Bradford BSCB Safeguarding Children Board

Annual Report 2015 - 2016

Contents

Introduction from the Independent Chair of the Board - David Niven

In some ways, introducing the Children's Safeguarding Board's Annual Report is easy. So much hard work and effort has been put in over the last year by the staff of the Board, individual members and the constituent agencies. In other ways, the kind of challenges faced separately and together; by all of us who are charged with keeping Bradford's children as safe as possible, are formidable. All face increasing pressure from the austerity measures that continue to be demanded by central Government.

Over the last year several serious case reviews have either concluded or are in process. The learning from these has been helpful and well responded to. Excellent work is being carried out in combatting child sexual exploitation, in improving intelligence and practice around children missing from home and education. The success of the CSE Hub where all new cases are received and worked on by a multi-agency team has shown clear improvement and progress in tackling one of the most challenging areas of child protection.

Regular meetings are now held with senior staff from all agencies looking at best practice in several areas as well as readiness for inspection. The focus on domestic abuse has continued and this work, along with substance abuse and the mental health of vulnerable parents , make up a strong overlap with the Adult Safeguarding Board and the Health and Wellbeing Board. These shared areas that have such impact on a child's experience at home are subject to continued efforts for the Boards to work together. Finding ways to engage the voices of children and young people is regularly reviewed.

Bradford is, as we all know, a varied and diverse community and the Safeguarding Board has worked to reflect this. In addition we have initiated a sub group, with its Chair becoming a member of the Board, to reflect the wide range of cultural and interest groups and advise the Board accordingly.

The Wood Review of local safeguarding boards initiated by the last government has yet to be taken forward by the new administration but the response in Bradford has been to consider how to best look to the future and continue to improve the safeguarding of our children.

The Board recognises that the way people communicate is rapidly changing and so is looking to improve how the people of Bradford see and understand our work. Our annual 'safeguarding week' in October is a valued showcase and opportunity to debate, educate and explain the challenges involved. Our website is marked for an overhaul to make it more contemporary and accessible.

I would like to conclude by saying that this report, contains information on the vast range of work undertaken by members of the Board and the agencies, organisations or individuals they represent . We often read or hear about

challenging cases or situations and, quite rightly, have to answer to them. However, so much good work is being carried out by those charged to protect the children of Bradford that rarely gets talked about, for all sorts of reasons. I would like to pay tribute to their dedication and look to find ways of better reflecting the success stories. We hear a lot about good news and initiatives, many of which you can read about in this annual report.

I truly believe that the Board's duty is not just to solve problems and confront challenges but to celebrate achievement and, in doing so, constantly look to improving trust between those working in safeguarding and the wider community.

David Niven September 2016

Background to the Report

The Children Act 2004, section 14a requires the Independent Chair of the Bradford Safeguarding Children Board to publish an Annual Report that explains and evaluates the effectiveness of the local safeguarding arrangements in protecting and promoting of children in the district of Bradford, and how the Board has been influential in achieving these improvements and thereby reducing harm.

This report reviews the previous year's safeguarding activity within and across the partnership, and the sufficiency of the budget available to support the Board's responsibilities. The annual report is published in line with other agencies planning and reporting cycles. Following acceptance by the main Board, the report will be submitted to the Chief Executive, Leader of the Council and Portfolio holder, the local police and crime commissioner, the Chair of the Health and Well-being Board and is presented to the Overview and Scrutiny Committee of the council by the independent Chair David Niven.

The report has been constructed to enable partners to review how effectively the Board has delivered on the 2015 – 2016 priorities as set out in the Board's Business plan. The report then sets out to explain how the Board is active within the local context, how it is governed and holds the partnership accountable for the safeguarding activity taking place and how the Board fulfils its responsibilities under its key functions.

The Report closes with a statement from the Chair on the Board's overall performance throughout 2015 - 2016, and with a summary of the Board's priorities for the period 2016 – 2018 resulting from the safeguarding activity across 2015 – 2016 and agreed by the partnership.

Chapter 1: The Safeguarding Context in Bradford:

1. Local Demographics

- **Bradford District** - Summary
  - It is currently estimated that there are:
    - 528,200 people living in the Bradford District
    - 8,361 births p.a.
    - 140,484 children 0-17 yrs
    - 33,180 children 0-3 yrs
    - 64% White British people
    - 20% South Asian (Pakistani)
    - 15,305 children with lone parent
    - 30,745 children 0-16 yrs living in low income family
    - Numbers of Children on role in the Bradford District

Year	Academy	Free School	LA Maintained	Total
2015/2016	28,224	3,168	68,418	99,810

The latest population figures produced by the Office for National Statistics (ONS) on 25 June 2015 show that an estimated 528,200 people live in Bradford District.

Bradford District is the fourth largest metropolitan district (in terms of population) in England, after Birmingham, Sheffield and Leeds although the District's population growth is lower than other major cities. In the last three years Bradford's population has grown at 0.3% which is slower than the regional average of 0.8% and the national average of 1.5%.

Bradford is a youthful district with the third highest number of 0 -15 year olds (124,650) in England; only Birmingham and Leeds have higher numbers. Nearly one-quarter (23.6%) of the District's population is aged under 16.

The population of Bradford is ethnically diverse. The largest proportion of the district's population (63.9%) identifies themselves as White British. The district has the largest proportion of people of Pakistani ethnic origin (20.3%) in England.

The largest religious group in Bradford is Christian (45.9% of the population). Nearly one quarter of the population (24.7%) are Muslim. Just over one fifth of the district's population (20.7%) stated that they had no religion.

There are 199, 296 households in the Bradford district. Most households own their own home (29.3% outright and 35.7% with a mortgage). The percentage of privately rented households is 18.1%. 29.6% of households were single person households.

Information from the Annual Population Survey in December 2014 found that Bradford has 214,800 people aged 16-64 in employment. At 65.3% this is significantly lower than the national rate (72.4%). 114,300 (around 1 in 3 people) aged 16-64, are not in work. The claimant count rate is 3.3% which is higher than the regional and national averages.

Skill levels are improving with 25.3% of 16 to 74 year olds educated to degree level. 16.5% of the district's employed residents work in retail/wholesale. The percentage of people working in manufacturing has continued to decrease from 13.2% in 2012 to 12.5% in 2013. This is still higher than the average for Great Britain (8.5%).

The IMD 2015 places Bradford as the 19th most deprived district nationally (where 1 is the most deprived authority and 326 is the least deprived). Bradford's position relative to other English districts has worsened by seven places since IMD 2010.

The pattern of deprivation remains unchanged from previous indices. Bradford has four LSOAs which are consistently within the most deprived 1% of areas nationally based on the IMD updates for 2015, 2010, 2007 and 2004.
The most deprived areas are concentrated in and around central Bradford, in outlying Bradford housing estates such as Holme Wood, Ravenscliffe, Buttershaw and Allerton and in Keighley.
The least deprived areas are found mainly to the north of the district in Ilkley, Burley in Wharfedale and Menston, but also Bingley and rural villages to the west of the district.

2. Vulnerable Groups of Children:

1. Maintaining efficient Standards of Safeguarding Practice :

- **Children subject to child protection processes:**
  - **(Full data report – Performance management Appendix 1)**

In 2015-16 there were 5549 referrals made to Bradford Council's Children's Social Care Services. The number of referrals in the year was about 11% higher than in 2014-15; this is a fairly steady increase across all age groups with the overall proportions by age band very similar to previous years. The "re-referral rate" for Children's Social Care Services in 2015-16, at 14.7%, was a reduction on 16.7% in the previous year.

There has been an increase in children subject to Section 47 Enquiries in 2015-16 (2351 compared to 1938 in the year before). Children will only progress to a child protection conference if the threshold of, or likelihood of significant harm is met and it is assessed that a multi-agency, child protection approach is needed to reduce the harm.

ICPCs were held in respect of 540 children in the year. Timeliness of ICPCs has much improved over the last 3 years; 93.4% were held with within 15 days of the S47 Enquiry compared to 15% in 2013-14. This is higher than the national average of 74.7%.

511 children were subject to a CP Plan as at 31st March 2016, with more males than females. This compares to 513 as at 31st March 2015; the numbers of children on CP Plans remained stable this year after a fall in the previous year. The number of children who *newly became* subject to a CP plan during the year was 524. Of these, 83 children became subject to a CP plan for a second time compared to 12.2% the year before. In the year, there were 522 children whose CP plans ended of which the proportion that lasted over 2 years was 4.2%.

- **Children Looked After:**

Before a decision is taken that a child should become looked after, a full assessment of need is carried out, and all preventative/protection work has to be undertaken to enable the child to remain in their family. Children can only enter the care system if there is parental consent, a court order authorising this or the child is of an age and understanding to request the service in their own right.

848 children in Bradford were looked after at 31 March 2016, a 3.7% reduction on the previous year of 880. 86% of children were looked after due to abuse and neglect reasons, a slight increase on last year's figure of 85%. The national figure at 31 March 2015 was 61%.

The proportion of young people looked after by age groups has remained very similar to last year. There has been a slight decrease in the percentage of 0-4 and 5-9 year olds and a slight rise in the percentage of 10-15 and 16+ year olds. 561 children looked after at 31 March 2016 were of White British origin compared to 582 last year. The number of BME children looked after has increased slightly, 271 compared to 266 last year.

In terms of legal status, 573 children were looked after under a Full Care Order, this is an increase on last year of 528. 114 were subject to Interim Care Orders, compared to 124 last year, and 52 under a Placement Order, the same proportion as in 2014-2015. 93 children were placed under Section 20 placements, a 2% drop on last year.

167 children were placed Out of District at 31 March 2016; a decrease on last year's figure of 186. 61% are placed with foster carers or friends and family carers, whilst 22% are in residential placements. The majority of children placed out of district are in the 10-15 age group.

2. Appraising the effectiveness of Early Help:

While the Journey to excellence process drives forward the Early Help strategy in Bradford, Early Help is currently delivered across a range of targeted services within the Bradford district that include :

- Early Help pathfinder gateways
- Children Centres
- Family Centres.
- Edge of Care
- Youth service
- Families First
- Community problem solver

Two new Early Help pathfinder Gateways located in areas BD 3.4.5.and Keighley have been established. Through the assessment process at the front door, the Children's Initial Contact Point (CICP) route non-MASH contacts through to the Early Help Gateways which triage the incoming contacts. The contacts are then either routed to the multi-agency panel for a review and consideration of an offer of targeted early intervention, signposted to universal services or sent to the Duty Suite at the MASH for review and a decision on whether the contact should become a referral to CSS.

When making the new birth home visits, health visitors seek consent from the parent to inform the children centre local to the family, of the new birth. This has resulted in an increase to 95.2% of families being registered with children's centres in the district. Children's centres then make an offer of a home visit and this has resulted in 42% of families engaging with the children centre services. The ambition of the centres is to raise this number to a target of 65% in the coming year.

Family Centres

There are four Family Centres in the Bradford District based in Keighley, Shipley, West Bowling and Farcliffe. Each Family Centre offers a service in the local area.

- **Low Fold** offers a service to BD13, BD15, BD20, BD21, BD22, BD23 and BD15
- **Farcliffe** offers a service primarily to BD7, BD8, BD9 and BD14
- **Owlet** offers a service primarily to BD16, BD17, BD18, LS29, BD1, BD2, BD3 and BD10
- **Burnett Fields** offer a service primarily to BD4, BD4, BD6 and BD12

The Family Centre service currently only take work from CSC. All cases have had a SW assessment.

LAC - Assessment of parenting capacity for LAC cases in care proceedings - A Community Resource Worker will supervise contact, model good parenting and provide guidance and feedback about changes required to improve parenting skills. Children normally attend contact between 7.5 hours and 10 hours per week. Historically courts have ordered contact to be 5 x 1.5 hour sessions, however recently courts are requesting 3 x 2 hours session. *In November 2015, the Family Centre Service had 169 LAC cases open.*

CIN cases - The FC service holds CIN cases. These cases have had a Social Care assessment and A Community Resource Worker is the case holder and works with partner agencies to effect change and improve outcomes for children. *In November 2015 the Family Centre service had 157 CIN cases open.*

CP cases - The Family Centre works alongside a social worker in CP cases - They work in the family home carrying out a detailed parenting assessment and monitor any safeguarding issues from the CP plan. *In November 2015 the Family Centre Service had 235 CP cases open.*

Joint work on CIN cases - The Family Centre Worker works alongside the Social Worker in CIN cases – In these instances, the case holder is a SW. The Family Centre Worker may be required to undertake a specific piece of work based on specialist skills. These cases are often stepped down to the Family Centre once initial concerns have reduced but still require statutory monitoring and review. *In November 2015 the Family Centre Service had 157 CIN cases open.*

This reflects the importance of early intervention and prevention in work with children and young people to reduce the incidence of abuse and neglect, family breakdown and social exclusion. *In November 2015 the Family Centre Service had 718 cases open in total.*

Range of Services offered are:

- Family Group Conferencing, Family Meetings and Family Mediation all help families to understand and take control of their own destinies after being made aware of the risks and concerns of the professionals.
- Special dedicated courses for parents for those children and young people who need a little extra support, Training for families whose children have Autism, Anger management, Courses for dads and other significant males in a family home, behaviour courses – ESCAPE, Short Breaks for children with disabilities.
- Behavioural specialist support for those children and young people with extreme challenging behaviour. A range of parenting interventions that deliver universal support through to one to one parenting in the home.
- Intensive Family Support within a family's home, who work on Signs of Safety and getting families alongside the children, using the outcome star, to show what a difference they are making or need to make.
- Support for placements whereby risk taking behaviour for teenagers has moved too far beyond the management of their parents or carers, whether this be substance misuse, risk of sexual exploitation, violence and conflict.
- Multi – agency **Family Support Panel** for any professional to attend with consent from the parent/carers

Edge of Care Services

Specialist Behaviour Team

Manage all violent and aggressive young people within the Bradford district to prevent exclusion from home, work on behaviour modification, self-injurious behaviour, destructive, sexualised behaviour, sensory led behaviours. Deliver behavioural tested behaviour programmes, use Applied behavioural analysis (ABA) ESCAPE, support AIMS assessments, Assess Foetal Alcohol Syndrome Disorder.

Deliver on Cygnet training, Behaviour training, Sleep Clinic – regional centre. All staff are Team Teach tutors, Triple P, BILD, Fostering Changes,

Measure work through Goal Attainment Scaling (GAS), HONOSCA – just developing tool for measuring outcomes for High Functioning Autism.

Specialist Inclusion Project

- Deliver short breaks agenda for children with disabilities tier 2 – not for children in CSC – unless part of a direct payment paid package.
- Support universal settings to become more inclusive
- Deliver training packages
- Run clubs and activities, workshops, ministry of food, Minecraft etc. 100 young people a week – 150 during school holidays
- Co-ordinate activities, link work around 40 cases
- Step down for leisure and recreation packages for children's social care around 45 cases
- Residential holiday care pilot - have to move to social enterprise to be able to income generate.
- Outward bounds placements at Nell Bank, Ingleborough and Buckdon for families, children and young people, support groups subsidised and non-subsidised packages, moving towards fully sustainable support.
- Monitor and review all children in commissioned placements around 70 places.
- Commission out small grants of up to £5,000 for inclusion agenda audit provision.
- Work with partner agencies who draw down money for more diffcult young people i.e. mind the gap – Duke of Edinburgh Award.

Placement Support Services

Placement Support Service priorities have altered over the last year to meet changing CSC priorities. PSS stopped working with child in need cases and targeted our intervention into 4 main areas

- Return Home from Care (22% of PSS work)
- Supporting foster carers when placement breakdown is imminent (16% of PSS work)
- High risk child sexual exploitation crisis – when the risk of becoming accommodated in informed by CSE (28% of PSS work)
- Disruptions – when crisis comes in out of hours, children enter care in emergency provision overnight. We offer intervention and support to return children to their families. (12% of PSS work)
- 22% of our work in 2015 were the CIN cases we carried over at the start of the year, as well as any other cases referred through family support panel as needing our intervention.

Return Home Statistics

- 16 children returned to their families from foster care
- 8 children returned to their families from out of local authority placements
- 8 children returned to their families from in house Bradford residential placements.
- Total: 32 children returned to their families.

Foster Families

28 foster families and their foster children have received intervention in 2015 with a further cohort of carers receiving group training. Foster care intervention is often longer term as if notice has already been given then the worker will support the transition and induction into the new placements to secure permanency. Delivering fostering changes in the home as well as in groups; working on outward bounds self-esteem and confidence, attachment work with the child and adult also being trialled.

CSE – Edge of care at risk of being accommodated only

Over the last 7 years PSS have developed a resilience based approach to CSE, working with the whole family to build resilience within family and community networks.

Work with children and families utilising various evidence based practice models, including Zoe Loddricks Trauma Bonds to aid parent and carers understanding of their children's behaviour whilst also offering CSE education to move them through the cycle of change so they are able to take action to safeguard their children. As we offer a whole family approach we also work with children and wider family and friends, to identify with them their vulnerabilities and resilience and support them to build further resilience which in turn reduces their risk to CSE.

CSE work is often longer term and more intensive. We work closely with the CSE hub but much of our work is out of hours and at weekends. We form part of the social work plan and work intensively with children and families. Unsurprisingly our referrals have increased dramatically for families facing CSE, increasing from 35 referrals in 2014 to 52 referrals in 2015.

Disruptions

This is a relatively new area of work for PSS, hence the low figures. PSS used to pick up referrals via placement co-ordination but have recently alligned our duty system to EDTs work and hence we pick up referrals directly as they come in out of hours. In the main these are placements with family that have been disrupted in the short term, We provide intervention and support straight away and pick up the next day with the aim of returning the child to family wherever it is safe to do so.

We provide duty support from 3pm – 10pm every weekday and from 9am – 10pm at weekends and bank holidays with a 24 hour telephone support line for open cases outside of those hours. We have very recently supported the work of EDT within these hours and are trained to act as appropriate adults, mediate home, support children in safe places away from police stations whilst decisions are made re their placements, carry out welfare visits when needed or any other practical response in a crisis. Quite often crisis occur out of hours for our open cases so we can respond promptly to these.

Other 22%

PSS evidence based practice methods:

- Trusted adult model.
- Resilience based approach – pull/ push / pull
- Motivational interviewing and the cycle of change assessments.
- Family meetings based on FGC philosophies
- Mediation.
- Various parenting programmes, time out for teen, nurturing parenting programme and tools learnt through level 4 in parenting.
- Family Star Outcome model
- Solution focused approaches

These were all used previously in CIN cases – this number will account for some of this 22% of cases – however we also pick up cases that require intervention from Family Support Panel.

Intensive Family Support

- Currently supporting families in c/p, PLO and court process
  - Referrals come from C/P plans, PLO/Gateway meetings and court directives
  - Work with all ages

Intensive support offering daily visits particularly around routine times i.e. Bedtimes, mornings and mealtimes, work times 7am -9pm including some weekend and BH work.

Key elements of our intense work-

- Having clear bottom lines at c/p and PLO stage can be a motivating factor if supported effectively

- Intervention builds on strengths whilst addressing vulnerabilities
- Incorporates modelling, practice, feedback/reflection and praise on an intensive level
- Intensive parenting input adapted to the family home/environment to enable hands on support at times of potential stress in the families own surroundings rather than false environments.
- Repetition is key and breaking down information into manageable aspects for parents who are compromised through substance misuse, learning disability and mental health
- Intensity of contact promotes building up of trusting working relationships
- Practical hands on support on a daily basis, someone who will do the "dirty work"- de-cluttering, cleaning, moving house
- Research tells us for something to become a routine it must be done consecutively 21 times to become a habit. Needs every day repetition cannot be achieved by weekly visits.
- Average number of visits per family over a 12 week period 34

IFST provides comprehensive up to date information on parenting capacity for court proceedings/parenting assessments, intensive change work using strengths based practice incorporating

Outcome star - To identify risky behaviours, facilitates useful conversations using motivational interviewing - measures motivation (cycle of change), Solution focussed practice, Measures outcomes.

Signs of safety - Individual work with children re their wishes and feelings using three houses and wizard/Fairy tools

Evidence based parenting programmes - Offered on a one to one basis – support provided at key times, bedtimes and mornings

  - Family Links – Nurturing, looking at attachment
  - Time out for teens
  - Change - A parenting programme for parents with learning difficulties, where information is broken down into pictorial resources- underpinning element being Demonstration- practice-reflection – repetition. Often requested via court

FASD – Foetal alcohol spectrum disorder - Support to LAC –Fostering and adoption/SGO support plans re caring for children with FASD/Early trauma and neglect.
- Education and awareness via workforce development to foster carers, adopters and partner professionals i.e. schools/YOT
- Individual work with children and young people re FASD what is it and what does that mean to me?

Framework of assessment - ICS recordings completed using framework of assessment to support s/w assessment

Sleep clinic-sleep Scotland - Staff trained in sleep therapy to support work with bedtime routines for mainstream children

The parenting programmes the team use to support families are:

- Family Links Nurturing Programme
- Family Links Nurturing Programme (Special Needs)
- Triple P (0 – 12)
- Triple P Teens
- Time Out for Teens
- Time Out For Dads

Parenting Programmes Monitoring Data for Last Quarter

Parenting Programme	Family Links	Time Out for Teens	Triple P	**Total**
Parents who start the course	531	65	42	638
Parents who complete the course	395	45	28	468
Amount of Groups	59	7	7	73
Individual Work	37	0	5	42

Children in Age Groups	Nurturing Programme	Time Out for Teens	Triple P
Under 1	32	3	3
1-3	243	23	11
4-11	429	29	23
12-16	154	40	31
17-20+	68	14	7
Total per programme	**926**	**109**	**75**
Total Children Potentially Reached = 1111			

Children who had a child protection plan in place	50
Children who had poor attendance at school	56
Children who were known to YOT / ASB Teams	55
Parents who were receiving support with substance misuse	32
Parents who were experiencing domestic abuse	42
Parents who were experiencing mental health difficulties	63

Family Links is run across Schools, Children's centres and some VCS organisations, whereas Time Out for Teens and Triple P is mainly run by Educational Psychologists, YOT, and Secondary schools.

Chapter 2 – Governance and Accountability.

1. The Bradford Safeguarding Children Board

The Bradford Safeguarding Children Board (BSCB) is a statutory body convened under the Children Act 2004, and its activity is driven by Working Together 2014 – section 13 and 2015 chapters 3-5. The BSCB comes together to agree how the safeguarding arrangements will work in the Bradford District, how priorities for the Board's business are defined and how partner agency's work activity is evaluated for effectiveness and where necessary hold each other to account where services standards raise some concerns

The Safeguarding Children Board in Bradford has undergone a change of leadership over the period of this report. The Vice Chair of the Board Julie Jenkins, stepped up to chair the Board in March 2015 while a new chair was recruited. A new Independent Chair, David Niven, was welcomed in place in September 2015. The new chair's history includes being chairman of the British Association of Social Workers and of being nine months into a contract as Independent Chair of Tameside Safeguarding Children Board, and he was looking forward to taking on the role for Bradford. The Chair reports directly to the Chief Executive Officer of Bradford District Municipal Council who is ultimately accountable for the safeguarding arrangements for the district.

Vision Statement

The Bradford Safeguarding Children Board is committed to improving the safety of all children and young people in the Bradford District. When children are safe, they can be healthy, happy, achieve and reach their future potential. We recognise and promote the concept that keeping children safe is everybody's responsibility.

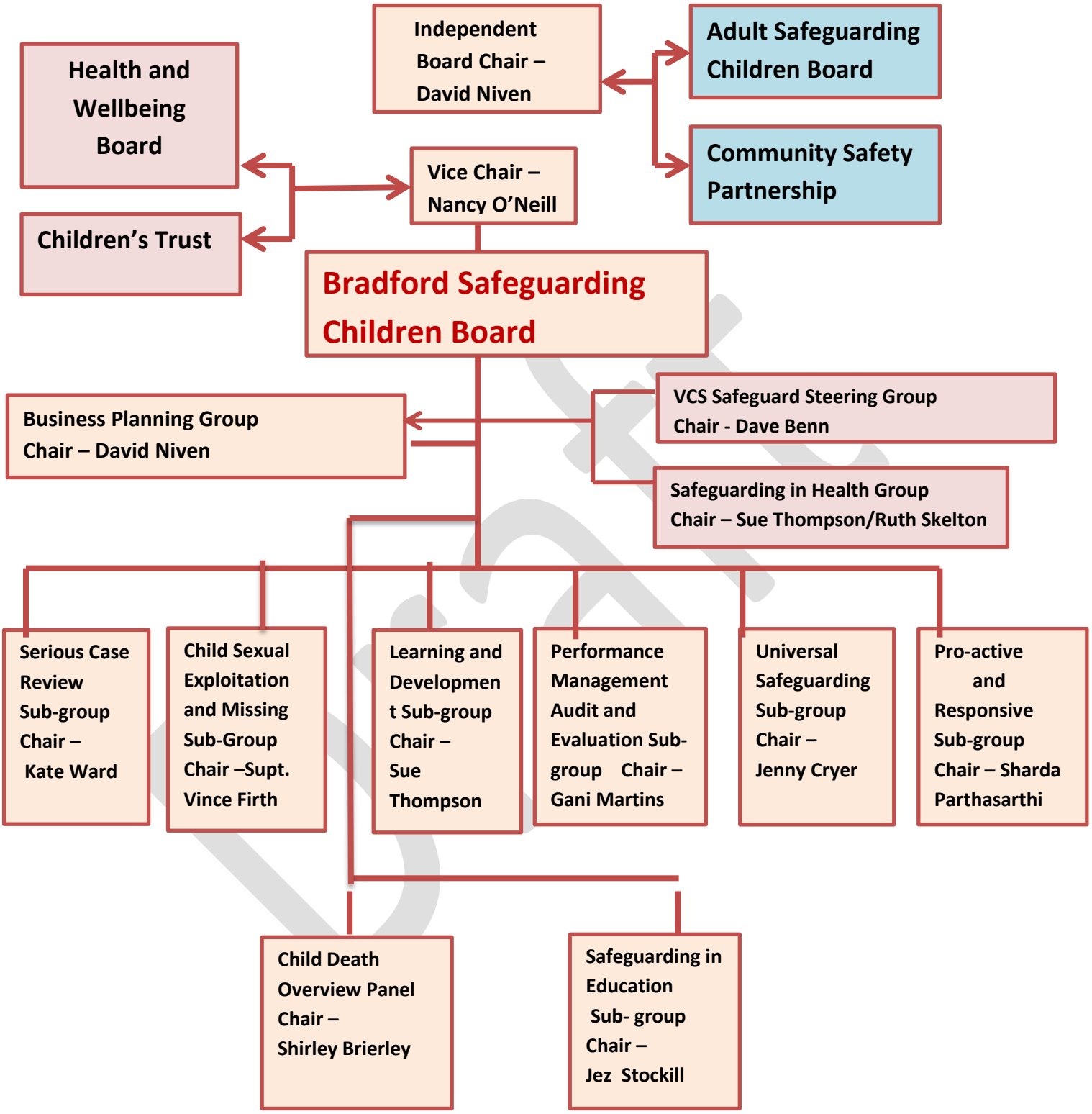
2. How we are Organised

The Board meets 6 times a year in 3 hourly sessions, supported by the business unit which covers the administration of the meeting. The Business manager ensures that the agenda is agreed prior to the meeting and that all required reports are provided prior to the meetings taking place. The Board also meets for an annual development day and holds extra-ordinary meetings as required. The Board is also sits above a business Planning Group which drives the work activity of the Board, and a sub-group structure which takes forward the work of the Business plan, and these groups also meet 6 times a year.

