeguarding training standards**, and document this in the way they have specified. This is a **competency-based approach**, with **case-based reflective practice and learning logged**.

1. All staff must access safeguarding training and supervision relevant to their role, at the correct level 1/2/3 and covering adult/children/all-age knowledge + skills.
2. All staff to be supported to achieve the expected standards for their role and have this evidence available for inspection at CQC/appraisal/revalidation.
3. All staff must be supported to engage with CPD/training in an 'adult-learning approach', identifying learning needs then meeting those on an individualised basis - there is **no** one-size-fits-all training package!

The **RCN** expect nurses to comply with their own safeguarding training standards, as per the **intercollegiate documents** for children and adults. This is a **time-based approach**, with training **hours logged**.

Therefore, primary care staff should follow the RCGP competence-based reflective learning expectations on an annual basis, and those who need to count the hours spent should also include that number in their reflective log entry. This ensures that over the course of 3/5 years, staff will have covered both the whole RCGP standards (curriculum) and will also have logged more than enough hours to meet the RCN / ICD expectations as well.

Safeguarding supervision

Supervision leads to **improving decision-making, accountability, and supporting professional development** among practitioners.

It also provides an opportunity for **self-reflection, peer support and pastoral care**.

- 1:1 supervision – Case based discussion with a colleague, manager or safeguarding lead within your practice.
- Group supervision – Case based discussion with multi-disciplinary teams within your practice (e.g. at practice meetings).

⟶ What is the safeguarding supervision structure at your surgery?

⟶ Do you know who to talk to for support?

This is on REMEDY, with all the live booking links for the webinars active.
For the conference and L3 local update, please email the admin inbox.

BNSSG ICB Safeguarding in Primary Care Team Training Offer 2025

Safeguarding Supervision

13:00 -14:00

Online via MS Teams – click link to register

Wed 19th February
Tues 1st April
Tues 1st July
Wed 17th September
Tues 4th November

Open to all - Please bring cases / queries for peer discussion and support

ICB Primary Care Safeguarding Team

Named GP Dr Marie McVeigh
Wednesdays & Alternate Fridays
Named GP Dr Vicky Donkin
Tuesdays & Alternate Wednesdays
Named Professional Kirsten Bowes
North Somerset, South Bristol and BIC (34 hours/week)
Named Nurse Louise Ledgerwood-Care
South Glos, North Bristol FABB & FOSS (Full-time)

All training & safeguarding enquiries:
bnssg.safeguardingadmin@nhs.net

GP Link Meetings

13:00 -14:30

Online via MS Teams – click link to register

Wed 5th March
Wed 25th June
Wed 3rd September
Wed 3rd December

Local updates, topic-based presentations and peer-support for safeguarding lead GPs

Bitesize Webinars

13:00 -14:00

Online via MS Teams – click link to register

Tues 25th March – Domestic Abuse
Tues 29th April
Tues 15th July
Wed 24th September
Wed 19th November

Open to all – Topics selected from local Statutory Review learning themes and outcomes

Level 3 Training 'Local Update'

9:30 -12:30

*Online via MS Teams – please **email** to register*

Wednesday 5th February - L3 Safeguarding Children

Wednesday 8th October - L3 Safeguarding Adults

Open to all – Topics selected from local Statutory Review learning themes and outcomes

Safeguarding Conference

All-age Level 3 update
Wednesday 4th June

All day, in-person
At BAWA, Bristol

Agenda TBC

*Please **email** to register interest*