|  |  |  |
| --- | --- | --- |
| Making a referral to First Response | 2017 | |
| This document contains information to assist trainers/safeguarding leads that are using the ‘Making a referral to First Response’ presentation and practitioner booklet. | | Referral to First Response Training Prompts |



# Introduction

These notes are designed to be read in conjunction with the slide presentation and the practitioner booklet. They are brief prompts to support single agency trainers or team members to provide consistent messaging across all the organisations.

Take time to read through notes, including the practitioner booklet before delivering the training – ensure that you have information that is relevant to your agency to provide to participants.

This session should take 30 minutes to deliver when the exercise is included.

To provide a high level of learning transfer (when participants take information they have learnt and apply to their everyday practice) it is important that they feel ownership of the issues raised and the solutions. One way to help achieve this is to relate learning to their own workplace and day to day experiences and ensure that they can see a clear benefit to them in changing their practice.

We are fortunate when delivering training that we also have the benefit of reminding participants about the positive impact they can have on other people’s lives and empowering them to strive for excellent practice.

Advice is provided regarding methods that can help to encourage learning transfer, however this is by no means exhaustive. Those with experience of delivering presentations and training will have many other ideas and these should be used freely, as long as the message delivered is consistent and reflects the information provided in the slides and booklet.

If you would like any further advice regarding this session then please contact:

Esther Lambert, BSCB Training and Development Officerat [kbsptraining@bristol.gov.uk](mailto:kbsptraining@bristol.gov.uk)

# Briefing Prompts by Slide

# Slide 2 – First Response

Refer to practitioners workbook here, there is plenty of information regarding the service. For example: there are 11 advisors, 2 administrators, 0.8 of an apprentice, 1 Early Help Coordinator, 4 deputy managers and 1 Manager. The Deputy Managers and Manager are qualified and experienced social workers.

Remind them that are very busy times (e.g. Monday mornings) – and that they have to manage any overnight contacts each morning. This is something that participants could bear in mind when completing non urgent referrals.

Ask room to imagine having a pile of referrals to work through each day – and none of the forms have been filled in correctly – how long would it take for them to become frustrated?

**Slide 3 – Referral Pathways**

Once again, additional information is in the practitioner booklet.

Focus on common ground – desire to keep children safe/protect them from harm/support families that are struggling at the earliest opportunity.

Remind that First Response do not have access to a magic database – in some cases they have to make decisions based only on what the referrer tells them.

Encourage participants to share all the information they have, and provide explanations for when they don’t have info.

Remind them WHY a referral is being made i.e: to safeguard/protect children – so it is important to get it right first time.

**Slide 4 – Making a referral: the Do’s**

Spend the most time discussing this slide.

Discuss the importance of explaining concerns, using specific, easy to understand language, avoiding jargon, avoiding vague statements (e.g. “behaviour issues”).

Highlight that information should relate to the impact on the child – not just what you are most worried about, but why it is worrying you – what evidence is there that the child is suffering as a result of these concerns? Give context to the worries, including what has already been done to try to help and whether it worked. Don’t be afraid to tell FR about successes – it doesn’t mean there is no need for additional support but it helps to understand what works.

Answering all the questions – if there is a good reason why you don’t know the answer to a question, explain on the form – that way time is not wasted chasing referrers, and the referral is less likely to be rejected. E.g of good reason = person unconscious, unable to provide info, fire officer who has had very limited contact with people in household and no access to other databases. Not a good reason = too busy to do it, don’t want to explain to family why need info!! Remind that a lack of information can lead to a referral being rejected, which means a delay in getting help for the child so important to get it right the first time.

If you can look something up then do it – First Response might not have access to the same database, and even if they do, working together spirit says don’t pass work on to others if you can do it yourself. Not enough time? Tell your managers, tell the board – our job is to challenge if people are not being given the time to work together to protect children – quality of referral info can be the difference between getting a service and not – which could save a child’s life.

Ask group to think about a time when they have read important paperwork in their own job, and discovered important information in the wrong place – why does that matter? Explain the impact of not knowing about other people in the household – e.g. children being missed, a visit to a house with a dangerous person present endangering staff – unable to accurately assess the family if don’t know who is in it.

Stress the importance of talking to a child (that is old enough to speak) and include their view on what is happening. If child is too young to speak then consider including what you have seen the child do non verbally that could be their ‘voice’. Referrals should not be made without the child’s voice (age appropriate of course).

Parent’s views – difficult conversations are part of everyone’s work where safeguarding is concerned. Unless it would put the child at risk of further harm then referrer should share concerns with parents and gain their view on the referral. In the case of requests for early help the parents should be made aware of what support the team could offer, and their views on what they would like help with should always be recorded.

If a parent doesn’t agree with the referral then record why they feel it is not necessary – this also helps with evidence. Referrals without consent will only be accepted if threshold is met for Child Protection (S47 enquiries).

If a referral is for S47 enquiries parents should still be notified – unless it would put child at further risk. If parent has not been notified then explain why not – including if you are still attempting to contact them. All referrers are expected to notify parents/carers or gain consent as part of the referral process.

Strengths are part of the signs of safety approach – and included on the new FR referral form – remember to include them both in your conversations with children and families, and in your referrals – they can play a vital part in any action plan to support families.