The membership of the Board is listed in appendix 3, and currently is well attended across the full range of statutory partners, lay members and schools (appendix 4). Communication and safeguarding activity between the Board and schools has shown a significant improvement with the establishment of the Safeguarding in Education sub group (SiE), chaired by the Head of an Independent School. An Education Hub has been established to focus directly on children missing education, and the hub reports into the SiE sub group.. There is a focus on increasing participation from children, faith groups and community leaders from BME groups, and there are plans to establish a community advisory group.

Communication across the partnership is currently achieved through the website, and work is taking place to upgrade the site to improve usability. A review of the communication strategy is to take place to take advantage of the breadth of media opportunities now available to transmit messages and briefings to professionals and the public.

3. Structure of the Board



4. Roles and Responsibilities

Independent Chair

The period covered by this report was a challenging one for the partnership in terms of unplanned changes to the leadership of the Board resulting in several changes across the year. The Board was chaired for 6 months by Julie Jenkins, vice chair and Assistant Director for Children's Specialist Services, while a new Chair was recruited and

appointed. The BSCB has been led by David Niven since September 2015. The Chair is directly accountable to the CEO of BDMC and they meet bi-monthly. The Chair also meets regularly with the Director of Children's Services.

The Local Authority

BMDC has a designated lead member for Children's Services who regularly attends the Board meetings and development day as an observer. The Lead member also works closely with the Leader of the Council and the CEO to ensure that the council exercises their responsibility for the safeguarding of children in the district. Regular briefings are provided directly to the Lead member on safeguarding issues, cases and concerns, and to the council through the Children's Services Overview and Scrutiny committee by the Director of Children's Services.

Designated Professionals and Advisors

Advisors to the Board:-

Board Manager
BSCB

Social Services Law Team
Legal and Democratic Services
City of Bradford MDC

Designated Nurse

NHS Airedale
Bradford and Leeds

2 Designated Doctors
NHS Airedale
Bradford and Leeds

Board Support and Administration:-

Deputy Board Manager

Performance and information officer

BSCB advisor for Faith Settings

Learning and Development Coordinator

Board Administrator
Training Administrator

The Board is supported by two designated doctors, each located at a teaching hospital in the district, and a designated safeguarding nurse who reports to the three CCG areas. The designated health professionals work across the Board's structure providing advice on commissioning processes, safeguarding in health issues, policies and procedures and input into the learning Improvement Framework. They also chair the Safeguarding in Health group, which monitors and supports the safeguarding agenda across the health landscape.

Child protection advice is provided by the Board's business manager, who also ensures that all changes to guidance, law and practice are made available to the partnership with a summary of Implications for the Board. The Board has access to legal advice through the Council's Legal Department, but is always mindful of potential conflicts of interest and is able to seek independent advice if the case arises.

Partner Agencies

Effective safeguarding arrangements depend on the partnership's commitment to the Board and sub groups. While representation on the Board is defined by the Children Act 2004 Section 13, the partnership in the Bradford District is fully engaged with the Board, and provides representatives appropriate to the level of authority required at each level of the structure in order to commit their agencies to agreed policies or practice developments. They are also of sufficient authority to hold each other to account for issues of concern or non-compliance, and challenges have been issued where attendance or concerns have not been resolved.

5. Key Relationships

The Chair of the Board has established close working links with the Adult Safeguarding Children Board and the Community Safety Partnership, and the vice Chair of the Board has close working links with the Health and Wellbeing Board and the Children's Trust.

Health and Wellbeing Board

There is an effective working protocol between the BSCB and the Health and wellbeing Board (H&WB) with excellent communication being achieved in both directions through the Vice Chair of the BSCB and the Strategic Director of children's Services who attend both Boards. The Chair of the Board also presents the BSCB's annual report to the H&WB and agrees shared priorities for the safeguarding of children in the Bradford District.

Children's Trust Board

The Children's Trust Board (CTB) is part of the Bradford District Partnership Board (BDP), which also includes the H&WB is chaired by the Leader of the Council and provides an overview and scrutiny of the work being carried out by the partnership. The CTB is chaired by the Strategic Director of Children's Services, who is in the position of communicating safeguarding priorities across all three of the Board's attended. The CTB is focusing on a range of safeguarding strategies that include:

- Developing our integrated Early Help offer across all key agencies
- Refocusing children's placement provision within the Bradford District
- Provide a better response to young people in crisis
- Develop an integrated service across children's, adult's and health services for young people with aged 14-25 years with complex health and/or disabilities:

Bradford Adult Safeguarding Board

The Chair of the Board has regular meetings with the Chair of the Adult Safeguarding Board to identify joint safeguarding priorities that cut across both areas of responsibility. This includes a joint focus on vulnerable adults experiencing domestic abuse, mental health challenges and substance misuse who are also parents and or carers. This is resulting in BSAB representation being invited into sub groups and challenge panels where practice expectations and protocols are being discussed.

Community Safety Partnership Board

The Board also has developed close links with the Community Safety Partnership Board through the police and national probation service both of which have members attending both Boards. The Chair of the BSCB also maintains close links through the work on substance misuse and domestic abuse.

6. Financial Arrangements

The Bradford Safeguarding Children Board functions, activities and business unit is funded through a pooled budget contributed too by a range of statutory partners, and begun the 2015 – 2016 year with a budget of £552,440.00

made up of a base budget of £376,340.00 and a carried forward underspend of ££176,100.00. The budget contributions and activity is as follows:

LOCAL SAFEGUARDING CHILDREN BOARD

Financial Statement 2015-16

Balance b/fwd from 2014-15					**-176,100**
Heading	**Outturn 2014-15**	**Actual as at 31st March 2016**	**2015-16 Budget**	**Variance**	
			£	**£**	
Employees (including agency)	407,572	311,328	288,000	23,328	
NHS based CDOP	51,520	51,000		51,000	
Admin worker based with the Police				0	
Staff travel	4,343	5,385	8,350	-2,965	
Staff Advertising	1,705			0	
Training(Incl Room Hire and Catering)	45,348	16,822	43,500	-26,678	
Materials	62	12		12	
Equipment	164	434	500	-66	
Printing/Publicity	2,637	5,329		5,329	
Independent Consultants for SCRs and other case reviews	5,660	40,914	8,100	32,814	
Independent Chair of Board	12,300	24,189	26,800	-2,611	
Expenses	4,826	9,726	1,000	8,726	
IT & Telecoms	22,455	935		935	
Total Expenditure	**558,590**	**466,074**	**376,250**	**89,824**	**0**
Contributions	347,225	376,340	376,250	-90	
Base Budget	27,300	0	0	0	
Admin Budget	72,100	0	0	0	
Misc Income	19,850	1,000	0	-1,000	
Total Income	**466,475**	**377,340**	**376,250**	**-1,090**	
2015-16 Total Surplus					**-85,186**

NOTES

CONTRIBUTIONS 2015/16

Bradford Council Childrens Services		**205,200**
social care	137,767	
Bfd Educ	34,467	
Early Years	16,483	
Youth Service	16,483	
Health		**148,350**
Police		**17,550**
National Probation Service		**2,345**
West Yorkshire Community Rehabilitation		**2,345**

Cafcass	**550**
Total Contributions	**376,340**

7. Effective Performance Management -Scrutiny and Challenge

The Board fulfils its responsibilities to ensure that performance across the partnership is effectively managed through a range of strategies. Through the Performance Management Audit and Evaluation sub group (PMAE), multi-agency data, both quantative and qualitative, pertaining to safeguarding activity, is recorded and analysed on a quarterly basis through the data scorecard and presented to the business planning group and full board for scrutiny. This activity had identified some previous issues with attendance at case conferences which resulted in a challenge being made to agencies and this has resulted in a protocol for police attendance which is fully implemented and complied with. There was a further issue around the timeliness of case conferences and a target was set for improvement which has been exceeded.

The PMAE also oversee the audit and challenge panel agenda, organise the panels and draft an outcome report and action plan that the subgroup over sees to completion. The sub group also reviews the outcome of individual agency audits to identify areas of good practice and issues for improvement. These two activities form two parts of the evaluation of practice triangle with training evaluation forming the third side. The work has resulted in improvements taking place across a range of multi-agency and individual agency safeguarding activity. A review of the CSE hub has begun, which includes a review of the risk assessment tool and a drafting of a CSE framework. A task and finish group has been established to review the risks of CSE for disabled children, and the services and tools available to identify and reduce the risk of harm.

The PMAE also monitors and scrutinises the Section 11 process for the Board. The process runs continually in Bradford through the Virtual College input and assessment tool. Agencies across the partnership are able to update their information, evidence and analysis on a quarterly basis. The PMAE sub group drafts an action plan from the information on the system and monitors each agency's progress on this. Currently, there is a high level of compliance, but where there has been delay in updating reports, challenges have been sent out to agencies with timescales to re-establish compliance with the agreed process. Feedback from some of the agencies identified that the tool was difficult to use, and this has been addressed with the College who put improvements in place and this issue is now resolved. The Performance Framework works alongside the Learning and Improvement Framework to assure the Board that all levels of improvement, resulting in the reduction of risks to children in the district, are being addressed.

8. Continuous Learning and Improvement

In accordance with Working Together 2015:

"Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result." (WT 2015: p.72)
The BSCB reviewed its Learning and Improvement Framework (L&IF) in April 2015 and it is available on the Board's website for public and professional access. The development of the local framework has enabled BSCB, partner agencies and local partnership bodies to be clear about how the learning and improvement cycle can be achieved through various methods. The framework offers guidance, as well as the way in which learning can be shared in order to improve practice.

It is important that agencies are clear about their safeguarding responsibilities and respond to the Board's learning and improvement activity, in particular the recommendations for their agency, providing evidence of their agency's progress on implementing the actions and using this as a basis for developing their safeguarding practice. In relation to the learning and improvement work undertaken, it is important that this is not seen as an end in itself but as a progression of improvement across the safeguarding partnership.

This is evident through the safeguarding activity arising from the different levels of reviews, audits and challenge panels carried out by the Board. Learning arising from local and national serious case reviews have resulted in a series of briefings and face to face learning events around CSE, the impact of incontinence, neglect and bruising in non-mobile babies.

9. Allegations Management

The Local Authority Designated Officer Service:

A well-established LADO service is in place that facilitates safer working practices in the Bradford District. It comprises of a Senior Manager as the designated LADO Officer in the Safeguarding Unit under Children's Services and is supported by a rota of experienced child protection LADO investigators, a police contact in the MSASH and a single point of contact (SPOC) for education by a senior officer in the access and inclusion unit. The SPOC is available to schools and education providers for advice and guidance on the 'Allegations Against Professionals' (AAP) procedure, and whether the threshold is met for an investigation. Where the threshold is met, the SPOC refers the case to the LADO and Police officer who implement the process. The SPOC continues to support the school/education provider throughout the process where required. This has resulted in schools and education providers experiencing the process as supportive and them being more actively involved in the process overall. The police officer reviews the referral and makes a judgement on whether the case will become a criminal investigation and the outcome is recorded on the file.

The LADO service has implemented 2 key initiatives which continue to demonstrate rigour and objectivity in the process around allegations made against residential unit staff and foster carers. Where an allegation is made against staff in a residential provision, an independent manager from another provider is commissioned to carry out the investigation and provide a report to the investigation team. Likewise, where an allegation is made against a foster carer, an advanced practitioner is commissioned from a different fostering team to carry out the same responsibility.

The designated officer is fully engaged with the West Yorkshire LADO network which ensures a level of consistency and application over the wider West Yorkshire partnership, and attends the National LADO conference to ensure that changes or improvements to guidelines in respect of safe working practices are disseminated across the Safeguarding partnership and that this supports the development of safe organisational cultures within organisations. This is achieved by the LADO making an annual report to the BSCB, leading on the Allegations Management and safer recruitment training events and by their presence on the Proactive and Responsive and Universal sub groups where emerging issues are considered and action identified for improvements.

Over the 2015 – 2016 period the total number of LADO referrals received was 236, this was an increase of 27 cases on the previous year. The duty to refer to the Disclosure and Barring Service was a highlighted event in the 2015 safeguarding week in Bradford. It is noted that the number of referrals being received from health services and independent nurseries has increased and evaluation is taking place as to why these increases are being noticed.

The total number of referrals successfully closed was 263, compared with a figure of 239 in 2014-2015. Ninety Eight of these closures (37%) were recorded as substantiated.

Overall Outcome:	Total:
Malicious	3
Substantiated	98
Unfounded	17

Unsubstantiated	141
Other	4
Grand Total	**263**

A total of 80 cases were recorded on the system for information only, which demonstrates that partners are using the service effectively for advice and guidance on whether a case reaches the threshold for an AAP or whether different action needs to be taken.

Child Protection Complaints:

Complaints, made by parents or children of sufficient understanding, about the child protection process are managed through the West Yorkshire consortium's inter-agency safeguarding child protection procedures. The process is organised over three levels of response, culminating in an appeal to the Board if the complainant remains dissatisfied with responses at the first and second level. Every effort is made to resolve the complaint at the earliest opportunity to enable the work with the family to progress constructively. During the period covered by the report, 2 complaints were received by the safeguarding team, and one was resolved at stage one of the process and the second is on-going.

Professional partners who wish to challenge the child protection process follow the conflict resolution process under the safeguarding procedures. To date, there have been no formal challenges under this process, and the reasons for this are being reviewed through the challenge panels. Learning from each of the processes is kept under review and is included as a key priority in multi-agency safeguarding training and action plans. A further improvement is being introduced under the Signs of Safety approach to each area of child protection activity. It is anticipated that the approach will enhance parent participation and lead to reduced risks to children.

Chapter 3 - 2015/2016 – progress and Improvement on the Board's priority Areas

The Bradford safeguarding partnership that makes up the membership of the Main Board approved the 2015 – 2016 Business plan. Through the planning process 4 key priorities were identified for further development and improvement throughout the course of year. This chapter will analyse and evaluate the progress of the activity within each priority area, what improvement was made and how this impacted on the safeguarding of children and what is next to do.

As activity progressed under the Board's Business action plan, further areas of development or improvement became apparent and resulted in additional actions being added to the work plan, targeted multi agency, focused learning events being organised, a deep dive review of high profile issues and the establishment of a rigorous challenge panel approach to holding partners to account.

Priority 1: Performance

- ***Priority Outcome: A Performance information system that gives an overview of the effectiveness of the safeguarding system.***

An LSCB that is good provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high quality services.

The BSCB has a statutory responsibility to ensure that partner agencies are effectively protecting children and promoting their welfare within the Bradford District. In order to carry out this responsibility the Board requires a sound performance management framework that enables the partnership to monitor and scrutinise safeguarding services, front line practice and triangulate evidence to identify where improvement is needed. Through this process the partners are able to hold each other to account and make constructive challenges where needed to facilitate improvement and reduce harm.

Activity identified under priority 1:

- A Performance framework to be developed
  1. The data set will be analysed to identify areas of declining effectiveness
  2. Provision of more comprehensive performance information and analysis about priority vulnerable groups
  3. The BSCB to have an overview of performance
  4. Section 11 (Children Act 2004) Audit review
  5. Impact evaluation of safeguarding training and the quality of front line practice on outcomes for children

Achievements to date:

1. The Performance Management, Audit and Evaluation sub group (PMAE) has worked together with the safeguarding partnership to evaluate the current performance management framework and data scorecard, to identify gaps and areas of improvement. Research has taken place over a range of models being delivered by other safeguarding boards to facilitate the development of a model that will meet the local needs of the Bradford Safeguarding children partnership.

2. A performance management framework and data scorecard model has been drafted and agreed by the sub group and is being tested across the partnership for rigour and robustness, local relevance and effectiveness in meeting the priority outcome 1.

3. The progress of the work is now routinely monitored by the Business planning group and scrutinised by the Main Board to assure the Board that progress is forward moving and meeting the responsibilities of the Board.

4. The Board, in conjunction with the Virtual College has achieved a design update in the toolkit for the on-line Section 11 report making the tool easier to use when updating progress and activity. The PMAE is continuing to monitor the self-reporting of partner agencies on their progress and is challenging non-compliance with their action plans, where timescales or activity has not been achieved. The outcome of this activity is reported to the Board on a half yearly basis and partners are being held to account for the progress being made and where improvements are required.

5. The Learning and Development (L&D) sub group continues to evaluate the impact of safeguarding training through a range of strategies. All courses are evaluated at source through feedback from the attendees, this is then routinely followed up with front line managers to establish the impact of the learning on the attendees practice. Partner agencies are carrying out internal audits to evaluate practice by their front line practitioners and the results of these are considered by the L&D group to evaluate impact. A further dimension to the evaluation has been introduced through multi-agency challenge panels, which spotlight a number of cases under a focused theme and the resulting report is highlighting areas of good practice and areas in need of improvement.

***** The threshold of need guidance has been placed under review to ensure that it meets the changing landscape in local front line services. This work is being carried out in conjunction with the development of the early help offer. The multi-agency Early Help Board (EHB) has established two pilot areas in Bradford to model two Early Help Gateways, and an evaluation of the effectiveness of the projects is being monitored by the PMAE sub group and reported to the Main Board.

Priority 1: - work achieved by Safeguarding Partners:

West Yorkshire Police – have invested considerable personnel resources into the Multi-agency Safeguarding Hub (MASH), the child sexual exploitation hub (CSE hub), CSE historical cases and children missing and missing from education. The collaborative front line activity has ensured that data from these vulnerable groups is now being robustly recorded.

The Police and Crime Commissioner – has funded a data analyst post within the MASH. This has resulted in a rigorous review of the recorded data and scorecard and has produced a racetrack of CSE and Missing activity which enables the Board the effectively evaluate partner services activity in these areas. The scorecard is routinely monitored by the child sexual exploitation and missing (CSE&M) subgroup which oversees the action plans for CSE and missing children and is scrutinised by the PMAE subgroup for compliance with the plans.

BLAST – Routinely participates in the CSE hub discussions on boys at risk of CSE and contributes to the collection of data in this area of safeguarding activity.

Barnados – 'NightWatch' programme has received further funding from the community safety partnership to continue their work in the district offering advice, guidance, support and training to businesses, services and the general public in raising awareness of CSE, thus generating further intelligence that supports resource planning.

Bradford Teaching Hospital Foundation Trust (BTHFT) and Airedale Hospital Foundation Trust (AHFT) – are in the process of upgrading their record and information systems to enable their contributions to the data scorecard to fully meet the new wider range of score card information required by the Board.

All Partner Agencies – are contributing to the continuous process of updating the Section 11 on-line tool.

Children's Services (CSC) – Continue to drive improvements in the electronic record and case management system (LCS) to facilitate and improve the quality, range and rigor of data being produced on children and their families.

Clinical Commissioning Group (CCG) and Bradford District Care Foundation Trust (BDCFT) – have worked to improve the interface between record systems within the health partnerships thus ensuring that their contributions to the data scorecard meet the new wider requirements.

NSPCC – Has reviewed and produced a draft multi-agency Neglect Strategy for the Board in conjunction with the review of the Threshold guidance and the Early Help offer – Journey to Excellence.

Children's Services – Journey to Excellence – is driving forward the early help offer in conjunction with the early help board, and further pilot EH gateways are being planned for implementation in the coming year.

How have these achievements made a difference to children and their family's:

- The improved data scorecard and CSE racetrack has enabled intelligence led, resource planning and safeguarding action to take place within agencies across the partnership:-
    1. The CSE hub now has dedicated police officer's and social workers who daily assess the risk to children who are referred to them and ensure that an appropriate level of response is made to protect them from abuse and reduce harm. Children are kept safer throughout the process and a multi-agency approach is taken to the provision of services to address the child's vulnerabilities and build resilience to reduce the risk of further harm.
    2. The risk to boys, of CSE, is now better understood across the partnership and they are therefore better protected. The awareness raising events that have taken place now routinely ensure that boys receive the same level of scrutiny and analysis as those completed on girls.
    3. Children who are recorded as missing receive a welfare visit from the police and a follow up return home interview from two dedicated services, one for looked after children and one for those missing from home. Preventative services are put in quickly to work with the child and family to analyse the driver for the behaviour and address the root cause. This has resulted in several new cases of CSE being identified and addressed through the criminal process.
    4. Children are now safer because all taxi drivers registered to the Bradford Municipal District Council will undertake a training event on CSE to ensure that they are able to recognise the signs and respond effectively in referring the child to the appropriate agency.
    5. Children are now safer because night time economy workers are in place and active on the ground working with hotels food outlet businesses that attract children and bring them into contact with abusive situation from groomers and paedophiles. Management and staff in these areas are provided with training on how to recognise the signs of children being exploited and abused and what action they need to take.
    6. As to be expected - the wider awareness raising of CSE and missing has resulted in a significant rise in the number of children being identified at risk, and this is evaluated as an important success in the current CSE and missing strategy
    7. Children are now safer within the district as non-compliance with safeguarding practice expectations, insufficiency in agency resources or failure to complete work in action plans is now identified within the performance framework, and the risk raised within the challenge and risk log at the business planning group and action taken to address the risk is provided to the main board for ratification and/or approval.
- Currently, the work sent to the two Early Help Gateways is filtered through the CSC front door and monitored by the MASH team manager. The Gateways have a multi-agency panel in place which considers the needs of the child and agrees the services to be offered. This has enabled children and their families, within the two areas involved, to receive targeted local services efficiently and with the minimum of delay thereby effectively promoting their welfare and preventing harm.

What needs to happen next:

- The performance management framework needs to be formally agreed and fully implemented across the partnership.
- All partners need to routinely provide an analysis of their own performance across the framework through the data provided to the scorecard, the training needs analysis process and the continuous section 11 audit process. This will enable the Board to fully understand the effectiveness of the safeguarding arrangements in place across the partnership and be assured that insufficiency and risk are identified quickly and formally addressed.
- That the Early Help Offer is formally agreed and implemented across the district, and that the review of the threshold guidance and the neglect strategy are also formally agreed and adopted.
- That the impact and implementation of the Early Help offer is evaluated through the performance management framework and scorecard to assess how partner agencies understand the contribution Early Help makes to safeguarding children; how effectively it is operating across the district in terms of multi-agency usage and what difference has made to children.

Priority 2: Engagement and Participation

- ***Priority Outcomes: Engagement with the wider community, schools and participation from young people.***

An LSCB that is outstanding is highly influential in improving the care and protection of children.

In order for the BSCB to be highly influential in improving the care and protection of the children within the district the partnership must be able to demonstrate how effectively it is able to engage with all sectors of the community through the activities that take place under the umbrella of the safeguarding arrangements. In order for the engagement process to be fully effective it must also reach out to the children and their families within the communities.

A further dimension in this process is the engagement with faith settings and the wider educational landscape that also influence the care and protection of children.

Activity identified under priority 2:

1. Build on the work done in engaging with mosques and madrassahs
2. Improve the awareness of safeguarding issues with new communities and facilitate their access to universal services
3. Further strengthen engagement with schools and FE colleges across the changing education landscape in the district
4. Increased participation of children in the safeguarding process

Achievements to date:

1. Building on the work carried out with mosques and madrassahs, a wider view of safeguarding across all faith settings has been taken by the Board. The BSCB now has a deeper understanding of the provision of unregulated Islamic/faith education within the Madrassahs sited in the Bradford District. The list of Massajids/ Madrassa continues to grow, there are approximately 125 places where teaching takes place, as well as 6 Gudwaraas, 75 churches, 1 synagogue and 4 Mandirs within Bradford District. The management and organisation of the units varies depending on the status of the provision which ranges from teaching provided in schools and faith settings, to those being carried out within private homes. An average sized madrassa teaches approximately 150 children with the biggest madrassa catering up to 500children.

Through the work carried out by the safeguarding advisor for faith settings (SAFS), the number of children being schooled is estimated to be between 12 to 16000 children attending religious studies from Monday to Saturday and as the population growth increase there will be additional demands put upon on madrassas to provide a service. As a result Bradford has a growing numbers of house madrassas where there are perceived additional risks to the children.

In partnership with faith settings, evening Road safety sessions have taken place in madrassas. Most madrassas have now taken the matter more seriously and are adhering to advice. There are encouraging signs that parents are escorting children to and from madrassa. Children wearing high visibility vests provided by the safeguarding Board and financed by partner agencies. Parents are encouraged to park elsewhere away from the main buildings thus not creating a hazard for the children or blocking an escape route.

Some of the more established madrassa are now providing on site, college education for both their staff members, the community, and are engaging with statutory agencies. Facilitated by the BSCB, the following courses are currently on offer to staff and volunteers in faith settings: -

Autism- Road Safety -Alcohol and drugs -First Aid -Governance -Workshop to Raise Awareness of Prevent Safeguarding (WRAPS) Crime Prevention & Awareness Programme -Complex Health and Disability -Safeguarding Adults -Smile with the Prophet /Brush up your smile -Cyber bullying.

New Muslims are now settling in Bradford, they have come from Europe, Africa, Middle and Far East, bringing with them their own religious beliefs, tradition and cultural identity

2. Having recognised the difficulties being faced by the new Central and East European communities in Bradford in accessing universal services and housing, the Board facilitated the drafting of a fast track referral process for both the front door and the housing service. All referrals through this pathway are considered by a multi-agency assessment team consisting of professionals from children's specialist services (CSS), West Yorkshire police, Education and health services. The referral is risk assessed and processed through CSS or signposted to targeted early help or universal services.

To ensure the pathway was effectively implemented, the BSCB organised a multi-agency conference in May 2015 - **Safeguarding Children from Central and Eastern European Families -** that focused on the safeguarding issues specific to children from the new communities. The conference included a mix of presentations, workshops and table top activity. It was attended by a range of practitioners and managers from the BSCB partner organisations. There were 105 delegates and 45 staff involved in presenting, delivering workshops and providing information and advice. Members from the local Central and Eastern European community assisted with the delivery of a session about cultural and community issues. This was led by the Access Lead BMDC Education Service for New Communities and Travellers.

3. In order for the BSCB to be assured that the responsibilities under 'Working Together to Safeguard Children in Education – 2015; and to strengthen the engagement and communication between the BSCB and the schools and further education providers in the district, the Board approved the setting up of a Safeguarding in Education sub group. The group first met in January 2016 and has been operating as a sub group since March 2016.

The sub group is to play a key role in strategically supporting the safeguarding of children under the age of 18 years in the full range of education settings, and through the appropriate provision of education support services. This will be achieved through promoting, supporting, coordinating and monitoring the effectiveness of safeguarding practice delivered in education settings and by education support services in the District. Particular emphasis is being placed on the changing demands arising from changes to the law and Government guidance – in particular Ofsted expectations on safeguarding reporting, the prevent agenda, child sexual exploitation, domestic abuse and female genital mutilation. The Board has carried out a survey in the schools to identify what level of safeguarding training is being accessed by the schools, and whether the training being accessed meets expectations in terms of content and quality.

4. The BSCB has support a range of initiatives across the year to increase the participation of young people in the safeguarding process. A Senior Manager in Children's Services at Bradford Council leads on Youth Voice, supported by youth service staff and youth organisations across the District. Bradford has a Youth Voice Working Group formed with the Council and Partner organisations supporting the development of District wide youth voice events. Over 500 young people have been involved in a number of recent youth voice events across the District including engagement with some high profile strategic groups. This has included engagement with the Children's Trust Board in December 2015, consultation around the District Priorities in February 2016 and participating in a youth voice event held by Bradford College in February 2016.

In addition Bradford has worked with external organisations to help us to listen to the voice of children and young people, and to raise the profile of Bradford's children nationally. The two key opportunities for this were the Home Office Select Committee visit and the two day visit of the Children's Commissioner.

Bradford makes good use of the Viewpoint programme with children in the care system giving a rich source of feedback data. It is anticipated that this will be further offered to children in the child protection system and children's voices will be fed back to the Board through emerging themes arising from the feedback from both areas.

In the Autumn of 2015, the BSCB completed a survey of children, schools and partner agencies on bullying. One hundred and eleven primary and 21 secondary schools were surveyed. Ninety Four children responded to the survey, and the data indicated that the numbers of children being bullied in Bradford was in line with national figures. The survey result indicated that the highest number of children being bullied was in the younger age range and this number significantly decreased in the older age group. Children overwhelmingly felt that adults could do better. The West Yorkshire safeguarding procedures were updated in November 2015 to strengthen the entry on cyber bullying, and there is to be a revision of the multi-agency Bullying Strategy for the Bradford District.

Priority 2: - work achieved by Safeguarding Partners:

Bradford College - In conjunction with BSCB, are currently developing an accredited basic teacher training course for faith teachers. It is envisaged this course will be rolled out in the coming year.

- As part of the 2015 Safeguarding Week, a performance company the **Further Education Performing Arts** students from Bradford College created a piece of devised theatre called "Breaking the Silence". This was in two parts. The students were supported by college staff to participate in workshops delivered by BSCB and Bradford Council's trainers. The students learned about the challenging world of safeguarding children, adults and domestic abuse. These workshops then sparked the student's creativity to develop and shape an original performance to launch Safeguarding week 2015, which was performed in two parts.

Education Bradford – Community Cohesion Team - In partnership with BSCB provide a number of one day courses for faith settings such as: - DBS, Child Protection, Behaviour Management, Fire Marshall , First Aid, Work Shop to Raise Awareness Of Prevent, Drugs Awareness including an annual Interfaith celebration.

BMDC - Road safety team have carried out road safety risk assessments in some of the Bradford madrassas.

- An educational drama tour was commissioned by the BSCB and funded by local authority for the District's secondary schools highlighting the risks of CSE to year 10 students.

- The MASH is being extended to include a Safeguarding Education Hub which will offer operational support to all educational setting in terms of safeguarding issues, monitor children missing from education under both known and unknown categories and develop effective links with other government agencies to enable vulnerable children to be tracked and action taken to reduce the vulnerability.

NSPCC School's Service – visited half the schools in Bradford – primary, non-mainstream educational provision and private schools to present the service to head teachers and demonstrate what the service has to offer to children to make them aware of how to keep themselves safe. The awareness is raised through video and work sessions with the children who then get a 'My Buddy Kit' to keep if they need to report abuse at a later date. This work has resulted in a successful conviction in Bradford.

BLAST School Development work - participation of Bradford schools in the development work for a CSE resource has been limited, but this work is now complete. The launch is of "Alright Charlie" is planned for the end of March 2016 – it is a CSE resource aimed at educating years 5-6 on awareness of grooming.

How have these achievements made a difference to children and their family's:

1. The risk of harm to children in faith settings is being reduced from a range of risks.
    - Road safety assessments and practical support strategies included wearing high visibility safety vests, a madrassa road safety custodian oversees the safe arrival of all children. Parents have to bring and collect their children from inside of the madrassa, and giving advice to the providers on setting expectations for children's safety have reduced the number of incidents involving children.
    - Fire risk assessments have been offered to providers – in particular to those being delivered in private settings.
    - The quality of care, teaching and child protection has been improved through the delivery of a wide range of safeguarding training through the Board and the Bradford College resulting in children having a safer experience while learning about their faith.
2. Children from the Central and East European communities are having their welfare and safety promoted through the receipt of effective and timely safeguarding services across the partnership. This is being achieved through the delivery of a fast track referral system for children in need and in need of protection,

and more widely through the provision to families and professionals, of a comprehensive guide to universal and targeted services.

3. The risk of harm to children attending educational settings is being reduced through the following activity:
    - Schools have engaged in the delivery of the CSE programmes for year 10 and children are now aware of the risks from CSE and how to keep themselves safe.
    - Schools have been trained to spot signs of radical behaviour emerging and know how to protect children in these situations.
    - That the bullying that children experience within the educational settings is under review and action is to be taken to revise the current strategy and work with children and schools to take action to reduce this form of abuse.
    - The risk of radicalisation of children is now being routinely monitored by the Challenge panel and reported to the Board to assure partners that prevent activity is effective in safeguarding children.
    - The relationships between educational settings and the Board are being strengthened through the implementation of the sub group and the hub. This will reinforce the expectations of safeguarding activity on both sides of the relationship which will improve communication and safeguarding practice.
4. Children's voices are now being heard across a range safeguarding, service delivery and planning and commissioning activities:
    - This is resulting in safeguarding themes being recognised from the feedback they are providing through Viewpoint. These themes will be considered in the PMAE sub group for on-going safeguarding scrutiny and challenge where appropriate.
    - Children's voices have been heard through the bullying survey, and have raised issues over the current bullying strategy and this will be revised as a result of their feedback.

What needs to happen next:

- Safeguarding work in faith settings needs to be widened to cover all providers across all faith groups.
- Home madrassas tend to cater between 10 and 60 children and some have developed shifts patterns to accommodate local demands. Often teaching takes place in one or more rooms such as cellars, lofts; front and back rooms or garages. The risks to children were identified as a failure to implement fire safety, road safety, health and safety assessments and first aid. Of the tutors who were interviewed, with the one exception, none of the rest had Disclosure and Barring Service (DBS) checks. Therefore, targeted work on safety/risk issues needs to focused on individual providers who are delivering teaching in their own buildings or homes.
- The basic teacher training accreditation course for faith tutors/teachers needs to implemented and taken up by the faith settings for their volunteers and in house tutors.
- An agreed LADO/DBS approach needs to be implemented for unregulated settings provided by individuals.
- To develop a contact list of faith settings to use Emails and the website for cascading relevant information in relation to free training and events. Furthermore highlighting and promoting the good work that is taking place in some of the faith settings and in the community to encourage places of worship to look at wider issues both internally and externally so that they can play a major role in shaping the local community.
- A review of the fast track system for referrals around new communities to test for effectiveness and outcomes.
- To review the activity in the safeguarding education hub for effectiveness around children missing education.
- The strategy and policy on Bullying in schools be reviewed and updated.

- That the Board discuss the options available to strengthen children's participation in the Board's activities, and the Commissioner for Children works with the Board manager to identify resource and to put the preferred option into operation.
- That the Board requests a regular paper on the results of viewpoint activity undertaken with children in the child protection process and in care.

Priority 3: Challenge and Change

- **Priority Outcomes: Effective Challenge, learning, communication, information exchange and embracing change**

An outstanding LSCB can demonstrate that their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters and effective learning culture.

In order for the Bradford Safeguarding Children Board to meet its statutory responsibilities it must be able to demonstrate through the Board's accountability framework that the activity taking place under the sub groups will be overseen at both the strategic and operational level. The framework will ensure that partners hold one another to account effectively, drive the improvements through the workflow of the Board and ensure that its core functions are met in the safeguarding of children in the Bradford District. The Board will have an effective communication strategy that enables learning to be disseminated across the partnership and drives improvement in practice.

Activity identified under priority 3:

1. A scrutiny and challenge of safeguarding issues so that change is effected and maintained
2. A review of the Learning and Improvement Framework for effectiveness and rigour
3. To improve the methods of shared learning to enable a wider reach across the partnership
4. To implement a comprehensive training needs analysis framework
5. To improve communication channels to ensure that front line staff understand the priorities
6. To ensure that front line practitioners understand the importance of effective information sharing, the expectations for practice, and the implications for children of poor practice.

Achievements to date:

1. The Board has continued its policy of carrying out multi-agency challenge panels on identified themes. Cases are selected for the panels at random following case audits carried out by service providers. Two challenge panels have taken place over the period of this report. The first challenge panel was completed on disabled children, the outcome of which identified that all assessments, and in particular child assessment framework (CAFs) should routinely consider disability. A further recommendation was that all front line practitioners should receive training on how to include this area in their assessments.

The second challenge panel was a follow up on children at risk of sexual exploitation (CSE). Children's Social Care had commissioned an audit of 75 cases where CSE had been identified as an issue. The challenge panel then reviewed 6 cases under a multi-agency spotlight. The outcome report identified a number of issues around analysis and assessment, potential role confusion, access to medicals and the allocation of work to appropriately experienced workers.

In addition to the deep dive focus of the challenge panels, individual partner agencies also provide reports on the audits they have carried out over the period and these are considered in the PMAE sub group to identify good practice, risks and areas of improvement. A quality and assurance framework is being developed to ensure that the salient points are identified and action plans are in place for improvements.
Each sub group has been tasked to ensure that minutes and actions reflect the process of holding each other to account, and what action is to be taken to answer the challenge. The Minutes format now includes an actions field to facilitate progress and clarity around responsibility for the tasks.
2. The learning and development sub group (L&D) has been working in consultation across the Board sub group system to review the current Learning and Improvement Framework (LIF). A dissemination of learning pro forma has been created to facilitate the analysis of learning arising from an event or process and how the learning is to be delivered. The learning and improvement activity across the Board currently takes place within each area of a sub group's responsibility and relies on communication between the groups being effective and consistent. This is currently an area for improvement and is part of the review taking place.

The L&D sub group has set up two multi-agency task and finish groups to take forward the work on sexually harmful behaviour and female genital mutilation and the sub group will then progress the learning needed to support the pathways and procedures. Further areas of work being undertaken by the sub groups are the Neglect Strategy, Missing Children – Children not at Home, Thriving families and Co-sleeping. Learning from each of these areas of work are being considered by the L&D group in terms of how each area will be delivered.

3. At present, shared learning is delivered through a range of conferences, seminars, forums, E learning and face to face events, briefings and Safeguarding Week. The learning is derived from BSCB and partner agency activity through audits, SCRs, agency reviews, challenge panels and from national reviews and changes to guidance and law. It is acknowledged that there are gaps in the current delivery methods in terms of the number of staff and volunteers that can be reached through these methods. The Board's business unit is currently working on the redevelopment of the Board's website to include further media opportunities to deliver podcasts and safeguarding messages that can be accessed by the whole of the safeguarding workforce in the Bradford district.

4. A comprehensive training needs analysis of safeguarding learning and development was carried out by the L&D sub group, which reported back to the Board in January 2016. The report identified that the majority of partners said they did have the capacity to meet the needs of their staff however there was a suggestion that some of it could be provided on an interagency basis by one respondent. Conversely another respondent highlighted the difficulties of releasing staff to attend multi agency training. Further, the answers indicated a wide range of methods of delivery were used on a single agency basis – E learning and briefings most popular closely followed by full and half day courses newsletters and websites.

The requirement to cover a range of issues within safeguarding training on the whole appears to be met. There are some gaps and uncertainties about coverage around the topics of "Young Carers "and "Children of Prisoners". These could be topics for consideration in the BSCB annual programme. The report has highlighted the difficulty some organisations had in responding to the request for information, it evidenced the need for partner organisations to have a system in place for gathering training needs intelligence which includes safeguarding children training needs data. This information is needed in order to ensure that the multi-agency programme compliments the single agency training partners are providing their staff / volunteers.

A review of the Section 11 area for training was also carried out. The review identified that organisations were not evidencing their training strategies effectively, and this issue is being responded to through the PMAE sub group in their responsibility for monitoring the Section 11 process. **5.** Communication with front line staff is currently achieved through messages being taken back through the Board and sub group attendees, messages on the website and through the learning and development events. Development of the BSCB news-letter is tied to the re-development of the Board's website and is currently an area for improvement.

The review of the Board's communication strategy is underway, and will consider a wider range of methods of getting the Board's priorities out to front line practitioners, local communities and families. Many new opportunities will be available when the website is redesigned.**6.** Current case audits and the outcome of the challenge panels have indicated that there is no block to the sharing of information under child protection and child in need processes. This also true for early help cases where consent has been agreed with the family. The on-going challenge for the partnership is the how the fullness of a child's history is captured and relayed throughout the case's activity.

A review of the Information Sharing protocol is taking place in the multi-agency safeguarding hub to ensure that the current version is fit for purpose and meets the changes needed to protect children under the safeguarding challenges of CSE, FGM, SHB and forced marriage. All learning and development events now highlight front line worker's responsibility to share information fully and effectively.

Priority 3: - work achieved by safeguarding partners:

Bradford Health Economy – Have developed a policy and procedural document for tackling Domestic and sexual abuse within the Bradford health services.
NSPCC – has produced the draft strategy for Neglect
Public Health Bradford – have produced a leaflet on the risks of co-sleeping
West Yorkshire Police – Prevent – Have established the Chanel panel, delivered a presentation on the work of the panel to the BSCB and are delivering training to schools in Bradford on the risks and responsibilities around radicalisation.
Youth Offending Service – are completing the strategy and process on sexually harmful behaviour.

How have these achievements made a difference to children and their families:

1. The improvement in practice resulting from the audit and challenge panel process means that children now receive an effective assessment that has clarity around risk and need, that their history and the impact of this is taken into account to inform decision making. Consequently, children are receiving services targeted to their need more efficiently and at the right level.
2. The process of continuous improvement driven by the LIF means that services and practice are continually under review and that the improvements result in more effective safeguarding services for children aimed at reducing harm and promoting welfare.
3. Children are being better safeguarded throughout the District as the front line staff they encounter at all levels have the skills required to equip them to carry out their safeguarding responsibilities.
4. Children are being more effectively safeguarded as all safeguarding providers have access to the required levels of safeguarding training that ensures their front line workers are skilled and equipped to carry out their duties.
5. Front line workers know and understand the priorities and expectations of the safeguarding partnership in Bradford, and through this knowledge are working to reduce harm to children in the district.
6. Front line workers have been skilled and equipped to share information effectively when participating in assessments, all children focused meetings and conferences. Consequently, children's needs are being effectively and efficiently identified and harm is being reduced in a timescale appropriate to the child's needs.

What needs to happen next:

- The next series of themed single agency audits and challenge panels needs to be planned into the sub groups work plans.
- The review of the LIF is to be a continual process that responds to changing demand and new forms of abuse, and the improvements to the framework will be routinely disseminated across the partnership.
- The review and update of the BSCB website is to be completed and launched across the partnership.
- The BSCB communication strategy to be revised in line with the opportunities presented through the revised website.
- All agencies need to review the effectiveness of their practice expectations around information sharing by their front line workers within the safeguarding system. This will include clear guidance on the completion of case summaries that provide an holistic overview of the child's history, and how this has impacted on the child over time.

Priority 4: Responding to Existing and Emerging Safeguarding Issues

- ***Priority Outcome: Safeguarding all children who are vulnerable, including those vulnerable to newer challenging forms of abuse.***

An outstanding Safeguarding Children Board is highly influential in improving the care and protection of children.

The BSCB has a responsibility to ensure that the safeguarding arrangements within the District are robust and effective, and are able to respond to changing demands that arise when newer forms of abuse come into focus.

Activity identified under priority 4:

1. Tackling child sexual exploitation
2. Counter radicalism
3. Online safety
4. Neglect
5. Female genital mutilation
6. Private fostering
7. Child death overview Panel – priority issues storyboard

Achievements to date:

1. In the Bradford District, partner organisations have decided that Bradford Safeguarding Children Board (BSCB) is the lead strategic body for the development and implementation of the District's response to CSE. The BSCB, in consultation with partner agencies developed a 9 point strategic response and action plan that identified key priorities for combatting the impact of CSE in the district. The priorities are:

- Our partnership response to CSE is child and victim focused.
- To successfully prosecute those who perpetrate or facilitate CSE.
- To limit the opportunities for organised criminals and potential perpetrators of CSE to traffick and abuse children and young people in this way through the use of all the regulatory functions of the Council and the legal remedies open to the safeguarding partnership.
- To support families and communities who are dealing with the consequences of CSE
- To develop preventative services which raise awareness of CSE among children, young people, parents and the communities of the District;
- To develop community resilience to the potentially divisive and damaging impact of CSE on the Bradford District and its constituent communities;
- To offer support and therapeutic services to survivors of CSE;
- To develop interventions to ensure that identified and potential perpetrators can participate in programmes to tackle behaviour and attitudes that can lead to further offending; and
- To ensure that arrangements are in place to undertake any necessary investigations into historic cases of CSE.

Through the 9 point strategic response, the BSCB continues to seek assurance from the partnership that the needs of children and young people who have been, or may be, sexually exploited and their families are considered as they:

- Plan and commissions services;
- Develops policies and procedures;
- Ensures that appropriate training is in place;
- Communicates and raises awareness; and
- Monitors and evaluates the work that is being done.

The BSCB and individual agencies working with children and families are continuously developing procedures, guidance and information about resources for preventative work and direct work to support children and families during and after victimisation through CSE. It is important that professionals working with children and families ensure that they are familiar with the knowledge and skills involved. In order to achieve this position, the BSCB has developed a multi-level training plan for all professionals and leaders regarding CSE, in particular training and support for schools to provide the skills and awareness required to enable pupils and teachers to recognise the signs of being groomed for CSE.

It is recognised that CSE is a dynamic and changing phenomenon. The BSCB and all its partners continue to be vigilant in recognizing the need for new responses and the need to learn from emerging evidence. All partners are committed to utilising data and research to engage in intelligence led resource planning to inform the responses to the changing risks to children. The monitoring and scrutiny of the CSE action plans is being overseen through the CSE sub group and reported to the Board.

Beginning in December 2015, the BSCB undertook a partnership review of the multi-agency CSE hub. A task and finish group, including representatives from 8 partner agencies, met to consider a range of issues that included levels of staffing and their support, roles and responsibilities; how the hub interfaced with CSC teams, the missing children services and communities across the district; support for victims and their families; procedures, pathways, the current risk assessment tool and the quality of practice; and recording systems, data collection and analysis and intelligence led service planning.

The outcome of the review was the development of a detailed framework for professionals working with children who experience or are at risk of sexual exploitation. This is further underpinned by revised, detailed practice guidance for all agencies located in, or working closely with the CSE hub.

The Board was also instrumental in commissioning an educative drama for year 10 students in schools across Bradford. An outcome of the success of this initiative has been to arrange a short tour of the play to 9 primary schools in the district funded by the Police and Crime Commissioner (PCC). The evaluation of these performances has been positive and work is currently being undertaken to extend the programme out to year 6 pupils.

The BSCB has supported two successful applications for funding for CSE support services. The Board supported an application for funding from the community safety partnership (CSP) for male workers to work with men and boys from the BME community to raise awareness of the risks of being groomed for CSE and other safeguarding risks. The Board also supported a further application from the CSP to extend the work of the Banardos Night Watch initiative. The project offers advice, guidance, training and support to businesses across the Bradford district, and engages in awareness raising for communities and the general public. It particularly focuses on the night time economy in keeping children safe after dark.

2. The BSCB received a presentation on their Prevent Duties in July 2015 to ensure that all partnership leads are fully aware of their duties and responsibilities under the Prevent regulations. The presentation highlighted key functions as follows:

Bradford Safeguarding Children's Board and the 'Prevent' Statutory Duty

The duty for the BSCB is likely to be relevant to fulfilling safeguarding responsibilities, and organisations working with young people should ensure that there are clear and robust safeguarding policies in place to identify children at risk. There are three themes throughout the sector-specific guidance: effective leadership, working in partnership and appropriate capabilities. These form the basis for the Bradford District Sector Prevent Plans.

Working in partnership *Prevent* work depends on an effective partnership. To demonstrate effective compliance with the duty, specified authorities and their LSCB's must demonstrate evidence of productive co-operation. In particular with local *Prevent* co-ordinators, the police and local authorities, and the co-ordination of activity through existing multi-agency forums for example, Bradford District Prevent Safeguarding group.

All specified authorities and their Boards, subject to the duty will need to ensure they provide appropriate training for staff commensurate with their role and responsibility. Training is now widely available, a nationally recognised product - WRAP has been developed to facilitate this delivery.

WRAP is a one and a quarter hour interactive facilitated workshop centred around a DVD and is intended to achieve an awareness and understanding of the Prevent agenda and the safeguarding role of staff; the ability to use existing expertise and professional judgement to recognise potentially vulnerable individuals, who may be susceptible to messages of violence and the confidence to use a common sense-based response.

To date, over four thousand staff in the District have received WRAP training.

The multi-agency Channel Panel is in place and is actively reviewing cases. A guidance paper is in place to advise professionals on the purpose and role of the panel and how to make a referral on a child of concern and is available on the BSCB website.

The Board has been asked to consider whether the representation on the panel is sufficient and this is being considered in line with review and evaluation of the Prevent Strategy.

The child protection procedure on radicalisation was amended in November 2015 and is available on the BSCB website.

3. The BSCB continues to monitor and scrutinise partnership activity on online safety. The risks in this area have grown to include cyber bullying, sexting and grooming for CSE and radicalisation and the use of social media to engage with children. Online safety is now recognised in the prevent strategy, sexually harmful behaviour strategy and the CSE hub review.

The BSCB is a member of the West Yorkshire child protection procedures consortium and consulted on the review of the child abuse and information communication technology procedure which was updated in November 2015. The BSCB also consulted on the child sexual exploitation procedure which now provides guidance on the monitoring of social media by a skilled professional when a CSE risk is identified in relation to a child. This update was completed in April 2015. The child protection procedures are available on the Board's website.

The Board's website also has pages for parent and for children. Both pages have direct links to online safety websites that target support for parents in recognising the risks and enabling them to take preventative action to protect their child; and for children who are worried about online safety, and who need support to take action to keep themselves safe.

The BSCB's safeguarding advisor to faith settings continues to provide online safety training in schools and faith settings for parents and the wider community. The Faith Setting area of the website provides a range of information and links to information sites and these are highlighted to faith setting leaders and attendees through Emails and training events.

As part of Safeguarding Week 2015, the Airedale conference agenda included a targeted focus on online safety delivered to a multi-agency audience.

The Universal sub group carried out a survey on bullying, including online bullying across the schools in the district. The survey received responses from 94 children who identified that online bullying was a significant factor in their experiences of being bullied. A recommendation of the survey was to revise the bullying strategy and this work is to be undertaken by a task and finish group under the Safeguarding in education sub group.

4. The Board has continued to monitor the progress of the revision of the neglect strategy through the proactive and responsive safeguarding sub group (PaRS). The strategy is being drafted in consultation with the revised threshold guidance to ensure coherence between the two documents, and it is anticipated that they will both be approved by the June 2016 Board.

5. The PaRS sub group has overseen the FGM task and finish group. FMG: Home Office Annex A and Child/Young Adult documentation was distributed to the sub group. This document makes reference to a link on pages 36/37: Department of Heath Guidance, FGM Risk and Safeguarding; Guidance for professionals. This was also circulated to the members of PaRS. A number of health professionals were now using this as good practice. The group members agreed this was a helpful Checklist and despite this being DRAFT members felt this should be circulated to professionals to be adopted as good practice. In the interim, the group is working to complete a referral pathway that will assist professionals in understanding the process and providing the knowledge on how to progress a case.