**Slide 5 – Making a Referal – the don’ts**

Most don’ts relate to the opposite of the do’s so may already have been covered. If this is the case then there is no need to repeat yourself.

Remind participants that early help does not mean a referral to the early help team – it means intervention at the earliest opportunity. Ask the room to make suggestions of support that they can access for children and families without making a First Response referral (be ready to help out with suggestions if they are unsure).

Use of humour can be appropriate here: point out that we all use jargon in our professions, give a few examples (police: CID, Protect/Manage, SCU or use your own) and encourage others in the room to suggest them. Acknowledge that everyone does this, and it is easy to forget when making notes/making a referral that others might not understand. Encourage participants to proof read their referrals for this before they send them off.

Gaps etc are the opposite of do’s so no need to go over them again at this point unless it is raised by the group.

Leaving the child out – remind group that the referral must focus on the impact on the child’s life – avoid focussing exclusively on 1 specific incident, or entirely on the parent’s needs without linking it to how this affects the child/children.

**The Exercise: Quality Assure a First Response Referral**

The example provided for participants has been provided by First Response as an example of a poor referral – it is anonymised but reflects accurately the quality of some of the referrals received by the service.

Before completing the activity remind participants that all the boxes would have expanded to fit whatever amount the referrer wrote so they are not indicative of the the space provided to respond to questions.

This is the 2017 referral form, some participants might not have seen this before so if necessary give some time to discussing the differences and improvements.

The questions for participants are in their booklet – when leading feedback after the session focus on highlighting the key lessons: vague language, lack of focus to the referral, missing information,and information provided in the wrong boxes on the form. Explain that this is why we are delivering these briefings – to improve the quality of referrals like this.

The key learning points will reflect the Do and Don’t slides – during feedback relate to participants own roles and how they would feel dealing with information of that quality in their day to day work (e.g. poorly completed patient history/notes, turning up to teach a class with no info about lesson plan etc, not being told essential safety info when responding to a police incident etc).

Ask the group why this referral might have been made as such a poor standard. Draw out comments regarding lack of time, lack of knowledge of the child etc. Acknowledge workload pressures etc – then ask participants if the children at risk deserve this.

## Slide 6: Still Need Help?

You need to ensure that participants know who their safeguard lead is (or team in some cases). Leads must be suitably trained to advise staff on making referrals.

Point out the benefits from the new referral form when completed correctly – strongly advise participants to print a copy.

Encourage discussion around making notes – if using jargon then likely to copy it onto referral forms – is there an opportunity to change record keeping to enable better referrals? E.g. using clear language, using signs of safety in internal record keeping – consistent approach.

Agencies that give advice: highlight that local are better as will know local processes – early help partnership managers, SET, BAND etc – you don’t need to know all the options out there – just encourage participants to find out what is available to them as follow on from the training.

Training that can help e.g.: signs of safety, having difficult conversations, advanced safeguarding, training related to specific forms of abuse.

Remind of link to KCS website where all guidance documents, including threshold guidance can be found.

Remind participants of escalation policy to resolve professional disagreements. If they are not happy with a decision from any agency regarding safeguarding (including first response) they should: discuss with their safeguarding lead, and go over any referral completed to check if they have provided all relevant information. If they still don’t understand why a certain decision has been reached encourage them to ask for clarification, and if still disagree with decision to escalate for further discussion.

Point out that professional challenge is normal in child protection as there are many ‘grey’ areas and that it is not a judgement on any individual to use the escalation policy to resolve disagreements.

Remind participants that all detailed information is in their booklet, as are links to relevant documents. Don’t forget to thank them for coming along – this is voluntary.

## Useful information

**First Response**: 0117 903 6444 – if urgent referral, immediate risk of significant harm. Otherwise refer at: [**https://www2.bristol.gov.uk/form/child-or-young-person-request-support-or-report-concern**](https://www2.bristol.gov.uk/form/child-or-young-person-request-support-or-report-concern)

**Outside office hours**- Emergency Duty Team- 01454 615165

**Early Help Teams** - North: 0117 903 8700, South: 0117 903 7770, East Central: 0117 903 6743

**Children’s Social Work Units:** contact numbers for all 27 units across the city can be found at:<https://www.bristol.gov.uk/social-care-health/social-work-contact-details-children-and-young-people>

**KCS website:** [**https://bristolsafeguarding.org/children-home/**](https://bristolsafeguarding.org/children-home/)

**Bristol Threshold Guidance:** [**https://bristolsafeguarding.org/media/1158/threshold-guidance.pdf**](https://bristolsafeguarding.org/media/1158/threshold-guidance.pdf)

**Bristol Single Assessment Framework Guidance:** [**https://bristolsafeguarding.org/media/1175/saf.pdf**](https://bristolsafeguarding.org/media/1175/saf.pdf)

**Escalation Policy:** [**https://bristolsafeguarding.org/media/1176/escalation-procedure.pdf**](https://bristolsafeguarding.org/media/1176/escalation-procedure.pdf)

**South West Child Protection Procedures**: [**www.swcpp.org.uk**](http://www.swcpp.org.uk)