The West Yorkshire child protection procedure on FGM was updated in 2015 to ensure that the procedure was compliant with the changes in guidance. There is a link on the BSCB website to access the E learning course being offered by the Home Office and the Health economy provided training on FGM across their sessions during safeguarding week to 81 professionals across the partnership.

6. The Board continues the welfare and protection of children privately fostered within the Bradford District. In May 2015, the BSCB received the bi-annual report on private fostering from the local authority along with the statement of purpose. Within the 2015 – 2016 period, there were 21 notifications of children being privately fostered within the district and 33 children were identified as meeting the criteria for being privately fostered. These figures are in

line with national figures on privately fostered children. The information on privately fostered children is monitored bi-monthly within the PMAE sub group and reported to the Board.

The Board produced a 10 point briefing for Bradford primary and secondary schools on how to recognise and respond to situations of, or of suspected private fostering. This has been sent out through the schools online network to all schools in Bradford. There is also a private fostering area on the website that links professionals to the current child protection procedure on children living away from home, and a leaflet on private fostering has been produced to be distributed to agencies for dissemination to the public.

7. CDOP – please see story board page

Priority 4: - work achieved by safeguarding partners:

1. BMDC – Require private hire and hackney carriage operators to undertake a specific module on CSE. Training is mandatory for all new license applications and license renewals. To date more than 3500 drivers have been trained. In June 2015 all operators were written to regarding their responsibilities in relation to CSE. They were provided with posters and leaflets about the issue, and were required to display the posters in their base for both the public and staff to see. Record of compliance is now routinely checked by the BMDC licensing officers and partners.

Barnados – are providing a number of preventative programmes for children and their parent's where concerns around CSE have been identified. Barnardos – 'Turnaround', in conjunction with national experts on CSE, have also produced an Education pack for parents that enables them to participate and contribute to the safety and protection of their children.

West Yorkshire Police (WYP) – in partnership with BMDC have established a specialist team focusing on non-recent sexual exploitation. Currently there are 12 on-going investigations and 127 potential victims have been identified and interviewed.

BLAST – are working with boys and young men who have experienced or are at risk of being sexually exploited. They offer therapeutic responses to meet the level of need required, and provide training to multi-agency groups and individual agencies.

The Muslim Women's Council (MWC) and the Keighley Association, Women and Children's Centre – have established the 'Fragile' project. Skilled staff work with women and girls in the BME community to raise awareness of safeguarding issues including CSE. Women and girls are provided with key information on recognising abuse and how to report it. Individual support is provided to support them through and after the disclosure of concerns.

2. Bradford Health Economy – have policies and procedures in place on how to respond to the prevent agenda. They have carried out a programme of WRAP training across the workforce.

BMDC and WYP – are providing leadership and championing the prevent agenda across the partnership.

Bradford Schools – have pro-actively taken up the prevent agenda and have accessed the WRAP training. 40 state secondary and 140 primary schools picked up the training to date.

3. BMDC – Education Innovation service has provided advice, guidance and training for non-maintained schools in the Bradford District.

4. NSPCC – has provided consultation and research on the drafting of the neglect strategy.

5. Bradford Health Economy – A multi-agency flow chart is being developed for the referral process for FGM cases.

6. BMDC – CSC – New process Private Fostering - Through training workers will be supported in ensuring they fully understand what the needs are for every privately fostered child and their carer. The new process will be embedded and briefings undertaken for all staff Visits to privately fostered children will be undertaken every 4 weeks in line with CIN, LAC and CP cases. Close scrutiny will be undertaken of the process and compliance with procedural expectation, ensuring these children are given the priority they should have. All managers including Service managers will monitor and take corrective action if there are any risks of not meeting expectations. A 3 monthly exceptions report will be produced by the lead service manager and scrutinised for compliance.

How have these achievements made a difference to children and their family's:

1. Through a range of strategic and operational activities that have raised the quality of front line practice, heightening awareness for parents and communities and targeted specific services, businesses and providers where

children are at high risk of sexual exploitation, children vulnerable to this form of abuse in the Bradford district are more effectively protected from harm.

2. Through the effective delivery of WRAP training across the partnership and in particular across 170 schools in the district, front line professionals have the skill and knowledge to recognise and respond to the prevent agenda and the risk to children vulnerable to radicalisation has been reduced.

3. Online safety is now considered as part of the safeguarding agenda across a number of strategies that are in place to reduce harm to children vulnerable to organised or targeted grooming, exploitation and bullying. Front line practitioners are being provided with the knowledge required to underpin their skills in recognising and responding to these forms of abuse. Consequently, children in the Bradford district are more effectively safeguarded across the partnership through improved practice in these areas.

4. The revision of the neglect strategy has brought into focus the key issues facing children vulnerable to or experiencing neglectful care. The BSCB's training team have taken the issues and devised learning and development events to ensure that front line workers are fully skilled to be able to respond effectively to neglect. As a result harm to children from this form of abuse will be reduced.

5. Front line practitioner, teachers and health professionals now have the tools in place to assess the risk to children vulnerable to the risk of FGM. This will result in an effective assessment of the risk to children and result in a proportionate response to the risk.

6. Regular reporting to the BSCB of children in private fostering placements means that their safety and welfare are kept under scrutiny by the Board and the services they receive are being monitored for compliance and quality.

What needs to happen next:

1. The CSE sub group will continue to monitor the activities laid out in the CSE action plans.

- The CSE sub group will review the work of the task and finish group on disabled children vulnerable to sexual exploitation and set a timescale for the completion of the work.

2. The Board will agree a reporting format with the channel panel so that assurance can be provided to the Board that children are being effectively safeguarded from radicalisation.

3. A multi-agency task and finish group will be constructed to formulate a comprehensive strategy to address the range of issues now prevalent under online safety.

- The safeguarding in education sub group will revise the bullying strategy.

4. The draft neglect strategy will be agreed by the Board and launched across the partnership.

5. Work with the Safeguarding in Health group to arrange the launch of the multi-agency FGM pathway.

6. To monitor the local authority reports on private fostering for compliance on process and duty.

Activity 7 - CDOP

Child Death Overview Panel (CDOP) storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

During the year April 2015 – March 2016, 61 child deaths were reported to the Bradford child death review team. The Bradford CDOP reviewed a total of 79 child deaths of children under 18 years during 2015/16; this includes the reviews of 45 of deaths that occurred in 2014/15 and the review of 3 deaths that occurred in previous years. This brings the total number of deaths reviewed by the Bradford CDOP to 607 since April 2008, out of 647 deaths reported (94%).

Of the 79 cases reviewed between April 2015 and March 2016, the majority of these deaths were infants under 1 year of age (63%) and 37% were children over the age of 1. There are 10 categories for cause of death (see Appendix 2 of the CDOP Annual Report 2015/16). The most common cause of death out of the 79 reviewed cases were

chromosomal, genetic and congenital anomalies (Category 7), and perinatal/neonatal events (Category 8), which accounted for 51% and 19% of the reviewed deaths in 2015/16 respectively. There were significantly more children dying in Category 7 in the Bradford district when compared to national CDOP data, and children of South Asian ethnicity were over–represented in the reviewed deaths (63%).

A total of 8 deaths were considered to have modifiable[1] factors in 2015/16, which was 10% of the total deaths reviewed, compared to 24% nationally. These modifiable deaths were in Category 2 (suicide or deliberate self-inflicted harm), Category 5 (acute medical or surgical condition), and Category 10 (sudden unexpected and unexplained death).

Recommendations identified in the 8 deaths with modifiable factors from 2015/16, covered the following areas:

- Formalise and circulate guidance on gastroenteritis;
- Discuss actions with specialist drug and alcohol team to reduce the risk of death in vulnerable people in relation to substance misuse;
- Continue awareness of safe sleeping through multi-professional work and media work and feed into the maternity network – this included an updated e-learning package on safe sleeping and a repeat audit of all deaths due to Sudden Infant Death (SIDS)/Co-sleeping;
- Work across local organisations to understand the management of asthma in young people with additional complex health needs.

Further to the recommendation set out above, issues were logged which although were not identified to cause the death of the child, were of note and required follow up with appropriate action with organisations or lead clinicians where needed. The issues identified were as follows:

- Smoking in pregnancy.
- Obesity in pregnancy.
- Diabetes in pregnancy.
- Mental health issues.
- Domestic abuse.
- Consanguinity.
- The importance of offering genetic counselling, where appropriate, to parents and siblings of those affected by genetic conditions and ensuring appropriate referrals to specialist services.
- The importance of rapid, high quality clinical assessment, transfer (if necessary) and management for acutely ill children and young people in relevant setting including: primary care, secondary care, urgent care centres and ambulance services.
- The importance of post mortems in ascertaining cause of death, which may influence management of future pregnancies.
- Access to timely and appropriate bereavement support.
- Access to chaplaincy services when required for parents/family.
- The importance of flagging the need for early foetal anomaly scans for future pregnancies, where risk is present of congenital abnormality.
- The continued access to high quality end of life care offered by Martin House Hospice, if children are on Intensive Care Units.
- Children who died abroad – in instances where a child died abroad there has been insufficient information to carry out a review.
- Foetal Magnetic resonance imaging (MRI) for diaphragmatic hernia is good practice.
- Early testing for Guthrie (MCADD) where possible.
- The importance of ensuring other diagnoses are kept in mind in categorisation of death, where the child has died due to a head injury.

1 A child death is defined as modifiable if *"the Panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths"*. Note: Modifiable death definition changed from April 2010 onwards, whereby the classification was changed from preventable/potentially preventable to modifiable factors.

Our Journey so Far – what are we doing/done:

- A detailed Action Plan for modifiable causes identified is in place to audit the response to the recommendations and ensure all organisations have completed their actions. Further to these recommendations, the panel records an issues log which leads to more general recommendations by CDOP and emerging themes worthy of being highlighted are identified and monitored.
- Work is on-going in many groups and networks to reduce the risk factors which contribute to the high childhood mortality rate in the Bradford district; the Every Baby Matters (EBM) steering group for example leads the partnership working to reduce infant mortality rates.
- Specific strategies and actions plans such as the Road Safety Plan and a range of interventions to reduce accident rates in children for the district.
- CDOP had led on-going awareness around specific areas encouraging parents to adopt safe sleeping practices and avoiding co-sleeping with their babies when additional risk factors are present and, in previous years, awareness around not leaving young children unattended in baths.
- CDOP has led work to update the e-learning package to promote safe sleeping in infants and will be re-launching this in the Autumn. In addition sessions around the work of CDOP will feature in the Safeguarding week in October 2016.

Findings from CDOP are shared with key groups and leads such as the Every Baby Matters steering group, Road Safety Team and Maternity Network and are also shared as part of Safeguarding Week.

What Difference has this made:

- Some encouraging signs of improvement; the three year infant mortality aggregate rate has reduced year on year for the last seven years especially in deprived populations and the child mortality rates are reducing too – although still higher than national and regional infant mortality rates.
- Emergence of key themes for 2008-2016 for potentially modifiable causes, which include co-sleeping and sudden infant deaths syndrome (SIDS), road traffic collisions, specific clinical incidents, and four serious case reviews over this period. Less common themes identified, include drowning in baths, death in fires, asthma, suicide in teenagers, and swine flu. All of these areas have been addressed via a range of groups and forums across the district
- Implementation of specific recommendations from Serious Case Reviews and Serious Clinical Incidents.
- Increased clinical awareness of management of specific medical conditions.
- CDOP Alerts to raise public awareness of the risks of leaving children bathing alone/supervised by another young child.
- Road Safety Actions to reduce further deaths from road traffic collisions.
- Swine flu vaccination programme in Special schools.
- CDOP Alerts re Safe sleeping practice and update on current E learning package for Safe sleeping for babies.

Areas for further action:

- The Bradford CDOP will continue to monitor overall causes of death for children, with a focus on modifiable causes; identifying specific recurrent issues and themes as well as conducting an annual CDOP Away Day, which allows panel members to assemble as a group and to examine the key factors of child deaths in more detail.
- Continue to work with partners to raise the profile of the Child Death Overview Panel and the understanding as to why children die in Bradford district thus ensuring all partners work towards reducing the risk of death in children in the district for the future
- We will review our criteria for modifiability of deaths in discussion with partners in the national CDOP network as our percentage of modifiable deaths is well below the national average.

What are the Key things we are doing next:

CDOP will continue to meet monthly to review child deaths and will keep the Modifiable Action Plan and Issues Log updated and monitored. In this way we will identify any new emerging themes and any actions required by partners across the district. In addition, we will hold an Annual Away Day in May 2017 to review all the data and findings for 2016/17 and will look at some areas in more depth.

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Chapter 4: Partner Agencies – Individual 'Improving Safeguarding' Stories

1. Childrens Social Care (CSC) storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

- Implement the' Journey to Excellence' model
- Development of the MASH
- Participated in the review of the CSE Hub and provided additional social work resource
- Challenge Panel – OLA Challenge Panel
- Arranged meetings with health colleagues and paediatricians to discussion and improve joint working.
- Undertook an audit of health referrals to assess quality and recommend improvements
- Developed a Missing Strategy and action plan currently in draft form awaiting sign off at relevant safeguarding sub group
- Implemented a Domestic Abuse Hub as part of the MASH
- Involved in the review of the CSE hub.
- Independent case file audit of 73 CSE case file audits and developed an action plan to address findings
- Participated in the BSCB Challenge and Scrutiny session on CSE and Missing
- Provided training for all social work staff on Signs of Safety and PACE
- Set up weekly missing meetings with senior managers and the police
- Implemented a Case Review Panel
- Review of Private Fostering and implement changes
- Implementation of Family Drug And Alcohol Court (FDAC) pilot project
- Revised the recruitment and selection process for social workers
- Working with radicalisation cases procedures for legal intervention
- Human trafficking processes
- Modern day slavery processes
- Meetings taking place with private children's homes providers in the district to improve communication and joint working
- Development of a Rapid Response out of hours service

Our Journey so Far – what are we doing/done

- The 'Journey to Excellence' is an improvement programme for Children's Services. CSC is developing Bradford's integrated 'Early Help' offer across all key agencies to provide One Early Help Gateway for the public and staff.
- Implementing a shared 'Signs of Safety' approach to need and risk assessment, ensuring the child's safety while using a family's strengths to promote change and Implementing Signs of safety - training .

- Creating smaller Children's Homes; providing more foster carers for teenagers, developing a shared model of support across care, health, education and other key services.
- Providing a better, faster response to children in crisis with more joint working across social care and key health teams and more safe spaces for children to be supported.
- Creating a new service for young people aged 14-25 years with complex health and/or disabilities: Improving transitions by closer working between children's and adult's services and promoting self – direction of support through increased use of personal budgets.
- Updated section 11 Virtual College tool for Children's Specialist Services and shared the learning with partners.

- Established a Case Review Panel The Case Review Panel meets weekly every Tuesday morning, to ensure robust decision-making regarding accommodation, gateway meetings and care proceedings.
- Bradford Children's Services in co-operation with the other 4 regional Authorities (Leeds, Calderdale, Kirklees and Wakefield) and has developed a pilot FDAC Team. The Specialist Team have taken lead responsibility for interacting with the FDAC, undertaking assessments, drawing up intervention plans, co-ordinating / implementing activity and reviewing the progress of the families involved.
- A focus on close multi-agency working with Adult Treatment Service, Domestic Abuse Programmes, Housing Providers, Family Support Services and CAMHS to deliver a problem-solving therapeutic approach to working with substance misuse.
- A Private Fostering review has been undertaken to ensure visits were undertaken within timescales and the regulation 8 visits carried out. The profile and importance of private fostered children is fully understood and managers are overseeing the process.
- Bradford has a Multi-Agency Safeguarding Hub (MASH) that provides effective responses to contacts and referrals. This is comprised of a multiagency team of social workers, police officers, a health professional and an education professional.
- A Performance Dataset for accurate CSE and Missing information is available and a performance management tool named 'the Racetrack' is currently being developed with partner agencies for the CSE Hub.
- A data intelligence analyst and a Missing Coordinator have been appointed and sit within the hub.
- CSC, education and the police have delivered two multi agency training days on the strategic response to 'Missing in Bradford', this included a member of the Youth Council giving a young person's perspective.
- CSC and Bradford Police made a presentation to the West Yorkshire Police senior leadership team on responses to children missing in the Bradford District.
- All young people who go missing in the district are offered a return to home interview.
- Front line professionals are being trained in a different approach to working long term with young people in order to improve relationships.
- Managers of private residential homes are engaged with local safeguarding arrangements to improve responses to missing children, and attend meetings to monitor effects.
- Children's Social care has appointed a permanent Principal Social Worker.
- CSC has established a monthly case file audit process across the service.
- CSE Hub open days for professionals and councillor have taken place.
- A Domestic Abuse Hub is now established as part of the MASH. CSS and WYP have provided a FTE experienced member of staff, to ensure that each and every occurrence reported to the police regarding domestic abuse / violence where a child was present or lived in the household was screened / reviewed and an appropriate level of support provided.
- Placement Support Service staff now provide an out of hours Rapid Response to work alongside Police colleagues and support the work of Emergency Duty Team. The team have access to a children's room at Sir Henry Mitchell House (SHMH).
- A single point of contact for missing has been created within the MASH. A daily report from the Police is received in relation to all missing children and all Police 'safe and well' checks are shared with CSS. A weekly

meeting chaired by CSS deputy director is in place to ensure a close oversight of all missing activity, actions and plans.

- There are a significant number of children in Bradford who regularly go missing and so In order to review and manage the most persistent and vulnerable cases, a monthly Missing and Exploited Tasking (MET) multi-agency meeting has been set up. Voiceability has been given funding to recruit a further worker to complete return to home interviews for looked after children (LAC) who have been missing and the Placement Support Service now offers an interview to all children and young people who are reported missing from home. The service has achieved 98% completion of interviews since starting in February.
- New guidance has been issued to all placement providers on how to prevent a young person going missing and how to respond when they do. There has been investment in the children's homes to provide an improved environment and additional recreational facilities. A Missing Children multi agency strategy 2016-18 and Action plan is in draft format, this will underpin the work of a partnership missing meeting that will meet on a quarterly basis. The group will report to the CSE / Missing vulnerable sub group of the BSCB.

What Difference has this made:

- The Journey to excellent plan around targeted early help has an ambition to reduce the number of inappropriate contacts to the front door of social care. By establishing a coherent early help offer in the district there will be earlier intervention and families will receive appropriate help at the right level to prevent re referrals into service. This ambition will over time reduce the number of children who become looked after and reduce the workloads within social care.
- The Section 11 Audit process has helped identify areas where agencies can improve e.g. training for staff, identifying gaps and areas of strength.
- The Case review panel ensures that any decision making regarding accommodation and care proceedings is made robustly in line with the child's needs.
- Oversight of children missing in the district is more robust, all occurrences are subject to scrutiny. Young people are spoken to after missing occurrences. The information gained is shared with partners to promote the child's welfare and safeguarding.
- Within the MASH - the co-location and increase in resources has led to better overall services for children and families – we are better placed to assess risk which leads to more informed decisions to provide support and intervention. Good quality, strategy discussions take place.
- The Rapid Response team have reduced the number of emergency admissions to care and supported the police in responding to, and supporting missing children. Our response to children missing from home or care now meets the revised 'statutory guidance on children who run away or go missing from care' January 2014. The themes from individual interviews are now collated and reported to inform intelligence led service planning.
- Children's homes now have access to a car to go and collect young people or go looking for them. Liaison has been undertaken with Ofsted and new guidance follows the principle of acting as a good parent. Young people can be prevented from leaving late at night and doors are now locked if this is appropriate. Recent checks have shown that the revised recording system is creating a more accurate record of missing episodes. The approach to missing is seen as good practice within West Yorkshire Police Senior management and leaders are fully engaged and aware of the issue in connection with children missing in Bradford.
- The Domestic Abuse Hub in the MASH has resulted in a faster multi-agency response to families. Joint CSC and Police assessments for DA/DV, early indication of risk, good quality strategy discussions are now routinely carried out within a multi-agency approach. The co-location and increase in resources has led to a more effective service for children and families – the multi-agency hub is better placed to assess risk which leads to more informed decisions to provide support and intervention.
- Through private fostering training, workers will be supported in ensuring they fully understand what the needs are for every privately fostered child and their carer. The new process will be embedded and briefings undertaken for all staff. Visits to privately fostered children will be undertaken every 4 weeks in line with CIN, LAC and CP cases. Close scrutiny will be undertaken of the process and compliance with procedural

expectations, ensuring that privately fostered children receive the appropriate response. All managers including Service managers will monitor and take corrective action if there are any risks of not meeting expectations.

- As this is the inaugural pilot year of Family Drug and Alcohol Court (FDAC) a formal evaluation is still to take place and will be completed after the initial pilot year concludes.
- Outcomes from the initial cases selected for FDAC indicate that the process has been successful in a number of key areas. The FDAC cases have led to timely decision making for all the children involved to date. For those children unable to return to the care of their birth parents this has meant early decisions about their permanence.
- Proceedings were extended in one case given the progress made by the parents in FDAC. The final outcome being that their two children remained in their care subject to Supervision Orders.
- The families involved have had the experience of a less adversarial and more restorative way of conducting care proceedings. FDAC has encouraged effective joint working with adult drug and alcohol treatment services with the effect of promoting mutual professional understanding.

Areas for further action:

- A new Transition (Preparation for Adulthood) Service for children with disabilities aged 14 plus is to go live in September.
- Early Help Single Point of Access & the new Early Help plan is to go live across the district from October. A Multi agency consultation and Safeguarding Board approval for the revised 'threshold of need' is underway. The ambition is to create a clearer partnership understanding of a whole family approach, and how staff implement this.
- Pursue multi-agency agreement that the Early Help assessment is aligned to Signs of Safety approach, and agree timescales for this to be introduced as a replacement for the CAF.
- Implementing the Council's Children's Services restructure, including embedding the children's centres contribution to the Early Help framework.
  - Re-align key teams in Social Care to targeted Early Help, for example Initial Contact Point, Family Centres, Child in Need work.
  - Create the necessary I.T. infrastructure to support service delivery
  - Update the Council's Children's Services Commissioning Team to support the framework.
- The DA Hub has continued to develop its processes and procedures, and is now moving towards a system of notification of contacts to schools for each child of school age 5-18yr and also for those in higher education establishments.
  - Development of Early Help and how this fits within the DV/DA process.
  - Development of the Signs of safety approach, particularly around DV/DA and how these can be screened under the signs of safety tools.
  - Understanding the increase in work load around notification and making this meaningful.
- On-going development of the placement strategy to reduce the number of young people placed in external placements will mean that local provision will be accommodating more challenging young people. The placement of children into the local area by other local authorities and those externally placed by Bradford requires close working between the local authorities and the police forces involved.
- CSS and partners need to undertake 'mapping' of data in relation to missing children in order to Increase understanding and awareness of missing children issues, around children, their parents and carers as well as professionals.
- The challenges to CSE information sharing with Education providers, needs addressing. While information is passed from CSC daily there is a lack of confidence that safeguarding leads in schools receive, act on and submit information about Children at Risk of CSE. There remains some uncertainty about referral responsibility to enable children to access mental health provision and the therapeutic support capacity of 3rd Sector Support Services. The volume of referrals can lead to delays in work being completed, or at times, periods where agencies won't accept referrals.
- Work is taking place to explore a CAMHS presence in the Hub – part of the improvement for greater therapeutic support for children who experience or at risk of experiencing CSE.
- To fully implement the BSCB '9 point CSE strategic response'.
- Ensuring that the development of the Early Help service complements and fits within the MASH Development / Introduction of the "Signs of Safety" approach, particularly around the initial screening of contacts.

- Planning for the longer term development of the CSE Hub.
- On-going development of new areas of work, such as FGM, human trafficking, modern day slavery and radicalisation and extremist ideology.
- Improvements in social care Out of Hours responses and working on developing a multi-agency, rapid response service.
- Development work is underway to change the Case Review Panel to a gateway and care proceeding panel.
- Sustainability of the FDAC pilot - The pilot is approaching its initial end date of November 2016. Discussions to determine sustainability are on-going at both local and regional level.
- Capacity - The pilot has made a good start, with core business being met by existing staffing. Further consideration needs to be given to how best to offer administrative support to practitioners, and as demand for FDAC increases, how best to extend the capacity of the service to respond.
- Review of the pilot - FDAC is returning data to the National Unit to inform their research and evaluation programme and partnership development. Outreach activity by staff, to inform stakeholders and other interested parties is on-going. FDAC Bradford has benefited from the support of clinicians within CAMHS. Further discussion is to take place to formalise that involvement, depending on referral rates there may be an opportunity to explore options for FDAC in pre-proceedings.

What are the Key things we are doing next:

- Evaluate the Early Help pathfinders launched in Keighley and Better Start (BD3, 4 & 5).
- Testing the new Early Help plan for ways to better identify children and provide specific support.
- Recruitment to the service manager post for the new Transition (Preparation for Adulthood) Service.
- Decision to be made on whether to bid for Social Impact Bond funding.
- Ensure consultation with parents influences the Early Help offer.
- Train approx. 1300 staff on "Signs of Safety" by the end of 2016. Deliver child protection conferences and planning under Signs of Safety framework by the end of 2016.
- New Transition (Preparation for Adulthood) Service for children with disabilities aged 14 plus to go live in September.
- Early Help Single Point of Access & new Early Help plan to go live across the district from October.
- To consider expanding the capacity of the workforce within the DA/DV area of the MASH to take on the additional role of notifying schools, health visitors, school Nurses, nursery schools, higher educational establishments, children and families centres for each child where there has been an incident of Domestic abuse /violence, to ensure that relevant welfare support is in place for the 24hrs following the incident. To refer to the relevant early help/universal support services if needed. To ensure that there is an audit trail - SW footprint on file that information has been shared. To review each case graded standard to look for patterns re-occurrences and take appropriate action on that case. To develop a system to ensure there is wrap around support during school holidays.
- The 'missing coordinator' post will provide a higher level of analysis of the issue to the service and partners. This analysis will improve the partnerships understanding of and swift response to changing circumstances. The post will also oversee the accuracy of recording of missing incidents to ensure that recent progress is maintained. We need to undertake 'mapping' of data in relation to missing children in order to Increase understanding and awareness of missing children issues around children, their parents and carers as well as professionals.
- MASH Review of the function and make-up of the CSE Hub.
- Review of threshold so that it is better understood by all partners.
- Improve the quality of case file recording and addressing and responding effectively to an increase in work load.
- Ensure that the progress of the areas identified for further action will monitored through the CSC senior management structure for compliance with timescales and ambitions.
- The FDAC Regional Meeting to consider sustainability during the September 2016 Presentation to the Adult Services, divisional management meeting.
- Meet with CAMHS Management to consider Information Governance and clinical support services to FDAC – September 2016 Participate in National FDAC Celebration October 2016

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Organisation: Children's Social Care

2. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST (BTHNHSFT) storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

- Revision of policies and procedures, including supervision policy.
- Updated section 11 Virtual College tool.
- Ensured full BTHFT representation at all BSCB subgroups, Health Safeguarding Group and MARAC.
- Secured Named Midwife post plus an additional 15 hours per week of seconded midwifery time to support the Named Role.
- Created Training Strategy for Safeguarding children following 2014 CQC report which highlighted low levels of training – strategy also involved re-levelling of ALL staff within the trust against the 2014 Intercollegiate training levels. The percentages trained at all levels has steadily increased until the re-levelling exercise in April when a significant number of staff were moved from level 3 to Level 3 Specialist and this caused a fall in compliance as expected. There are numerous opportunities for training within the Trust and externally, including through BSCB.
- Introduction of Integrated Safeguarding Committee for the trust which promoted collaborative working for safeguarding vulnerable adults and children.
- Re-instated regular meetings with Senior Social Care staff to discuss operational issues and joint work, eg auditing the quality of referrals.
- New audit strategy – see link. In addition, recent audit looking at evidence for benefit of flagging medium risk CSE children as well as those that are deemed high risk. In addition, we are involved in numerous rolling audits (including audits of documentation in the TOP clinic and the paediatric ward, audit of DNAs). We carry out an on-going monthly audit of high risk CSE which ensures that the correct action has been taken by our staff and liaison with partner agencies has been completed. If not, the audit acts as a safety net, and liaison is then completed.
- Contribution to regional meetings about the future of sexual assault services in West Yorkshire (on-going) and setting up of a local service for assessment, following non-acute sexual assault.
- Case management meetings for high risk CSE children who are frequent attenders to the Emergency Department, in order that care is streamlined and responds to individual needs.
- Safeguarding Children Medical Conference day October 2015 – well received.
- Established formal Peer Review process for Paediatric Consultants.

Our Journey so Far – what are we doing/done:

Key Achievements 2015-16

1. **Policy**

- Child Sexual Assault guideline created and ratified.
- Safeguarding Supervision policy revised and updated.
- DNA (Did not attend) policy revised for the trust regarding children's attendance.
- FGM (female genital mutilation) policy, procedure and national reporting requirements developed.
- Contribution to the development of the multiagency FGM pathway district wide.
- Expansion of the safeguarding children's website to hold all policy and procedure together.
- Flagging system developed to identify Looked After Children (LAC) and children identified to be high risk CSE who attend the trust.
- Development of policy and procedures for receiving information from the Child Protection Review Unit and sending of medical reports for the organisation.
- Shared contribution to the domestic and sexual violence policy.
- Audit strategy written.

2. Training

- Safeguarding children's training is now mandatory for all staff at their assigned level.
- Training matrix updated to bring training requirements in line with national requirements (Intercollegiate document 2014) and all staff levelled according to their roles and responsibilities within the Trust.
- On-going monitoring of training figures and training booked to allow the required numbers of employees to attend to meet mandatory training requirements.
- Safeguarding children's training figures are presented at both children and adult steering group and the team has the ability to identify non- compliance down to a specific member of staff.
- Level 3 training sessions written and delivered to cover multiple subjects across the Trust and bespoke clinical governance sessions offered. Maternity services have increased delivery to twelve 2-hour sessions per year.
- Hosted lessons learned event following Trust serious Incident.
- Organised events on FGM, PREVENT (government's work to deter people from terrorism) and medical aspects of the child protection process, as part of safeguarding week in October 2015, attracting delegates from within the trust and the district.

3. Supervision

- Number of supervisors has now increased and safeguarding supervision is being provided for staff in a variety of areas throughout the trust.
- Roll out of safeguarding supervision throughout the Trust to all staff continues.
- Introduction of peer review for all paediatric consultants as recommended by the Royal college of Paediatrics and Child Health (2016).

4. **Management**

- Expansion of Safeguarding Children Team Autumn 2015 – includes a second Safeguarding Specialist Practitioner (Band 7), 1.4 WTE Paediatric Liaison Nurses (Band 7), and formalisation of the Named Midwife role.
- EPR (electronic patient records) has seen significant contribution from the safeguarding Childrens team, with consideration for national systems to be introduced in the future CPIS (child protection information system).
- The team has made a significant contribution to Joint Area Targeted Inspection (JATI).
- Contribution to BSCB-led Challenge Panels and Serious Case Review

5. Other

- Major update of section 11 audit November 2015 – presented at the PMAE subgroup
- Exploring benefit of flagging Medium Risk CSE children in Trust, following recent audit
- Introduced provisional medical report slip for Child protection Medicals to hand over to accompanying Social worker/Police officer, in order to ensure clear communication
- Collection of good practice examples held internally – specific health cases

6. Example of good practice in health

- Health agencies are often at the forefront of recognition in child protection. Through the persistence of safeguarding leads in the various local health agencies, via the Health Safeguarding Children's Group (HSCG), challenge panels were set up recently to explore a number of cases which were felt to hold common themes for learning. These were cases which fell into two mina groups: 1) where there had been a non-accidental head injury to a child and 2) where a child had presented with further episode of injury whilst on a child protection plan. This led to further scrutiny of all partner agencies in a more formal approach through the BSCB, rather than simply holding a" health- only" review with incomplete information about the children and their circumstances. It was clearly very apparent, once the cases were considered and the full picture understood, that there was additional strength in assessing these groups of cases in such a way and this has led to the creation of further actions and learning across the locality.

What Difference has this made:

- Thorough revision and update of the section 11 audit process it has allowed us to critically assess Safeguarding within our Trust and to identify areas of strength plus gaps and challenges. This led to a comprehensive action plan which we have steadily worked through. We were highly commended by the PMAE subgroup of the Board for the work we had completed.
- Improved communication with other agencies through BSCB subgroups, JTAI work, new process for child protection medical provisional reports, regular meetings with social care managers and contact details for staff to approach with more urgent concerns, which now get resolved more easily after escalation.
- More robust arrangements for Safeguarding Supervision and Peer Review – improved confidence in practitioners and ensured no silo-working; also provides a safety net.
- Improvement in quality of training and number of staff trained. Still some way to go as demonstrated by recent knowledge and awareness audit.
- Enhancement of PLN role in Emergency Department has resulted in improved communication with community staff, CAMHS, Social Care
- Involvement in the Electronic Patient Record development has ensured that safeguarding children is inherent in and stretches throughout the system, including for example safety net questions for safeguarding and domestic violence.
- Readiness for CQC and JTAI inspections.
- Overall improvements in our safeguarding ability as a Trust body and therefore better outcomes for children and young people.

Areas for further action:

- Explore ways of obtaining views of child/young person and family to inform and improve our service development within safeguarding.
- Safeguarding team to explore how to capture information about staff contributions to CAF and Early Help process, and to re-launch notification process for when staff are involved in a CAF. In addition need to identify measurable outcomes regarding effectiveness of Early Help.
- Improvement in SG services for 14-17 year olds placed on adult wards, as part of Paediatric Liaison Role.
- CSE HUB development remains on-going as with development work on the 9 point strategic plan.

What are the Key things we are doing next:

- Template created for" Voice of the Child " to enable practitioners to demonstrate consideration of child-centred approach - piloting in Community Paediatric Nursing
- Audit of patients, families and accompanying professionals' opinions of the service for child protection medicals – demonstrated user involvement
- Development of joint safeguarding children and adult work within areas of shared responsibility eg. DHR's where children involved, FGM, DV, PREVENT
- Development of a Safeguarding nurse forum, to enable individuals to cascade key messages in relation to SG children within their areas of work.
- Creation of new e-learning package for Level 2 reflecting LOCAL issues as well as usual level 2 training

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Organisation: Bradford Teaching Hospitals NHS Foundation Trust

3. NPS: Bradford and Calderdale (B/C) storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

- NPS has responded to requests for increased involvement in Interagency working
- There has been increased focus on risk of CSE in case management
- NPS issued new Safeguarding Guidance: Our "full part" in August 2015, which introduced revised expectations

Our Journey so Far – what are we doing/done:

- NPS contributes to daily DRAM (DV Hub) by screening referrals for NPS and CRC cases.
- NPS sends an Officer to MARAC meetings to represent cases with NPS involvement.
- We have amended our 'known person check' to include CSE and Early Help referrals.
- The Safeguarding Lead created an Action Plan with RAG rating in January 2016 to Review 'Our "full part", which has been updated in August 2016.
- In addition to being a panel member for the 'Clare's Law' Disclosure meeting, NPS contributes to the IOM Meeting for High Risk DA Perpetrators.

What Difference has this made:

- A tighter system is in place to check that 'known person checks' are responded to in a timely fashion, and now include those below the threshold.
- There is now a Safeguarding Lead Probation Officer for each Offender Management Team in B/C.
- The Safeguarding leads are booked onto Signs of Safety 1 day training.
- All B/C NPS operational staff have completed E learning on DA and Safeguarding over the last year.

Areas for further action:

- Working through actions in B/C Safeguarding Action Plan.
- Ensure that young people supervised by YOT, who will be transferred through to adult services, have a smooth transition.

What are the Key things we are doing next:

- B/C NPS is liaising with MASH to ensure that there are no gaps, if there is any NPS involvement
- NPS NE is working on a system to capture named children at High Risk of Harm for senior management oversight.
- Safeguarding leads are due to cascade NPS Team Briefing with perpetrators of CSE.
- Safeguarding Lead is reviewing process for transfer of YOT cases to adult services, to ensure these fit with NPS/YOT guidelines for best practice as per the Joint National Protocol.

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Organisation: NPS

4. Bradford District Care Foundation Trust (BDCFT) storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

- **Theme:** Coping with Crying
- **Theme:** Meeting the needs of young people who have a learning disability who have experienced or who are at risk of child sexual exploitation/sexual abuse (BDCFT)

- **Theme:** Elective Home Educated children where families are not engaging with services and child not being seen.
- **Theme:** Meeting the safeguarding needs of children with complex physical or mental health needs or disabilities. Identification of a learning gap and subsequent development of a specialist safeguarding training package.
- **Theme**: External agencies report difficulties accessing and/or understanding referral pathways and thresholds into specialist CAMHS, particularly when children are at risk and/or in mental health crisis and those from identified Vulnerable Groups.(Both locally and nationally CAMHS services have seen significant increases in referrals. In Bradford this has risen from 2096 in 2012 to 2937 across 2015).

Our Journey so Far – what are we doing/done:

- The Coping with Crying programme consists of a short film that is shown to parents that aims to influence the way they respond to their baby's crying. The film was part of an innovative research project developed by the NSPCC and implemented within BDCFT
- Worked with the safeguarding adviser for the office of the police and crime commissioner (West Yorkshire) to undertake multi agency work to identify key work streams necessary to effectively safeguard children with learning disabilities from Child Sexual Exploitation (CSE) and Child Sexual Abuse (CSA) both online and in person. Organised CSE/ CSA – Children with learning disabilities workshop event (June 2016)
- Development of a School Nurse - Missing from Education Standard and flow chart for Home Educated children, which incorporates guidance around geographical cover for children not in school and making contact with families
- A collaborative safeguarding disabled children 'workshop style' training package was developed, and delivered to a multi-agency audience during Safeguarding Week in October 2015. This package was further developed and delivered in August 2016. The sessions had an evidenced based focus on working with children and families who are considered to be on the margins of child protection processes. The underlying theme of the training in October 2015, was 'Effective support and Respectful Challenge'.
- CAMHS is currently commissioned to accept referrals from professionals working with children who are experiencing mental health problems, which are having a moderate to significant impact upon their functioning, and are at moderate to significant risk of harm. CAMHS offer specialist assessment, formulation and interventions within a Multi-disciplinary team. BDCFT First Response is an ageless open door crisis response service offering direct support and intervention to anyone in mental health crisis (working to all BDCFT Safeguarding Policy and Procedures and appropriate referral pathways for such vulnerable groups).

What Difference has this made:

- Due to the emotive content of the film, 'Coping with Crying', BDCFT's health visitors have been highly motivated to show the film and encouraged parents to view and talk about it.
- Has identified ways to hear the' voice of the child 'on how best to deliver support services to children.
- School Nurses have developed a good practice Standard for Home Educated children to ensure that they are still offered an equitable School Nursing Service and that children do not become invisible. BDCFT staff have a clear pathway to follow when children/families become missing including multi-agency information sharing
- Reactive evaluation of the targeted training session indicated that practitioners had begun to embed the learning into practice.
- A Crisis Care Concordat for Children with an action plan for the development and delivery of a coherent 24/7 crisis response services. This includes membership of the LA, Police & Health. Funding has been allotted to increase specialist CAMHS capacity and expertise within the First Response Service.

Areas for further action:

- To make health visitors aware that even though the pilot has finished they need to continue to show the film making all parents aware of non-accidental head injury.
- Raise staff awareness in regard to the CSE risks related to children with learning disabilities.
- The Specialist Safeguarding Practitioner, BDCFT Safeguarding Team, to attend the newly commenced weekly Safeguarding Education Hub multi-agency meeting to ensure safeguarding concerns regarding children are documented and shared with relevant BDCFT health staff in a timely manner and any actions required by health are requested.
- Participants need to be asked to consider how the training influences decision making around supporting and safeguarding the well-being of vulnerable children and their families and to develop actions for their practice
- Continue to provide specialist training for practitioners working with caseloads of disabled children with complex health needs/ mental health needs.
- On-going work to improve inter-agency relationships and working, and increased understanding of CAMHS services.

What are the Key things we are doing next:

- Incorporate the NSPCC's evaluation findings into practice.
- Incorporating key messages within BDCFT Safeguarding Team's CSE training, newsletters and supervision.
- BDCFT Specialist Practitioner, Safeguarding Team, will continue joint working with Education and multi-agency team, and engage in any new developments regarding Home Educated and Missing children and to incorporate messages regarding missing children into training.
- A further specialist training session is planned for practitioners working with caseloads of disabled children with complex health needs/ mental health needs, and this will be delivered on the 20th October 2016 - as part of Safeguarding week. The underlying theme of the 2016 training is 'Grief, beliefs and conflict' – and how these issues impact on safeguarding disabled children.
- Formal agreements are required regarding the model of CAMHS input into Early Help Hubs and to support Journey to Excellence objectives, and improved experiences and outcomes for those children that are Looked After.
- Completion of an internal review alongside stakeholders, children and young people and their families to inform necessary service changes.

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Bradford District Care NHS Foundation Trust

5. AWC, BC and BD CCGs storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

- CSE
- Domestic abuse
- Female Genital Mutilation

Our Journey so Far – what are we doing/done:

- Cross-health CSE Specialist Practitioner post on CSE Hub –commissioning of one year's secondment.
- Cross-Health Domestic Abuse Manager (Health) commissioned on a permanent basis.

- Designated Nurse led a cross-health group to develop a co-ordinated response to identifying and making appropriate referrals re risk of, or harm from, FGM. This then fed into the multi-agency pathway (currently in final draft form).

What Difference has this made:

- Leadership and co-ordination re CSE across health, and more effective multi-agency working around CSE, via Hub post.
- Leadership and co-ordination across health re domestic abuse, and more effective implementation of the Local Health Economy Domestic and Sexual Violence Strategy.
- Advice and support to GPs around FGM, via Domestic Abuse Manager (Health).
- Strengthening the referral and feedback mechanism for GPs re MARAC, via Domestic Abuse manager (Health).

Areas for further action:

- Development of a Domestic Abuse Policy for primary care.
- Review of the flagging options, to identify children at risk of CSE across the various health recording systems.

What are the Key things we are doing next:

- Policy development as above.
- Dissemination of key messages from SCRs, DHRs and Challenge Panels to GPs via the CCG safeguarding team training programme.
- Leading the review of the multi-agency sexual assault pathway.

Author: Sue Thompson, Designated Nurse – Safeguarding children and Looked After Children
AWC, BC and BD CCGs

6. Children missing from Education (CSC) storyboard

Improving Safeguarding Outcomes 2015/2016

Safeguarding issues:

- 3000+ Children Missing Education (CME) referrals each year
- Between 70%-80% of all referrals relate to children from Central and Eastern Europe (C&EE)
- High mobility rate of C and EE families
- Only a limited number of resources to gather information from specifically regarding children and families leaving the UK
- The situation as we understand it - the 'Out of School Register' on Thursday 7 April 2016 shows 483 live CME cases in four referral categories, Children missing with their families, Children living in Bradford but not on the roll of a school, Children who have lost their places in school having failed to return from extended leave of absence, Other Local Authority enquiries

Our journey so far….what we are doing:

- Since 2006 the Education Social Work Service has designed and developed processes and procedures for the management of CME cases
- Schools, generally know what action to take when a child stops attending school and they and their families whereabouts are unknown

- Agencies know what to do if they come across a child who is not registered at a school and This will be re-enforced through multi agency 'Missing' workshops 12 and 20 May 2016 (2 sessions per day)
- The Education Social Work Service has ensured that sufficient resources are in place to manage the high volume of CME work
- CME caseloads and reviewed regularly via supervision to ensure timeliness and appropriateness of intervention
- Current service position. The service has 3 officers who work specifically with CME cases and all Education Welfare Officers and Education Social Workers carry a number of CME cases in addition to school attendance cases. There is also significant Admin support for the CME process
- Work with partners – The Education Social Work Service work closely with partner agencies, Schools, Children's Social Care, Health, Housing, Police, Welfare Benefits, Council Benefits and Other Education Services and Other Local Authorities to gather and share information regarding Children Missing Education
- The Education Social Work Service are routinely made aware of children on a Child Protection Plan who have moved into the area. Support is provided to Children's Social Care to identify school places and ensure timely admission.

What difference has this made:

- Missing Children and children not on the roll of a school once identified are responded to in a timely manner.
- Between 01.09.15 and 01.04.16 ESWS intervention with 1300 children referred as CME led to:
  - 58% of those children being found in or admitted to a Bradford school - excluding the 9% who had left Bradford or the country, and the 1% who opted for Home Education.
  - 14% of children not located after all enquiries were exhausted.
  - 27% remaining open with enquiries on-going.
  - What challenges remain for safeguarding children
  - It is not always possible to trace every missing family
  - Admission to a school is not always timely due to a shortage of school places in certain areas of the city
  - a reluctance on the part of schools to admit some pupils due to the possible impact on results.

Areas for further action:

- The register of CME contacts in each Local Authority, maintained by the DfE and updated yearly is at times, out of date. This results in delays in making contact with other LA's.
- We cannot be entirely confident that Independent and Private Schools are routinely following Children Missing Education Procedures
- The resources available to LA's to trace families are limited and this results in a number of cases been closed without the families being found. Whilst there are good local systems in place for tracing children, national support is limited. For example, no access to DWP Child benefits systems and information regarding families leaving the country.
- A shortage of school places in areas of the city delays admission to schools.

What are the key things we are doing next:

- Preparation for and the implementation of the changes to the Pupil Registration Regulations which will require all schools including Independent and Private Schools to inform the Local Authority of any child the remove from or add to the school roll from September 2016
- Engage with the Private and Independent schools to ensure they comply with the regulation changes
- Develop stronger links with private and independent schools to promote the proposed changes to the Pupil Registration Regulations and reinforce the safeguarding messages and risks to children who slip through the net of education.
- Develop links with UK Border Agency and the Immigration and Asylum Team regarding families deported and assisted to return to their country of origin.
- Engage with the DfE to explore ways of maintaining the LA CME contacts list to facilitate quick and efficient communication between authorities.
- Continue to explore new information sources to assist in tracing missing families
- Contribute to the planned Missing Children – Partnership Workshops (May 2016)

- CME is a key agenda item of the newly formed BSCB Safeguarding in Education Sub Group and the partnership Education Hub.

Neil Hellewell; Principal Education Social Worker
CBMDC.

7. West Yorkshire police (WYP) Night Time Economy storyboard

Improving Safeguarding Outcomes 2015/2016

1. Taxi operators and drivers:

What was the issue:

- Recognition of taxi involvement in CSE offences within Bradford and on the national stage.
- Intelligence suggesting that Bradford vehicles were involved in facilitating offences by transporting children to locations of concern.
- Between 3500 and 3800 licenced drivers in the Bradford District.
- Many on contracts transporting vulnerable children.

Our Journey so Far – what are we doing/done:

- Strong partnership links developed between the police and taxi licensing.
- All drivers and operators have been required to attend CSE training and awareness seminars – including how to report concerns.
- All new taxi licence applicants receive mandatory training in CSE awareness and reporting.

What difference has this made:

- There has been an increase in intelligence and referrals made to the police on CSE.
- Evidence from cases supports that children have been safeguarded due to improved recognition and reporting
- Drivers are now engaged with safeguarding, challenging situations such as parents wanting to place young children in the taxi alone.
- Drivers now understand and consider the level of personal responsibility involved whilst conveying children.
- Drivers and operators can no longer argue a lack of awareness if issues occur.

Areas for further action:

- Debate is on-going on in-car CCTV – mainly based on cost.
- Utilising SRANS colleagues for increased roadside checks.

What are the Key things we are doing next:

- Consideration is being given to develop a CSE special constable by dedicating 2 officers to work with taxi enforcement officers.
- Identify suitable timescales for refreshing CSE training and awareness raising to ensure a continued focus and compliance on the issue.

2. Oversight of premises and disruption activity:

What was the issue:

- Intelligence connecting premises to drugs and sexual offences against children.
- Lack of co-operation with neighbourhood policing team when challenged.
- Difficulties in addressing concerns due to obstructive behaviour from staff.

- No regulatory body had direct responsibility as there was no licensing requirement.
- Despite general intelligence and concerns, no disclosures identifying the premises as a scene of crime were made.

Our Journey so Far – what are we doing/done:

- PC CSE problem solver (PCCSEPS) role was created in the WYP to target locations such as these.
- Staff/owners confronted robustly with regular visits detailing ownership and daily operations.
- Errors found in practice around insurance, music licences and health and safety provisions resulted in owners requiring to undertake actions to address the issues.
- Legislation was identified that could enforce closure of the premises – Section 136.Sex Offences Act 2003
- This legislation was used to close a business in November 2015 by Bradford Magistrates at a civil hearing (First use of this legislation in England and Wales).

What difference has this made:

- Appropriate media exposure was utilised when the business was closed – sending out a message about disruption across the Bradford District.
- Similar businesses are now aware of this legislation and the impact it has when used by the police.
- Owners of businesses now understand the benefit of engaging with the police.
- Risks to children have been reduced as owners now understand there are legal and financial consequences for failing to protect children.

Areas for further action:

- Extend training for premises staff in CSE awareness.
- Monitor businesses on re-opening and to ensure that improvements are maintained.
- Implement a shared responsibility for visits between the PCCSEPS, neighbourhood teams and specialist roads policing officers.
- To identify where CCTV systems need to be installed in premises of concern.

What are the Key things we are doing next:

- Maintain an overview of operations between police teams.
- Identify the exact nature of businesses that re-open and any relevant partners that will support the process.
- Work with premises owners and staff to ensure written safeguarding policies are in place.

Inspector Esther Hobbs
PC Matt Catlow
West Yorkshire Police.

8. Voluntary and Community Sector Organisations (VS) / Young Lives Bradford

Improving Safeguarding Outcomes 2015/2016

Safeguarding Issues addressed over this period:

- There is a wide variety of voluntary and community sector (VCS) agencies that work on a number of specialist areas of safeguarding including Child Sexual Exploitation, Domestic Violence, Mental and emotional health, substance misuse and bullying.
- Other agencies work with a broad cross section of young people. They ensure that their provision has appropriate safeguarding in place and respond to safeguarding issues that emerge.

- Young Lives Bradford as the network of VCS organisations that work with children and young people has worked to
    - Promote safeguarding across the VCS
    - Ensure VCS org are active in safeguarding developments across the district
    - Support local safeguarding initiatives and priorities

Our Journey so Far – what are we doing/done:

- Young Lives co-ordinated sharing of information on and VCS input into various safeguarding issues including:

- Supporting the development of the Journey to Excellence, including Early Help and Signs of Safety.
- Support work on safeguarding in Eastern European communities, in particular the Safeguarding Board's conference.
- Raising awareness regarding the work of the Safeguarding Board.
- Ensure as many voluntary sector organisations receive information /support regarding safeguarding issues.
- Promoting safeguarding week and ensuring VCS contributions.
- Informing the VCS about the Prevent agenda and their role in supporting it.
- Promoting training and opportunities.
- Supporting the Board's work on Bullying (in the lead up to the conference).
- Supported the development of a section 11 audit tool for VCS organisations to use to support their work.
- Supported engagement in serious case reviews and dissemination of learning across the VCS.

What Difference has this made:

- All VCS organisations that responded to YLB's survey have safeguarding polices and a majority update these each year.
- VCS organisations report that they have an increased awareness of safeguarding issues and use the information to inform their safeguarding practice.
- Organisations have been supported to develop their safeguarding policies and procedures.
- Knowledge, skills and intelligence has been shared with the Safeguarding Board and its sub groups.
- The VCS has had a high uptake of Signs of Safety training.
- Individual agencies are also able to demonstrate the impact that their work has had.

Areas for further action:

- There will be a continuing need to support the development of Early Help and the roll out of Signs of Safety.
- There will be a need to support organisations with completion of Section 11 returns.
- We need to be clear on the sector's future priorities based on dialogue between the district VCS and BSCB.

What are the Key things we are doing next:

Young Lives Bradford will

- Continue to work on Early Help and signs of safety.
- Identify key priorities for VCS safeguarding steering Group.
- Respond to emerging need.
- Undertake work to promote VCS services to schools and education providers.

Author: Peter Horner and Dave Benn
Organisation: Young Lives Bradford

9. FAMILY ACTION HOPE SERVICE

Improving Safeguarding Outcomes 2015/2016

The HOPE Post Domestic Abuse Service works with children and young people aged 5 - 13 years old and their families, in all areas of Bradford and Keighley who are living in a safe situation free of domestic abuse. The aim of the service is to support recovery from trauma, repair family relationships and improve emotional wellbeing of children and families who have lived with domestic abuse.

Safeguarding Issues addressed over this period:

- Children who live with domestic abuse experience trauma which impacts on their emotional health and their social, intellectual and behavioural development.
- Living with domestic abuse affects whole families and family relationships.
- Domestic abuse impacts on children's emotional attachments and relationships with safe parents, as well as abusive parents.
- Children who live with domestic abuse need to feel safe before recovery.
- Some children and young people reproduce abusive behaviour modelled to them and can pose a risk to peers, siblings and non abusive parent who may already be traumatised by domestic abuse.
- Awareness of children who are sexually or physically abused within families are often invisible and the focus on CSE although crucial sometimes distracts from this.
- There are many crossovers for traumatised children who can experience neglect, sexual abuse and also live with domestic violence.
- There are well evidenced links between experience of physically abusive parenting and the development of young people's own abusive behaviour and this includes sexually harmful behaviour.
- Current research (Women's Aid new model) suggests an over reliance in addressing domestic abuse, on management of risk rather than building on strengths of families and assessing needs.
- Incorporating learning from new legislation such as including coercion and control in definitions of domestic abuse.
- Make links with other agendas where harmful practices occur such as FGM and forced marriage and PREVENT.

Our Journey so Far – what are we doing/done:

- Hope service was previously delivered by two different agencies- Family Action in Bradford and in Keighley by DVS and since July 2015 it was agreed delivered solely by Family Action. This brings consistency and is rooted in a safeguarding child centred organisation, with strong safeguarding and domestic abuse policies and focus.
- In 2015 our first goal was to improve quality of risk and needs assessments ensuring they are holistic and include family and professional system around the child. We now deliver assessment of unique family needs and offer packages of support in line with Bradford early help vision of thinking family. The Hope service was previously focussed primarily on individual work with children, this is still important, but is only one aspect of the service offer.
- Our second goal was to widen the range of services available to meet needs of whole family, including therapeutic work with child, or family, or parent and child and also group work and consultation to other professionals around the child and family.
- Within this to ensure the service for children who have experienced domestic abuse is trauma informed and has attachment and systemic focus.

- A package of support can now include other family action services such as practical benefits advice following domestic abuse (Canterbury Advice service) and also recovery work for parents with mental health issues, from Building Bridges sister project.
- Our third goal was to research and develop evidence based services to improve safeguarding outcomes. We bought licence, manual and training for DART recovery programme from NSPCC and are sharing this with early help partner agencies.
- Staff are now trained in Signs of Safety Model of risk assessment and created SOS Practice lead to attend Bradford Practice lead Sessions and service manager part of SOS steering group to drive SOS forward in Bradford voluntary sector and is part of VCS safeguarding steering group.
- Created senior practitioner role as safeguarding lead and to quality assure assessments.
- Created systemic family practitioner role to ensure skills in working with whole families and professional systems.
- Staff has access to systemic trauma informed consultation on monthly basis.
- Staff have accessed training in working with families and working with trauma and group work skills as well as NSPCC DART training.
- We have developed a strategy of supporting parents as volunteers and we have one parent who is now a group facilitator for the Dart programme.

What Difference has this made?

- Assessments are now holistic and family focussed and support is bespoke to family's needs.
- Following assessments we have also been able to signpost families to more suitable services or refer back to CSC if safety not yet achieved for children.
- We have been able to provide systemic family work which has included previously abusive parents and we are now more inclusive of fathers in our assessments and service delivery.
- We have been able to pilot evidence based group work (DART) with a focus on repairing attachment relationships between mothers and children and also customise and deliver the programme on a 1:1 basis where group work is not suitable using our learning from the DART manual (HEART programme).
- The Keighley pilot of NSPCC DART evidence based group work programme for mothers and children recovering together from Domestic Abuse was positively evaluated by parents and children. A short community film has been produced with joint funding from Family Action national DA coordinator (Comic Relief funding) to share information about the DART pilot.
- We have been able to share learning with other partner agencies delivering support to families experiencing domestic abuse, such as Families First (Brathay Trust) currently co delivering our second pilot of the DART programme in Bradford.
- The quality and depth of assessments and multiple levels of intervention with families and parents as well as children means our numbers of open cases are small. This is significant as we have a waiting list for the service.

Comments from parents

I am more confident and stronger.

I understand my child better. Everyone is in/ has been in similar situations so they understand you.

I feel DART has helped us as a family more than I could ever imagine ☺

Areas for further action:

- The Hope Project received 164 referrals from the 1st April 2015 to the 31st March 2016, however we are commissioned to provide an in depth assessment and recovery service to 50-60 children and families, which illustrates the need.
- We need to secure longer term funding for the service for more than 1 year at a time. The short term funding situation makes it difficult to recruit and retain staff and plan services which affect quality and

quantity of service delivery and innovation. Our funding ends in March 2016 which leaves 22 weeks of service delivery and all our therapeutic programmes are for 10-12 weeks following 4 weeks assessments.

- We would like to explore with our Bradford commissioners the discrepancy between funding for children who have been sexually abused and those who have experienced domestic abuse as we receive a small amount CCG health funding for recovery sexually abused children and we know there is a much larger need for this service. Our domestic abuse recovery service is funded from early help and not funded by health. Our vision would be for one trauma and loss recovery service within Family Action for all traumatised children whatever the form of sexual or physical violence, with ideally joint funding. This would allow us to work with children and parents at an earlier stage and also do more support work with parents and psycho educative groups for parents of the children who have been sexually and physically and emotionally harmed, so that they can support their children's emotional needs and manage their behaviour.
- We would also like to meet with the Police Crime Commissioner to discuss needs of Bradford children who are victims of familial abuse and explore potential other sources of funding.
- There may be a gap in service for young people over 13 years old for a recovery service and this needs to be explored with other local services who provide youth work, such as Bradford Women's Aid and other providers. A forum of service providers for children would be useful to ensure we are mapping local services to be most effective. This is also crucial as we know that the most important way to keep children safe is to support prevention and early intervention which means working in schools on healthy relationships and definitions of gender and masculinity.

What are the Key things we are doing next?

- Evaluating second pilot of DART group work programme with Families First (Brathay Trust) and exploring how we can embed the learning into the wider early help strategy.
- Hope staff are to be trained in enough is enough programme currently being delivered by Families First, so that we can meet the needs of our families where children are abusive to their parents or siblings.
- Exploring outcome tools for family work and models of working with whole families including fathers. Family Action has whole family services in Wales and we would like to learn from their experience.
- Further staff training on working with trauma is planned for December 2016.
- Embed SOS model to HOPE service and amend paperwork in line with SOS developments as they evolve, such as early help assessment.
- Building relationships with other partners working with domestic abuse to maximise positive outcomes for children.
- We have developed an equality and diversity forum within Bradford Family Action to look at how we can increase access to our services to families from marginalised communities.
- Seeking clarity on the early help strategy and how we can support the development of a mature model of early help with evidence based services.
- Raising awareness of HM Government Ending violence against women and girls Strategy 2016-2020 (March 2016). Within this document there is the demand to stop violence to women and girls and for local services to ensure all victims get the right support at the right time, driving a real transformation of service provision, providing support to local commissioners so that all areas rise to the level of the best. The government is pledging to ensure all local partnerships will have access to the best examples of local practice, along with the data, tools and information they need to provide an integrated, effective, whole family approach to addressing and stopping violence and abuse
- Also raising awareness of Domestic violence and abuse: NICE quality standard 3 [QS116] February 2016 which underlines the importance of appropriate support for children and families from specialist supports services which address the emotional, psychological, physical and sexual harms arising from domestic violence and abuse.

Author: Debra Glover , Service Manager

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October 2016.

Chapter 5 – Ensuring the workforce is skilled and equipped to carry out their safeguarding roles and duties.

1. Learning and Improvement - Dissemination of Key Messages

LOCAL LEARNING

BSCB has a local Learning and Improvement Framework, which means that a range of quality assurance activities are on-going these include single and multi-agency audits of practice, multi-agency challenge panels, local learning lessons reviews and Serious Case Reviews.

In addition to highlighting where practice needs to improve there are also examples of good practice which is useful to share. It is important that key learning is disseminated to all partner agencies so that practice can be developed with the ultimate aim of keeping children safe.

There is a template which partners complete to record key learning which is collated by the BSCB Learning and Development Coordinator. In the last quarter there have been contributions from BDCFT, BSCB, and Airedale NHSFT.

Key Messages

Theme:-Recognising the importance of the role of fathers and men in the lives of children and young people

An audit of records in found there was evidence of good practice where clinicians actively encouraged the involvement of fathers. However there were some inconsistencies in how and where in clinical notes the names and contact details of parents and carers were recorded.

Where it is not appropriate to involve fathers it is still important to think about the significance and history of this relationship when working with a child and family. Therefore family history, names, contact details should be recorded clearly , this information should be requested on the form for the initial appointment , clinicians should go through this form with parents/ carers and the young person and discuss consent

Key Learning - all agencies should ensure that their work with children and families includes fathers and that their processes for recording contact encourages this from the first meeting.

- **Partners -** Are you confident your organisation has such processes in place?
- **Staff -** Do you make sure you include the role of the father in your assessments even when it is not appropriate to include them in direct work?

Theme:-CSE - Spotting the signs, information gathering and sharing

An individual management review found that there was a need to improve information gathering and sharing for all children attending Emergency Departments and Children's Services within the hospitals.

There is now a requirement that the social circumstances of all children attending Emergency Department (ED) / children's services is checked and that ED staff have to inform school nurses of children attending as a result of a fight.

In addition there is a requirement that all ED consultants and paediatricians should complete level 3 safeguarding training within 3 months of starting employment.

Key learning - is the importance of the timely gathering and sharing of information with the most appropriate staff in other organisations and the need to ensure that key staffs are appropriately trained within a specified time frame.

- **Partners -** Are there robust arrangements for ensuring staff are trained and that this is monitored and reviewed in your organisation?
- **Staff -** Are you clear on when to share information and who it should be shared with?

West Yorkshire Information Sharing Procedure which can be found on the BSCB website. This policy is being updated. It can be found at http://westyorkscb.proceduresonline.com/chapters/p_info_shar_confid.html

The Bradford Protocol is being updated

Theme:- Supervision Practice and recording

A partner undertook an audit which focussed on the recording of safeguarding supervision and adherence to their "Safeguarding Children Supervision Policy". There was evidence of timely recording in both electronic systems in use in the organisation e.g. 83%.

However not all recording was compliant with the use of the SBAR tool (Situation, Background, Assessment and Recommendation) which is part of the policy.

Key Learning - Therefore there is a recommendation that all staff need to follow the policy about how to record supervision in order for full assurance to be achieved.

- **Partners -** Do you have a policy for supervision which includes good practice and an expected timeframe?
- **Staff -** Are you clear about your organisations supervision policy and do you adhere to its requirements?

Theme:-CSE Review of Practice – Risk assessment Template

The BSCB led a multi-agency challenge panel case file audit on CSE which included the use the current risk assessment template.

Good practice - There was consistent appropriate involvement of CAHMS and generally appropriate flagging on hospital systems for children at risk.

Areas to improve - There were concerns that the current risk assessment tool should always be used and professionals must use the case history and an analysis of the child's journey, which should be in the chronology. The chronology should not be just a list of events it must always include analysis considering "what does this mean for the child".

Key Learning - There needs to be a purpose and focus on all interventions, each of which should have measurable outcomes, this will ensure that risk is assessed appropriately.

Recording about missing episodes needs to be kept up to date especially when children are placed out of area.

When a number of professionals are involved it is especially important to be clear about roles and responsibilities and make sure the child and family is clear who is doing what

Recommendations

- complex cases should be allocated to experienced social workers
- a paediatric medical assessment should always follow an alleged assault.
- make use of the Fair Access panel to assist finding suitable school placements

BSCB - Needs assurance that

- All staff use the local procedures for completing a CSE Risk assessment
- There is information and advice about Child Sexual exploitation on the BSCB website

http://bradford-scb.org.uk/cse.htm

- Safeguarding Children from Sexual Exploitation E learning includes all the up to date documentation and advice for completion of a risk assessment
  http://bradford-scb.org.uk/training/e_learning.htm

- Medical assessments are undertaken as expected detailed in the Safeguarding Board procedures
  http://westyorkscb.proceduresonline.com/chapters/p_sec_47_cor_ass.html#med_assess
- Assessment and analysis and planning is meeting expected standards
  http://westyorkscb.proceduresonline.com/chapters/contents.html#assessing_need
  http://bradfordscb.org.uk/training/pdfs/2016_17/Safeguarding%20Assessments%20Flyer%202016_17UPDATED.pdf

Local Lessons Review neglect and physical injuries

1. The BSCB undertook a local lessons review on cases of young babies with non-accidental head injuries which recommended that:

- Training on neglect to focus on professional judgement, professional curiosity and challenge, disguised compliance and overcoming acclimatisation to a neglectful presentation and the rule of optimism. A course has been developed.
- A multi-agency neglect one day course "Neglect can you recognise it what should you do?" is available now details of how to book can be found on the BSCB website
  http://bradford-scb.org.uk/training/pdfs/2016_17/Neglect%20-%20Can%20you%20recognise%20it%20and%20what%20should%20you%20do%202016-17.pdf
- Working with Disguised Compliance - details of how to book can be found on the BSCB website
  http://bradfordscb.org.uk/training/pdfs/2016_17/Working%20with%20Disguised%20Compliance%20Flyer%202016-17.pdf
- Working with resistant families details of how to book can be found on the BSCB website
  http://bradfordscb.org.uk/training/pdfs/2016_17/Working%20with%20Resistant%20Families%20Flyer%202016-17.pdf

2. New National E Learning

- Seen and Heard - The Children's Society have created a 60-minute video-based e-learning session to help you build your awareness to make sure young people who have been abused are seen and heard.

2. Learning and Improvement report:

Terms of reference

On behalf of the BSCB, to coordinate and evaluate the effectiveness of safeguarding children learning and development activity in the Bradford District so that those working with children, young people and families are appropriately skilled and competent.

Contextual information

- Sue Thompson has continued in the role of Chair of the sub-group throughout the year.
- The police now have a representative on the group, education have not been represented this year.

Main issues covered and analysis of sub-group's effectiveness

During 2015-16, a variety of learning experiences was offered on a multiagency basis including:

- 1250 on the annual training schedule;

- 80 participants attended other learning and development events - briefings, focus groups;
- 5150 professionals registered for e-learning courses, some of the most popular ones were:-
    - *Awareness of child abuse and neglect 1734*
    - *Safeguarding Children from abuse by Sexual Exploitation 773*
    - *Awareness of Domestic Violence and Abuse including the Impact on Children, Young People and Adults at Risk 325*
    - *Hidden Harm - The effects of parental problem substance use on children 178*
    - *Safeguarding Children Refresher Training 137*

Approximately 2000 local workers attended learning events, lectures and workshops during **'Safeguarding Week 2015' –** which is a practice-focussed collaboration between Bradford Safeguarding Children Board, Bradford Safeguarding Adults Board and the Sexual violence and Domestic Abuse Board.

During the week over 60 events took place across the district all with the focus on "Safeguarding – its everyone's responsibility".

A key development this year has been the delivery of advanced CSE training for practitioners who work directly with children at risk of CSE. The programme was reviewed and developed throughout the year. The personnel involved in delivering the course changed due to staff changing roles and a decision was made to re - commission training for 2015 /2016 based on feedback from the evaluations.

Another significant development was completion of the review and update of the E-Learning Programme *Missing Children – Bradford protocol* -so now all practitioners working with this vulnerable group of young people have access to up to date training to help them put into practice the local procedure.

In February 2016 the BSCB added the *Safeguarding Children refresher Training* to the courses freely available to all partner agency staff to use to update their safeguarding training as required.

The Learning and Development Coordinator has worked with partners in the BMDC and Collingwood Learning to develop a series of web based training materials, "Real Safeguarding Stories". These are case scenario based and performed by professional actors they will be freely available for use in training and development sessions.

Evaluation of training has continued to be developed working towards an electronic pre and post course follow up system through the purchase of a software package "Paper data".

Alongside this courses have been evaluated through some telephone follow up which produces good qualitative information but is very labour intensive.

BSCB commissioned a follow up embed session for the *Working with Resistant Families course* which provided very detailed feedback and evidence of impact of learning.

A report was produce for the BSCB and a further session was commissioned to take forward some of the themes with board members at the BSCB Development day.

A training needs analysis was undertaken by the BSCB which highlighted that some of our partner agencies were not able to easily provide data about compliance with training requirements.

The BSCB has challenged partners to ensure that this improves. For example the local authority has recently invested in a new learning management system which they have assured the BSCB will mean they will be in a position to provide data in the future.

Links to other sub-groups

The *Learning and Improvement Framework* has been re written and as part of this process it was reviewed by the sub-group. There continues to be the need for strong links between the Serious Case Review group and the Performance Management, Audit and Evaluation Sub-group.

Priority issues for 2016-17

- To develop the Training Needs Analysis process to give the BSCB assurance that partners are meeting their statutory training requirements
- To develop the impact of safeguarding training and quality of frontline practice and outcomes for children, through use of the Paper data tool. To consider the new BMDC Evolve LMS and how BSCB can make use of this for evaluation and training booking
- To embed the *Learning and Improvement Framework* and its comprehensiveness with particular focus on identified learning needs emerging from the work of all the sub-groups.

Sue Thompson
Designated Nurse CCGs
Chair of the Learning and Development sub Group.

3. Training Needs analysis report 2015-2016

Safeguarding Training Need Analysis Questionnaire:

Organisation / partner	Completed	Partial Completion	No response	Other
ANHST	X			
BDCFT	X			
Banardo's	X			
BTH - NHS	X			
BMDC Workforce Development		X		
BMDC CCHDT	x			
BMDC Fostering Service		x		
Bradford YOT	X			
BLAST	X			
CCG + GP	X			
CAFCASS*				X
Connexions	X			
Education BMDC			X	
Education Schools			X	
Horton Housing	X			
National Probation Service		X		
NSPCC			X	
Oasis	X			
WY Police		X		
BMDC Youth Service			X	

*Provided own written report did not complete the questionnaire.

Responses and Commentary:

Responses provided by and range of compliance

Airedale 59.4% - 100%
BDCT 51% - 92%
Banardo's 80% – 100%
Bradford Teaching Hospitals 70 %– 100%

BMDC CCHDT 100%
Bradford YOT 75% - 100%
Blast 100%
CCG/GP 64% - 100%
Connexions 100%
Horton housing - 100%
Oasis – 100%

2.2 In your service/organisation, do you have the capacity to meet the safeguarding children training needs of all staff/volunteers to the required standards/professional requirements?

Please specify

Yes – what evidence can you provide?

- All answered yes to this and gave examples of evidence.

No – what are the gaps / issues?

- Some difficulties highlighted in releasing staff for training, not having all the records due to changes the organisation, some specialist staff needing level 3 training on a multi-agency basis

Is this likely to change in the next 12 months?

Please indicate Yes / No

- No was the majority response

3. Please indicate if in your single agency training/updates, you cover basic definitions/awareness of:

	Yes	No	Unsure
Domestic Abuse	13		
Child Sexual Exploitation	14		
Female Genital Mutilation	12	1	1
Forced Marriage	13		1
Prevent	12	1	1

Children with Additional Vulnerabilities

	Yes	No	Unsure
Children with disabilities	12	1	1
Young carers	8	4	2
Children of prisoners	7	5	1

4.1 Single agency - What methods of delivery do you currently use to enable your staff to meet their safeguarding training needs?

	Indicate with an X where appropriate

E-learning	14
Full day course	11
Half day course	11
Briefing	13
Practice forum	5
Blended Learning (mix e-learning/face to face)	9
Distance learning	4
Self-directed learning/reflection	10
Newsletter	10
Websites	10
Other please specify	***

*** Themed supervision, shadowing, booklets, network meetings, reflective case discussions, conferences, external trainers. Mentoring for ASYE, team meetings, policy and procedures

4.2 Multi-agency – BSCB - What methods of delivery do you require the BSCB to use to enable your staff to meet their safeguarding training needs?

	Indicate with an X where appropriate
E-learning	14
Full day course	14
Half day course	14
Briefing	9
Practice forum	9
Blended Learning (mix e-learning/face to face)	6
Distance learning	2
Self-directed learning/reflection	5
Newsletter	11
Websites	10
Other please specify	Conferences and workshops

5. How many of your staff are currently active safeguarding children trainers?

	Number of trainers
Single agency	31

Multi-agency – BSCB Training Pool	11
What topics do they cover?	Variety

6. Is your service/organisation able to support staff to become part of the multi-agency pool of safeguarding children trainers?

Yes / No

How many staff could you support to become part of the multi-agency pool of safeguarding children trainers?

Number :

The majority who already part of the pool willing to continue but could not offer any additional trainers.
West Yorkshire Police offered 1 or 2
Horton housing offered 9?
Blast if funding provided
Connexions 1

Do you have staff you would like to develop as safeguarding children trainers on a single agency basis?

Yes / No
If Yes how many?
Horton housing 8
CCG / GP Leads potential interest

Commentary:

Completion

A completed questionnaire was received from a range of partners; however some of the key partners did not provide any response and / or were unable to readily provide the data needed.

This highlights the need for organisations to have in place mechanisms for knowing how many staff they have and what their safeguarding training requirements are, especially as it is a statutory duty of such organisations to safeguard children they need to be able to show they are compliant.

It might be possible for partners to learn from each other / share ideas about systems they have in place to be able to monitor and report on progress in relation to safeguarding children training.

Summary of Responses

1. All organisations had a range of ways of collecting information about training needs

2.1 The information from this table indicates that there are a number of organisations who are 100% compliant at all levels and in the main these were smaller organisations.

It is recognised that this is a snapshot of the current situation and that training programmes are delivered on a rolling annual programme.

It is interesting from the point of view of providing a multi-agency programme that in "Target groups 3 and 4" there was a range from 51 – 100% and 71 – 100% respectively of compliance. These are the target groups that the majority of the multi-agency programme is aimed at – could the BSCB Training programme assist with this?
2.2 The majority of partners said they did have the capacity to meet the needs of their staff however there was a suggestion that some of it could be provided on an interagency basis by one respondent. Conversely another respondent highlighted the difficulties of releasing staff to attend multi agency training.
3. The requirement to cover a range of issues within safeguarding training on the whole appears to be met.

There are some gaps and uncertainties about coverage around the topics of "Young Carers "and "Children of Prisoners".

These could be topics for consideration in the BSCB annual programme.

4.1 The answers indicated a wide range of methods of delivery were used on a single agency basis – E learning and briefings most popular closely followed by full and half day courses newsletters and websites.

4.2 Regarding what is required from BSCB, E learning, full and half day courses were all equally popular, followed closely by newsletter, websites, practice forum and briefing.

5. In total there are 31 active safeguarding trainers, 11 of which are currently part of the multi-agency training pool. Most organisations felt this was as much as they could offer currently. Although there was an offer of 9 trainers from Horton Housing and a suggestion that CCG / GP leads would welcome some "Training for Trainers" to help meet some of their training need gap.

In addition BMDC workforce development response indicates that there are 25 trainers who will deliver some aspect of safeguarding training as part of their role.

Conclusion

This exercise has provided some useful information, however in relation to planning for the annual programme the information is limited.

It has highlighted the need for partner organisations to have a system in place for gathering training needs intelligence which includes safeguarding children training needs data.

This information is needed in order to ensure that the multi-agency programme compliments the single agency training partners are providing for their staff and/or volunteers.

Julie Evans
Learning and Development Coordinator
BSCB

Chapter 6 – Responding to Serious Incidents and Child Deaths

1. CDOP - The work of the Child Death Overview panel was a business priority for this period of the Board's activity and their storyboard is in place under Priority 4 on page . The full CDOP report is available at appendix 3.

2. Case Reviews – The LSCB must undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out the LSCB's function in undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

A **serious case review** (SCR) takes place after a child dies or is **seriously** injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. (NSPCC)

In Bradford serious cases are referred to the Serious Case Review (SCR) sub group, who after reviewing the evidence available at that point, make a recommendation to the chair of the Board on whether the case reaches the threshold of a serious case review, or whether another type of review should be held. Ultimately, it is the Chair's decision on how the Board will respond to the case.

Work completed in this period

During the period covered by this report, the Board has received one serious case review (SCR) which has been completed and the Chair has agreed to two further SCRs which have been started. Partner agencies are also involved in two domestic Homicide reviews (DHRs), one locally and one with another local authority.

The completed SCR - On March 22nd 2016, Bradford Safeguarding Children Board (BSCB) published the overview report of a serious case review (SCR) that is commissioned following the tragic death of Diljeet (not real name). Diljeet died on 18th February 2014 as a result of significant injuries experienced whilst in the care of her mother. This case has been the subject of both a criminal trial and a coroner's inquest.

The two new SCRs started in the period are both cases of Child Sexual Exploitation. One involves the exploitation of a female child by a criminal gang resulting in sexual offences being committed against the child, a number of criminal trials and twenty sentences being handed down to the perpetrators. The second involves online sexual exploitation resulting in sexual offences being committed against a male child which also resulted in successful criminal prosecutions against twenty one offenders.

In both cases, work was carried out under the guidance for SCRs where criminal investigations and proceedings were taking place and this had an impact on the timescales for the SCRs so that there was no prejudicial impact on the prosecutions. The work on the DHRs is on-going, as both cases involve families where there are children involved, and the safeguarding partnership is active to support the process.

Learning and Improvement arising from the reviews

- The need to ensure how critical and significant information is held, shared and understood across the front line of the partnership has been the subject of all learning events being held on the cases. As a result all agencies have agreed to implement the 'Signs of Safety' (SOS) approach to their practice when carrying out assessments of children and their carer's and analysing risk through the 'Danger Statements', a tool in the SOS approach. Multi agency and single agency training is being commissioned to ensure that all professionals engaged in these processes will be skilled to use the approach.
- The need to ensure that all professionals understand the impact of group think, when working in a multi-agency safeguarding system of protection or child in need, when decisions are being taken a round planning services for the child or evaluating the progress of the work taking place. All agencies professionals are being reminded of the need to challenge decisions or assessments when they have a different understanding of the risks evident to the child. This includes assessments around domestic abuse and mental health issues with professionals in the vulnerable adults services.
- The need to ensure that professionals understand each other's roles and responsibilities when working on a case where more than one agency is involved. Effective communication between agencies has been raised as a critical factor in safeguarding children, and that there needs to be clarity around who is involved with the child's case and bringing together that knowledge so that risks can be effectively assessed and reduced.
- The need to ensure that issues of culture and ethnicity are challenged and reflected upon within supervision sessions for front line professionals, and that decisions are not made based on subjective assumptions around gender, the ability to protect or driven by systems thinking based on a particular mind-set.

What difference has this made

- A full account of the impact from the learning reviews is contained in Chapter 5
- The impact on practice and service planning and delivery is contained in Chapters 1 & 2

What needs to happen next

- The learning and Development sub group is looking at different media opportunities to disseminate learning from the reviews to the widest possible audience, including to children and communities, so that everyone understand the challenges of safeguarding children, and what works to reduce the risk of abuse and harm.
- The Performance Management Audit & Evaluation sub group is planning a programme of challenge panels to address priority areas of concern for the BSCB while scrutinising and monitoring the progress of the action plans arising from the activity..
- The Serious Case Review Sub Group will continue to monitor and scrutinise progress of the BSCB and individual agency action plans to ensure that improvement to practice continues to make progress.

Chapter 7 – The Board's overall Performance and Priorities for 2016 - 2018

1. The Board's Overall performance

This has been a very busy year for the Bradford Safeguarding Children Board. Evidence provided throughout this report has demonstrated the significant level of safeguarding activity taking place under the Board business plan and within Individual agencies. The overall evaluation of this activity shows that the Bradford Safeguarding Children Board is fulfilling its statutory responsibilities under the Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. The individual agency storyboards further demonstrate the co-ordination of the range of safeguarding activity taking place within the Bradford District to promote the welfare of the children, protect them from abuse and reduce the risk of harm. It shows how the Board has organised the work under the business plan and the frameworks in place to scrutinise and monitor the activity taking place and provide challenge where needed to hold each other to account.

2. Priorities for 2016-2018

Previous BSCB business plans have been of one year's duration, and this has raised concerns that not all work can be completed within this timeframe. Consequently, the Business plan for the next Board period will stretch over two years to allow for improvements to be fully embedded in practice and a period of time to elapse to enable a rigorous evaluation of impact to be undertaken and fully understood. It will also enable longer term priorities to reach fruition and ensure real progress can be made.

The extended period for the business plan will also facilitate a proactive approach to emerging safeguarding themes and trends within the District, the West Yorkshire partnership and nationally, while enabling the Board to react where necessary to changes in Law and Statutory Guidance. The longer timescale for the plan will also enable a balanced approach to be taken over the focus of the Board's activity. As understanding grows about the nature of the abuse of children through female genital mutilation and forced marriage, and in the exploitation of children through criminal targeting, online grooming, sexual abuse, trafficking and radicalisation; the Board will use intelligence led problem solving techniques to gain an understanding of the scale of the problem and to ensure that safeguarding responses are effectively targeted and proportionate. Thereby ensuring that all children in the District are effectively safeguarded, their voices are evident in the activity and the wider safeguarding landscape is kept in focus.

The Business plan for 2016-2018 has been developed in consultation with the safeguarding partnership throughout the Board, and is leaner and focused on three key areas of activity as follows:

Ensure that the care and protection of all children in the Bradford District remains the highest priority while delivering the improvement programme:

- Scrutinise, challenge and evaluate the impact of the Journey to Excellence strategy on its role in the safeguarding of children in Bradford.
- Evaluate and challenge multi-agency safeguarding performance on neglect.
- Ensure that safeguarding practice meets the needs of children experiencing Violence in the Home.
- Ensure that the therapeutic needs of children who have suffered abuse or neglect are met through a range of services across the Tiers of Need.
- Evaluation of the effectiveness of child protection processes and plans.

By ensuring we have strong and effective safeguarding arrangements and a collective accountability across the system the Board will improve outcomes and reduce the harm to children in the district:

- Develop a range of multi-media approaches to communicating across the whole safeguarding landscape.
- Develop a culture of constructive challenge and openness within the accountability framework to improve the impact and quality of safeguarding services.
- Ensure that learning from challenge, audit and case reviews is disseminated effectively across the partnership and is evaluated for impact.
- Work with communities and children to raise awareness of safeguarding risks and seek their engagement in identifying effective responses.
- Work effectively as a partnership in response to a climate of changing expectations for the Board.

The high level risks experienced by marginalised and/or highly vulnerable children are understood and targeted through intelligence led problem solving, and receive a proportionate multi-agency response:

- Online Safety - grooming, sexting and cyber bullying.
- Grooming and exploitation of children through gangs, radicalisation, sexual abuse and trafficking.
- Prevention and disruption strategies to address the perpetration of abuse and exploitation
- Motivation of children who go missing
- Misuse of substances
- Female genital mutilation
- Forced marriage
- Disabled children

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Date of Publication –	December 2016
Approved by –	The Partner membership of the Bradford Safeguarding Children Board
Copyright –	This report is a public document and is published on the BSCB website.
Authenticity of information –	This report is based on evidence contained within Board records, contributions from agencies across the partnership and information provided by the safeguarding community in the Bradford District.
Contact details -	Bradford Safeguarding Children Board Business Unit - info@bradford-scb.org.uk

Appendix 1

Safeguarding Children Performance Information

BSCB frequently monitors information and data regarding the performance of partner agencies in their work with the most vulnerable children in Bradford. This information is considered by the BSCB Performance Management, Audit and Evaluation Sub Group, which has a role in ensuring that BSCB has a thorough understanding of the effectiveness of services in keeping children safe in the Bradford District. This section summarises the key performance information and analysis for the year 2015-16.

Any references made to national and regional comparator data is from 2014-15 as this remains the most recent available data. The Department for Education will produce a statistical release containing national and Local Authority level data for 2015-16 in autumn 2016.

Child Protection Data

Number of children subject of:	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Referrals	7547	5777	4712	4609	5246	5011	5549
Section 47 Enquiries	1539	1534	1431	1844	1810	1938	2351
Initial Child Protection Conferences	504	441	376	406	568	569	540
Child Protection Plans at year end	405	379	390	374	577	513	511

Referrals

When a member of the public or a professional has concerns about the welfare of a child, a referral should be made to Local Authority Children's Social Care Services, who have a duty to investigate any concerns.

In 2015-16 there were 5549 referrals made to Bradford Council's Children's Social Care Services. This is a rate of 360.6 per 10,000 child population which is much lower than the national rate for 2014-15 (548.3 per 10,000). The number of referrals in the year was about 11% higher than in 2014-15; this is a fairly steady increase across all age groups with the overall proportions by age band very similar to previous years. 96.3% of referrals went on to further action (similar figure to last year).

Re-referrals

When working with vulnerable children and families, it is important that professionals try to develop a prompt and accurate assessment of what help is required, from the start, at the point of referral to Children's Social Care Services. One method of judging this is the number of children and families who needed to be helped repeatedly. The "re-referral rate" for Children's Social Care Services in 2015-16 at 14.7% was a reduction on 16.7% in the previous year and lower than the national average re-referral rate of 24% in 2014-15.

Section 47 (S47) Enquiries and Initial Child Protection Conference (ICPC)

A S47 Enquiry is a child protection investigation. Where a child is believed to have suffered or be at risk of significant harm, a strategy discussion takes place. Professionals from the relevant agencies will meet to decide whether to initiate a section 47 enquiry. This refers to an enquiry under section 47 of the Children Act 1989 and initiates further investigation. The social worker leads an assessment gathering more information from the child, parents, family members and other professionals in order to determine whether the child is in need or at risk of continuing harm. If the section 47 enquiries substantiate concerns about a child, an ICPC will then be convened.

The ICPC is held to decide whether or not to make a child subject to a CP Plan. The conference should be attended by the child or the child's representative, child protection social workers, other relevant professionals who have been involved with the assessment process, and family members.

There has been a 21% increase in children subject of Section 47 Enquiries in 2015-16 (2351 compared to 1938 in the year before). Bradford's rate of 169.2 per 10,000 child population is higher than what the national rate was in 2014-15 (138.2).

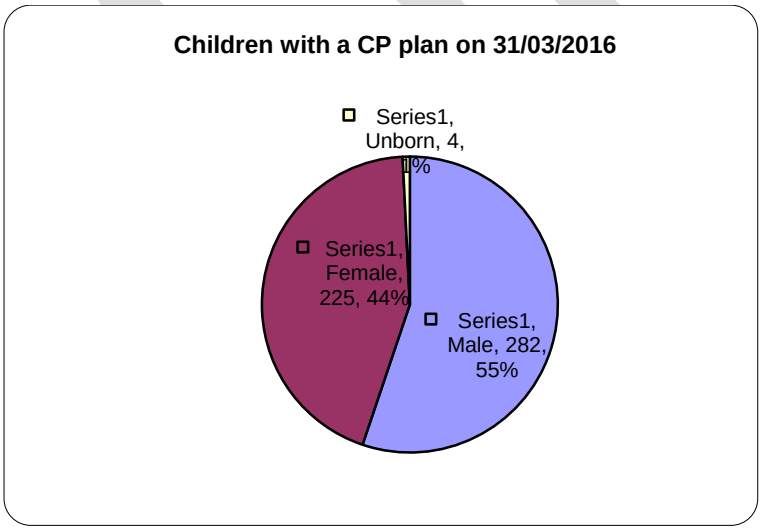
23% of children subject of S47 Enquiries in the year progressed to ICPCs - lower than 29.4% last year. ICPCs were held in respect of 540 children in the year (38.9 rate per 10,000); this is much lower than the 2014-15 national rate of 61.6.

Timeliness of ICPCs has much improved over the last 3 years; 93.4% were held with within 15 days of the S47 Enquiry compared to 15% in 2013-14. This is higher than the national average of 74.7%.

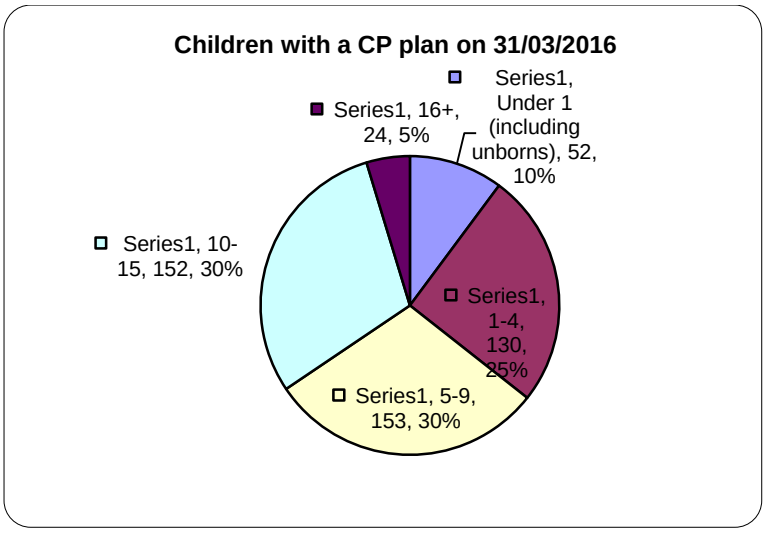
Child Protection Plan (CP Plan)

A CP Plan contains details of how Children's Social Care Services will check on the child's welfare, what changes are needed to reduce the risk to the child and what support will be offered to the family.

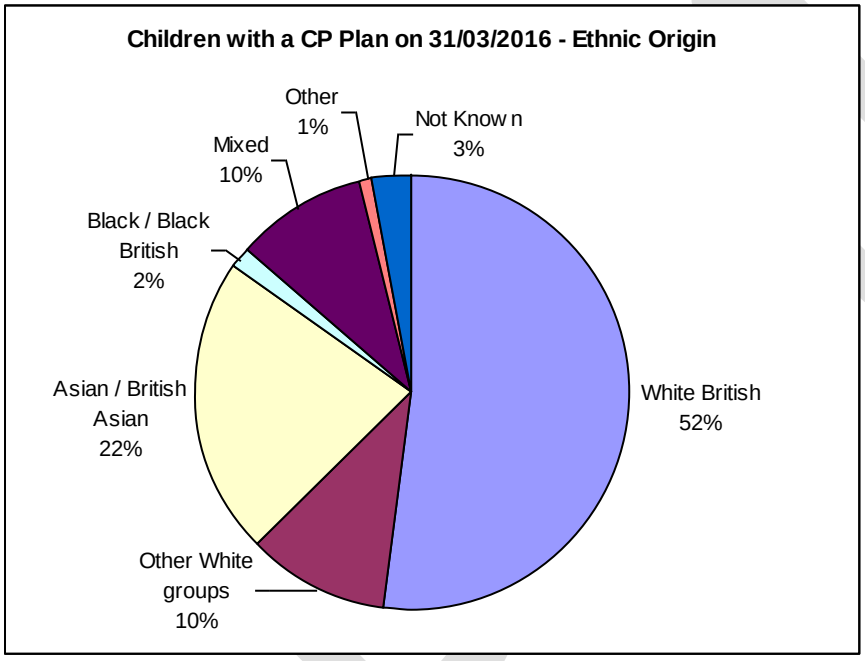
511 children and young people were subject to a CP Plan as at 31st March 2016, with more males than females. This compares to 513 as at 31st March 2015; the numbers of children on CP Plans remained stable this year after a fall in the previous year. Bradford's rate per 10,000 child population was 36.8; lower than the national rate for 2014-15 (42.9).



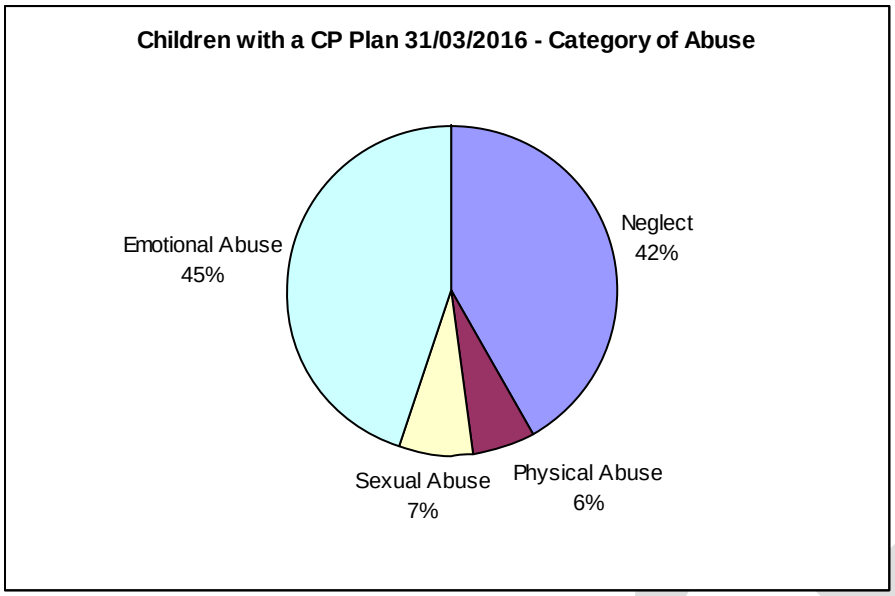
The ages of these children were roughly evenly split between the age groups 5 to 9 and 10 to 15, with slightly fewer 1 to 4s, a small number of babies under 1 and a very small number of young people aged 16 to 17.



Children from a black and minority ethnic (BME) background are under-represented in terms of being subject of a CP plan (35%), compared to 47% of BME children and young people in the District. However, this is still an increase compared to 32% from the previous year. There has been a slight rise in the proportion of children from Eastern European countries subject of CP plans at 31 March 2016 (11%) in comparison to 9.5% at 31 March 2015.



Emotional abuse (45%) is the main CP category for children being subject of a CP plan at 31st March 2016. This is followed by neglect (42%); sexual abuse (7%); and physical abuse (6%).



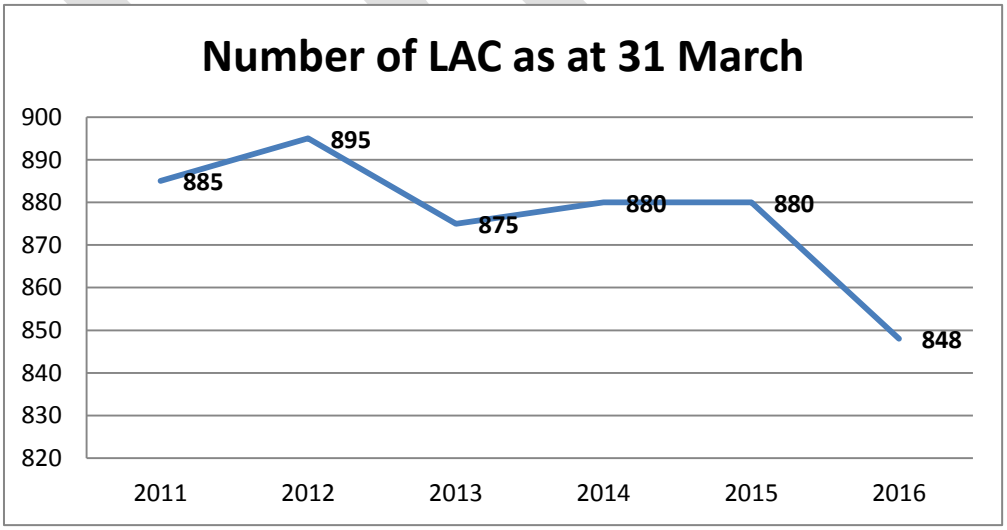
The number of children who *newly became* subject of a CP plan during the year was 524. Of these, 83 children (15.8%) became subject of a CP plan for a second time in their lifetime compared to 12.2% the year before. The national average in 2014-15 for this performance measure was 16.6%.

In the year, there were 522 children whose CP plans ended of which the proportion that lasted over 2 years was 4.2%. This is a reduction compared to 6.5% in the previous year at a time when the national average was 3.7%.

The percentage of children subject of CP plans who had all their review meetings held within required timescales was 95.63%, down from 98.3% last year.

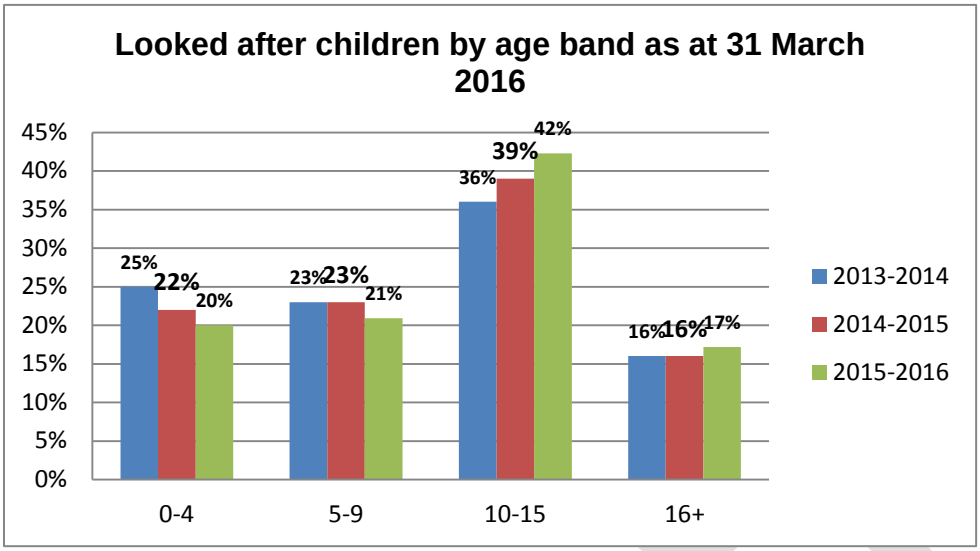
Looked After Children

848 children in Bradford were looked after at 31 March 2016, a 3.7% reduction on the previous year (880). The graph below shows the number of LAC at 31 March over the last 6 years.



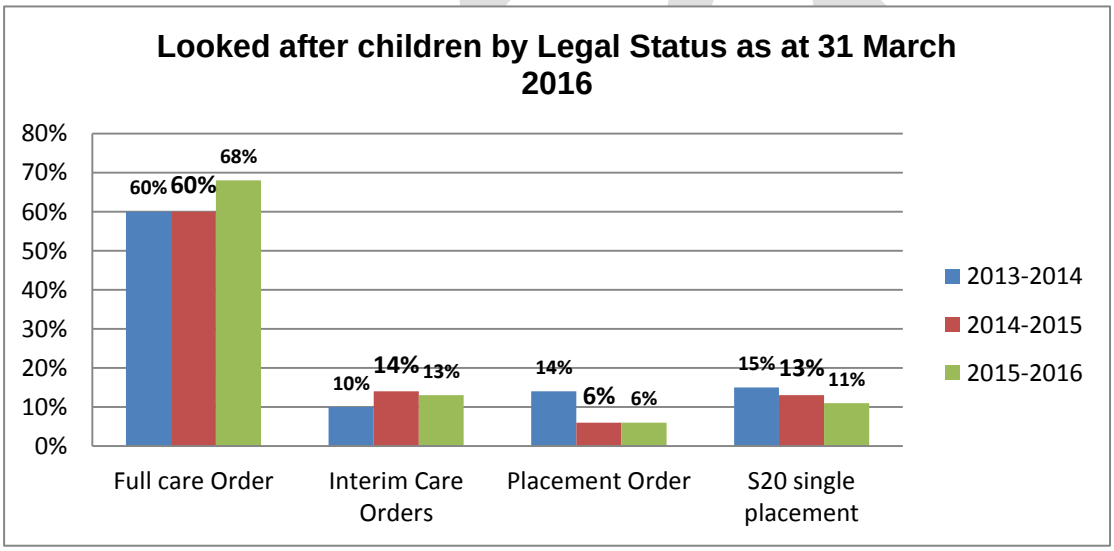
86% of children were looked after due to abuse and neglect reasons, a slight increase on last year's figure of 85%. The national figure at 31 March 2015 was 61%.

The proportion of young people looked after by age groups has remained very similar to last year. There has been a slight decrease in the percentage of 0-4 and 5-9 year olds and a slight rise in the percentage of 10-15 and 16+ year olds as shown by the graph below.



561 children looked after at 31 March 2016 were of White British origin compared to 582 last year. The number of BME children looked after has increased slightly, 271 compared to 266 last year.

In terms of legal status, 573 children were looked after under a Full Care Order (67.5%), this is an increase on last year of 528 (60%). 114 (13%) under an Interim Care Order, compared to last year of 124 (14%). 52 (6%) under a Placement Order same as last year of 6%. 93 (11%) on a Section 20 single placement compared to last year of 13%.



167 children were placed Out of District at 31 March 2016; a 10% decrease on last year's figure of 186. 61% are placed with foster carers or friends and family carers, whilst 22% are Residential Purchased. The majority of children placed out of district are in the 10-15 age group.

Author – Saheed Khan
Performance Officer - BSCB

Appendix 2

Safeguarding Audit Strategy
Bradford Teaching Hospitals NHS Foundation Trust

Updated July 2016

Topic	Start Date	Completion Date	Area and lead	Aims	Key Findings	Action Points	Status and re-audit date
The Health Response to Children following a sexual assault	March 2013	Jan 2014	Across All Health Organisations H Jepps	1. To audit medical examination against RCPCH standards 2.To study liaison across partner agencies in Health 3. To study if information recorded appropriately	1. Medical Examinations carried out in keeping with RCPCH standards 2. Only 2 cases had optimal sharing of information 3. Good records within acute Trust	1. Explore need for Colposcope for out of hours medicals 2. Ensure medical reports disseminated appropriately	Update presented to the Trust Safeguarding steering group July 2015. New Colposcope purchased and old one now for use on ward 2.
Quality of Medical Reports	Completed Feb 2013	re-audit planned for August 2016	Paediatrics J Sims and R Skelton	To audit the quality of medical reports produced against RCPCH guidelines	1.High quality of medical reports in general 2.Clarity of opinions could be improved in some cases	1. Results to be presented to paediatricians at consultants meeting. 2. Recommend avoiding jargon and increasing clarity 3. Further training to be provided	Yet to be commenced
Child Protection Medicals	Feb 2011	Completed but on-going	Paediatrics Jo Sims and Ruth Skelton	To determine number of medicals carried out, along with place for medical, referrer and reason for referral.	1. Significant number of medicals occurring out of hours. 2. Commonest reason for referral physical abuse. 3. Limited findings on sibling medicals.	1.Update guide and training for social care re when medicals should take place out of hours	On-going annual re-audit, data is presented in the annual Board report for safeguarding children 2016

Communication including report writing and training.

Topic	Start Date	CompletionDate	Area and lead	Aims	Key Findings	Action Points	Status and Re-audit date
Local knowledge of safeguarding policy	February 2016 to date.	On-going spot checks	Trust-wide for all nursing and medical staff.	To determine Knowledge of local procedures and policies amongst staff on paediatric wards.	Most staff aware child is up to age 18 and that SG is everyone's responsibility. Varied response to questions about different categories and risk factors, but better in areas where high SG. Need to increase access to newsletter and website.	Action plan created July 2016 – to be reviewed at SG Team meeting, actions already underway.	Complete July 2016. Re-audit July 2017
Safeguarding Practice in A&E	June 2013	On-going monthly audit	Sally Guest	1. To re-audit medical record keeping where caution codes are in place 2. Ensure that all safeguarding flags and actions are actioned.	1.Highlighted need for on-going training in A&E	1. Individual staff feedback 2. On-going assurance regarding the flags and alert process for safeguarding.	On-going cycle.
Safeguarding Practice in A&E	June 2013	On-going monthly audit	Sally Guest	1.To audit written safeguarding information, including the accompanying adult is and does the child have current children's social care involvement.	1.Highlighted need for on-going training in A&E	1.Individual staff feedback 2.On-going assurance regarding the flags and alert process for safeguarding	On-going cycle.
Safeguarding Practice in A&E	January 2016	On-going	A&E Sally Guest	Vetting of teenage attendance cards in A&E for quality assurance and missed opportunities. To provide direct feedback to staff and discuss during training sessions.	Feedback for missed caution codes	Still some missed – feedback directly to staff and also included in the ED Safeguarding Supervision sessions	Ongoing cycle – method of "safety netting" attendances, particularly for CSE

Patient Satisfaction.

Topic	Start Date	Completion Date	Area and lead	Aims	Key Findings	Action Points	Status and Re-audit date
Patient and professional Satisfaction following Child Protection Medicals	June 2016		Jo Sims	1.To explore the patient, family and professional experience of having a child protection medical at BTHFT.			Audit work just commenced June 2016 – audit protocol submitted and accepted, data collection underway.
Adolescent admission.	Jan 2014	Aug 2014	Vicky cotter SG children's team.	1.To determine if children between 14-18 years were offered the choice of adult or children's wards.	1.The majority of children over 15 were admitted to adult wards.	1.Ensure staff who are looking after children in adult areas are trained in safeguarding children. 2.Ensure all adult wards have all the SG children's information readily available. 3.Regular training compliance monitored for adult areas and levels to be fed back through both adult and children's steering groups.	Complete.

Documentation.

Topic	Start Date	Completion Date	Area and lead	Aims	Key Findings	Action Points	Status and Re-audit date
Safeguarding families documentation.	Aug 2015	October 2015	Vicky Cotter SG children's team.	1.To audit if antenatal safeguarding concerns were transferred into baby notes.	1.Results of the audit were fed back to the NNU and maternity staff at a formal lessons learnt event regarding a joint SI. 2.Further education required from the Named Midwife to reinforce the need to transfer the information across.	1.Re-audit April 2016	Complete with re-audit scheduled for April 2016.

Safeguarding children's documentation and development of Profile A	Sept 2014	Feb 2015	Vicky Cotter SG children's team.	1. To explore the types of documentation used to capture SG information within the paediatric areas.	1.Lack of clarity and diversity regarding places to document SG concerns within trust records.	1. A standardised approach to where information is recorded is required in relation to SG. 2.Revision of one the profile A to incorporate all the relevant SG information.	Complete To audit completion of new Profile A on paediatric wards January 2016 – done. Now moving to Electronic Patient record (EPR) and similar info built into this as in Profile A.
Lilac and Trinity (GUM) documentation (adolescent documentation)	Jan 2014	March 2014	Vicky Cotter SG children's team.	1.To monitor if safeguarding information was captured in patient records, specifically for adolescents. 2. To be able to monitor the number of notification sent to the team.	1.The use of a specific SG Performa used within the records, increased the consideration for SG and raised the number of notifications	1.Justification for on-going used of the specifically designed Performa moving forward.	March 2014

Risk factors for safeguarding.

Topic	Start Date	Completion Date	Area and lead	Aims	Key Findings	Action Points	Status and Re-audit date
Are patients being asked routinely about domestic abuse and sexual violence?	January 2015	November 2015	Joint safeguarding Children's/adults/ maternity. In maternity and A&E attendance.	1.To find out if patients were being asked about routine enquiry.	1.Despite this being a mandatory question for areas like maternity, evidence was found that this did not happen	1.Repeat audit to look at barriers to asking the question. 2.Re-audit to look at compliance	December 2015, audit complete. plans for further re-audit are currently under review by the new district wide VAWG manager.
Late Bookers for antenatal care	Sep 2012	Aug 2013	Midwifery Karen Bentley Named Nurse Safeguarding children.	1. To study associated links between late bookers in pregnancy and safeguarding concerns, especially alcohol abuse, domestic violence and mental health issues 2.To study	Presented to Trust Steering Group Noticed prevalence of 'toxic trio' amongst late bookers, highlighting need for caution	Michelle Khan manager for VAWAG for health to re-audit.	Presented to Trust Steering Group and Midwifery

				social care involvement in women who book late			
Medium CSE cases being flagged	July 2016		Karen Bentley	1 to review all attendance to A&E of children who have been risk assessed by the CSE HUB as being at medium risk of CSE to review safeguarding assessment and information and communication to identify if had they been flagged additional practice would have taken place.			July 2016 all data has been collated and currently id is waiting for analysis.
Lilac clinic DNA and safeguarding	March 2016	July 2016	Jemma Tesseyman	1.To follow the management of under 18s who DNA to Lilac clinic 2.To ensure a standardised approach is developed if not in place.	1 inconsistent management of children who DNA for TOP at Lilac clinic.		Audit report finalised mid July 2016, finding to now be feedback to women's services
High risk CSE flagging procedures.	Nov 2015	Monthly - ongoing	Safeguarding children team	1.On-going audit of flagging of all children who have been notified of being at high risk of child exploitation on a monthly basis. 2.Ensure that staff are recognising the flag and notifying the safeguarding children's team, to ensure all relevant safeguarding concerns have been communicated.	1.On-going assurance provision. 2.Identification of training needs.		

Multiagency audit

Topic	Start Date	Completion Date	Area and lead	Aims	Key Findings	Action Points	Status and re-audit date
Multi-agency challenge panel audit re Non Accidental Head Injury (Health Safeguarding Children Group/BSCB)	June 2016	June 2016	Karen Bentley	1.To review NAHI that have been presented to the SCR sub and not met the criteria, to review if any joint health lessons learnt can be established. 2.To review children who had received significant injuries whilst being subject to a child protection plan.	Multiagency action plans are currently being produced.	General themes were: Back to basics. Toxic trio. Bruising in a non-mobile child. Professional reassurance. Professional challenge. Judgements and professional curiosity.	LSCB joint action plans currently being developed July 2016
Multiagency health audit of hospital DNAs	March 2015	Final write up due sept 15	Helen Jepps	1.To look at which professionals were informed about non-attendance. 2.To determine if the appropriate health professionals received letters re a child's DNA. 3.To establish if safeguarding concerns became apparent for a period of time following the non-attendance at hospital. 4.To make recommendations to health partners regarding children who do not attend for their medical appointments.	Recommendations are currently being produced by Dr Jepps as of December 2015	1.Meeting planned for January 2016 to discuss DNA management with the elective access treatment group.	Currently waiting for people to be allocated to complete the work. However, new Standard operating Procedure created and ratified for within Trust, regarding paediatric DNAs.
Audit of practice in sexual assault medicals in the Yorkshire region.	February 2014	August 2014	Ruth Skelton	Study the number of medicals at different sites, who referred, whether FME present, findings and management.	1.Wide variation in quality of medicals 2.Half of medicals done out of hours 3.Other types of abuse picked up	Information forwarded as part of the regional SARC planning.	Complete August 2014.

New development audits

Topic	Start Date	Completion Date	Area and lead	Aims	Key Findings	Action Points	Status and re-audit date
Integrated Assessment Team: Quality of children's social care referrals.	July 2016		Karen Bentley	To capture the number and quality of referrals to children social care from BTHFT			KB meeting with senior social care manager July 2016 to review referrals and plan the audit work.

Appendix 3

BSCB Membership

	Independent Chair
	Vice Chair and Director of Collaboration, Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCG
	Strategic Director, Children's Services, City of Bradford MDC
	Interim Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust
	Deputy Director, Education, Employment and Skills, Children's Services, City of Bradford MDC
	NHS England
	Public Health Consultant, City of Bradford MDC
	Police Superintendent West Yorkshire Police
	Deputy Chief Executive / Director of Nursing, Bradford District Care NHS Foundation Trust
	Deputy Director of Nursing, Children's and Specialist Services, Bradford District Care NHS Foundation Trust
	Children's Service Manager Banardo's representing Young Lives Bradford,
	NSPCC Service Manager Leeds and Bradford

	Assistant Director, Performance, Commissioning & Partnerships, City of Bradford MDC
	Director of Nursing, Airedale NHS Foundation Trust
	Service Manager, Bradford & District Youth Offending Team
	Head of West Yorkshire National Probation Trust (Bradford & Calderdale)
	Head of Bradford and Calderdale Probation, The West Yorkshire Community Rehabilitation Co. Ltd
	Lay Member
	Lay Member
	CAFCASS
	Head Teacher, Crossley Hall Primary School
	Head Teacher, One in a Million Secondary School,
	Head Teacher, Horton Grange Primary School
	Head Teacher, Oastlers School
	Chair of Community Advisory Group Muslim Women's Council
	Head Teacher, Bradford Academy
	Yorkshire Ambulance Service

Appendix 4

ATTENDANCE OF REPRESENTATIVES AT BSCB MAIN BOARD DURING 2015-2016
1st April 2015-31st March 2016

AGENCY	Number of Meetings Invited to attend	Number of meetings attended	Apologies Provided	% of Attendance
BSCB Independent Chair: JJ / DN	6	6	N/A	100%
Adult Services:				
Advisory Board Manager: Paul Hill	6	6	N/A	100%
Advisory Designated Doc's CCGs – KW / RSk	6	6	N/A	100%
Advisory Designated Nurse: STh	6	5	1	83%
Advisory Legal – MM	6	4	2	67%
Airedale NHS Trust: RD	6	4	1	67%
BDC FT: CW	6	6	-	100%
BDMC (Public Health): SB	6	3	2	50%
BTH FT: SS / JR / KB	6	3	2	50%
CAFCASS	6	5	1	83%
CCGs – NO'N	6	5	1	83%
Children's LA DCS: MJ	6	4	2	83%
Children's LA CSC – GM	4	4		100%
Children's LA Education: LM /JK	6	5		100%
Community Rehabilitation Co: NH	6	6	1	100%
Lay Members x 2	6	6	2	100%
Lead Elected Member	6	1	3	
NHS England: EC	6	2	1	
NSPCC: SP	6	6	N/A	100%
Police: VF	6	6	1	83%
Probation	6	4	1	84%
Prospects: JC	6	6	N/A	100%
School Head: Primary – CS / MT	6	3	2	50%
School Head: Secondary – JS/ GD	6	6	N/A	100%
VCS: DB	6	6	N/A	100%
Youth Offending Team - CJ	6	6	N/A	100%

Notes
Adult Services – no representation
Gani Martins – attending the Main Board as of September 2015. Where the number of attendances and apologies does not add up to six, there was no attendance or apology for that particular agency on one or more occasions.

Appendix 5

Bradford Safeguarding Children Board

Child Death Overview Panel

Annual Report

April 2015 – March 2016

CONTENTS

1. Introduction and Key findings

In April 2008, the Bradford Safeguarding Children Board (BSCB) established the Child Death Overview Panel (CDOP) in response to the statutory requirement set out in Working Together to Safeguard Children[2,3,4,5]. The aim of the CDOP is to systematically review all child deaths from birth to 17 years 364 days of age in order to improve the understanding of how and why children in Bradford die, identify whether there were modifiable[6] factors which may have contributed to each individual death, and use the findings to take action to prevent future such deaths.

During the year April 2015 – March 2016 (2015/16), 61 child deaths were reported to the Bradford child death review team. Bradford CDOP reviewed 79 child deaths during 2015/16; these reviews included 45 deaths that occurred in 2014/15 and 3 deaths that occurred in previous years. This brings the total number of deaths reviewed by Bradford CDOP to 607 since April 2008, out of 647 deaths reported (94%).

The CDOP has a role in the judgement regarding whether there were modifiable factors in relation to the deaths reviewed and makes recommendations and learning points which are communicated to both national and local agencies as appropriate, ensuring an effective inter-agency response to child deaths. The CDOP also has a role in categorising a child's death into one of the 10 cause of death categories highlighted in Appendix 2.

A total of 8 deaths were considered to have modifiable factors in 2015/16, which was 10% of the total deaths reviewed. These modifiable deaths were in Category 2 (suicide or deliberate self-inflicted harm), Category 5 (acute medical or surgical condition), and Category 10 (sudden unexpected and unexplained death).

Four main recommendations arose from the 8 deaths reviewed in 2015/16 which were identified as having modifiable factors:

- Formalise and circulate guidance on gastroenteritis;
- Discuss actions with specialist drug and alcohol team to reduce the risk of death in vulnerable people in relation to substance misuse;
- Continue awareness of safe sleeping through multi-professional work and media work and feed into the maternity network – this included an updated e-learning package on safe sleeping and a repeat audit of all deaths due to Sudden Infant Death (SIDS)/Co-sleeping;
- Work across local organisations to understand the management of asthma in young people with additional complex health needs.

Key themes for the whole period 2008-2016 for potentially modifiable causes of are:

- Co-sleeping and SIDS
- Road traffic collisions[7]
- Specific clinical incidents over a range of causes
- There have been 4 Serious Case Reviews over this period and a Learning Lessons Review identifying specific areas of neglect

2 Department of Children, Schools and Families (2006). Working Together to Safeguard Children. Available from: http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/WT2006%20Working_together.pdf

3 Department of Children, Schools and Families (2010). Working Together to Safeguard Children. Available from: http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/00305-2010dom-en-v3.pdf

4 Department for Education (2013). Working Together to Safeguard Children. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417669/Archived-Working_together_to_safeguard_children.pdf

5 Department for Education (2015). Working Together to Safeguard Children. Available from: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

6 A child death is defined as modifiable if *"the Panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths"*. Note: Modifiable death definition changed from April 2010 onwards, whereby the classification was changed from preventable/potentially preventable to modifiable factors.

7 No such cases reviewed in 2015/16 (One child death abroad due to road traffic accident – insufficient information to review)

Less common themes occurring include:

- Drownings in bath and death in fires[8]
- Asthma
- Suicide in teenagers
- Swine Flu[9]

Further to the recommendations set out above, the panel records an 'issues log'. The log includes issues which did not cause the death of the child but were identified as a contributing factor. Identifying potential issues surrounding the child's death allows follow up action to be taken with organisations or lead clinicians, which in turn can potentially impact on the reduction of future child deaths. In 2015/16, the following issues were highlighted:

- Smoking in pregnancy
- Obesity in pregnancy
- Diabetes in pregnancy
- Mental health issues
- Domestic abuse
- Consanguinity
- The importance of offering genetic counselling, where appropriate, to parents and siblings of those affected by genetic conditions and ensuring appropriate referrals to specialist services
- The importance of rapid, high quality clinical assessment, transfer (if necessary) and management for acutely ill children and young people in a relevant setting including: primary care, secondary care, urgent care centres and ambulance services
- The importance of post mortems in ascertaining cause of death, which may influence management of future pregnancies
- Access to timely and appropriate bereavement support
- Access to chaplaincy services when required for parents/family
- The importance of flagging the need for early foetal anomaly scans for future pregnancies, where risk is present of congenital abnormality
- The continued access to high quality, end of life care offered by Martin House Hospice, if children are on Intensive Care Units
- Children who died abroad – in instances where a child died abroad there has been insufficient information to carry out a review
- Foetal Magnetic resonance imaging (MRI) for diaphragmatic hernia is good practice
- Early testing for Guthrie (MCADD)[10] where possible
- The importance of ensuring other diagnoses are kept in mind in categorisation of death, where the child has died due to a head injury

Specific common risk factors noted in the issue log were obesity in pregnancy, smoking in pregnancy and consanguinity; whilst it is not possible to state specifically that these risk factors caused an individual child's death, national evidence clearly demonstrates the factors all increase the risk of infant death at a population level.

Bradford CDOP will continue to monitor overall causes of death for children, with a focus on potentially modifiable causes, identifying specific recurrent issues and themes as well as conducting an annual CDOP 'Away Day', which allows panel members to assemble as a group and examine the key factors of child deaths in more detail.

8 Encouragingly it should be noted that there were no such cases reviewed in 2015/16.

9 The last case of Swine Flu was reviewed in November 2015

10 The neonatal heel prick or Guthrie test is a screening test done on newborns. The blood samples can be used for a variety of metabolic test to detect genetic conditions, including Medium-chain acyl-coenzyme A dehydrogenase deficiency (MCADD)

Analysis of the reviewed deaths for 0-17 year olds for the full period 2008-2016 reveals that 73% of all the deaths reviewed, were in Category 7 (chromosomal, genetic and congenital anomalies) and Category 8 (perinatal/neonatal). Infants (aged under 1 year old) accounted for 69% of all child deaths. South Asian children are over–represented in the deaths (63%) compared to the demographic profile of the Bradford District. There is a higher proportion of Category 7 deaths in the district, compared to national CDOP data[11,12,13,14,15,16] and this analysis is used to inform the focus of key work to reduce death rates in children in the future.

Overall child mortality rates in the Bradford district are higher than national and regional averages, and the Bradford district infant mortality rate remains higher than nationally and regionally. However, there are some encouraging signs of improvement; the three year infant mortality aggregate rate has reduced year on year for the last six years[17] especially in deprived populations and the child mortality rates are reducing too (see Figures 3 and 7, Appendix 5 for details).

Chair of the Bradford Safeguarding Children Board

Work is on-going in many groups and networks to reduce the risk factors which contribute to the high childhood mortality rate in the Bradford district; the Every Baby Matters (EBM) steering group for example leads the partnership working to reduce infant mortality rates[18].

There are also a number of specific strategies and actions plans such as the Road Safety Plan, and a range of interventions to reduce accident rates in children for the district.

In addition, CDOP has promoted awareness around specific issues, encouraging parents to adopt safe sleeping practices and avoiding co-sleeping with their babies when additional risk factors are present. In previous years, CDOP promoted awareness around not leaving young children unattended in baths. CDOP has also led work to update the e-learning package to promote safe sleeping in infants and will be re-launching this in the Autumn. Sessions around the work of CDOP will feature in the Safeguarding week in October 2016.

CDOP continues to work with partners to raise the profile of the Panel and the understanding as to why children die in Bradford district thus ensuring all partners work towards reducing the risk of death in children in the district for the future.

David Niven
Independent Chair of Bradford Safeguarding Children Board

11 Department for Education Statistical Release (2016). SFR23/2016 Tables. Available from:https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016

12 Department for Education Statistical Release (2015). SFR23/2015 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2015

13 Department for Education Statistical Release(2014). SFR21/2014 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014

14 Department for Education Statistical Release (2013). SFR26/2013 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2013

15 Department for Education Statistical Release (2012). OSR14/2012 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-completed-in-england-year-ending-31-march-2012

16 Public Health, City of Bradford Metropolitan District Council (December 2014). Why children die in Bradford District 2008-2014: differences between local and national CDOP profiles. Presentation at the first National Network of Child Death Overview Panels' Conference on Investigating Child Deaths, Warrington.

17 Source: Office for National Statistics (ONS)

18 Every Baby Matters details Available from: https://www.bradford.gov.uk/health/improve-your-childs-health/every-baby-matters/

2. Background

This report details the work of the Child Death Overview Panel (CDOP) during 2015/16. Having been established for eight years Bradford CDOP is able to identify emerging trends and themes in the data, and this enables the panel to make more meaningful recommendations. We now have 4 complete years of reviewed deaths (100%) from 2008/09 to 2011/12, and near complete reviewed deaths (95%) between 2012/13 and 2014/15 (see Figure 2: Child deaths reported to and reviewed by CDOP, Section 5).

CDOP looks for factors contributing to a child's death that could have been modifiable, and where shared learning could reduce the chances of a recurrence of the circumstances around that death. This in turn would lead to a reduction in child mortality rates in the future. In addition, CDOP identifies and collates key issues in relation to individual child deaths, including risk factors. Whilst it is not possible to state specifically that these risk factors caused an individual child's death, they are relevant to the child population as a whole.

3. CDOP Process

The remit of CDOP is fully documented in the Terms of Reference in Appendix 1 (CDOP).

3.1 Membership of Bradford CDOP

CDOP is composed of a standing core membership as follows:

- Specialist Children's Services
- Health – Primary care
- Education
- Police
- Coroner's Office
- Hospital Chaplain
- Public Health
- Sudden Infant Death in Childhood (SUDIC) paediatricians
- Health – Acute Trusts
- Health – Bradford Teaching Hospitals NHS Foundation Trust and Airedale Hospital NHS Foundation Trust
- Other members as co-opted to specific meetings

Also in attendance is the manager of the Bradford Safeguarding Children Board, as an advisor, and the CDOP Manager.

Figure 1: Membership of the Bradford CDOP

Name	Role	Organisation
Dr Shirley Brierley - Chair	Consultant in Public Health	City of Bradford Metropolitan District Council (CBMDC)
Louise Clarkson	SUDIC/CDOP Manager	Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
Paul Hill	Bradford Safeguarding Children Board Manager	Bradford Safeguarding Children Board
Dr Eduardo Moya	Consultant SUDIC Paediatrician	BTHFT
Dr Catriona McKeating	Consultant SUDIC Paediatrician	BTHFT

Dr Louise Clarke	Clinical Specialty Lead for Children and Young People Named Doctor for Safeguarding Children	NHS Bradford City Clinical Commissioning Group (CCG), NHS Bradford Districts CCG and NHS Airedale, Wharfedale and Craven CCG
Jude MacDonald	Deputy Designated Nurse for Safeguarding	NHS Bradford City CCG, NHS Bradford Districts CCG and NHS Airedale, Wharfedale and Craven CCG
Joanna Fraser	Serious Case Review Officer	West Yorkshire Police
Malcolm Dyson/ Sam Cariss	Coroner's Officer	Coroner's Office
Cath Dew	Service Manager	Specialist Children's Services, CBMDC
Linda Chavasse	Principal Educational Psychologist	Bradford Children's Services, CBMDC
Shaheen Kauser	Muslim Chaplain	BTHFT
Dr Chakra Vasudevan	Consultant Neonatologist	BTHFT
Dr Kate Ward	Consultant Paediatrician	Airedale NHS Foundation Trust
Karen Bentley	Named Nurse Safeguarding	BTHFT

The Bradford CDOP meets on a monthly basis. Additional members have been co-opted to the panel when relevant, for the cases scheduled to be reviewed. Since the establishment of CDOP in 2008, the panel has consistently strived to increase the number of cases reviewed each month, and additional meetings are held if required to ensure a backlog does not build up. This also allows for modifiable factors and issues to be identified sooner, and changes to practice can be implemented. This year a new database has been set up to allow accurate transfer of information between the CDOP Manager and Public Health to assist with analysis.

3.2 Notification of Death

Any professional who becomes aware of a child death is required to notify the Child Death Manager at the Child Death Review office either by completing a notification form or by telephoning the office. The Coroner's Office and the Registrar of Births Deaths and Marriages have a statutory responsibility to engage in the child death review process by notifying the Manager of all deaths reported to them. There can be confidence, therefore, that information on all deaths is captured by the Child Death Review Manager.

Each agency involved with children and families has a nominated individual who takes responsibility for coordinating the information required for the review of each death. The data collection forms (Agency Report Forms – Form B)

are distributed via the administrator and copies of the various forms can be found at the Department for Education on the Gov.uk website[19].

3.3 Serious Case Reviews

Local Safeguarding Children Boards (LSCB) commission serious case reviews (SCR) when a child has died or been seriously harmed through abuse or neglect. The purpose of the SCR is to ensure that lessons are learned which help to better protect children in the future.

The CDOP may refer a case to its LSCB Chair, if it considers the criteria for an SCR may be met, and an SCR has not yet been initiated. Any case that is considered under the remit of SCR will not be reviewed by CDOP until the SCR has taken place.

3.4 Sudden Unexpected Death in Childhood (SUDIC)

BSCB funds a full-time Child Death Manager post. The three local CCGs[20], also provide funding for a part-time SUDIC (Sudden Unexpected Death in Childhood) Paediatrician post, which became operational in November 2008. Bradford Teaching Hospitals NHS Foundation Trust hosts both the SUDIC and Child Death Manager posts. The SUDIC protocol for Bradford and Airedale has been updated. The rapid response process has been improved, with a multi-disciplinary team discussion surrounding sudden unexpected deaths in children being brought to Accident and Emergency units.

Samples are taken at the earliest opportunity to try to identify a cause of death. With the Coroner's approval, tests are undertaken to identify metabolic or microbiological cause of death. This is especially important as inherited metabolic diseases are a relatively common cause of death in the Bradford district and these conditions can be identified in early sampling.

4. Population Demographics

Bradford has a significantly higher proportion of children and young people than the UK average. According to the 2011 census, the population of the area served by Bradford Council was 522,452[21]. A large proportion of the Bradford population are from ethnic minority communities, which comprise nearly one quarter of the population total; around 23% of the population described themselves as Pakistani (20%) or Indian (3%)[22]. Just under two-thirds (64%) of the population describe themselves as White British.

The birth rate in Bradford District is continuing to grow and the proportion of the population that is children and young people is forecast to rise at a greater rate in Bradford than nationally. Bradford has a young population with one of the highest percentages of young people in England[23]. The 136,579[24] children in Bradford aged 17 and under represent 26% of the Bradford population, which compares with 21% in England as a whole[25] In the 2011 census[26], 37% of Bradford's children (under 18 years of age) were South Asian of Pakistani, Indian or Bangladeshi heritage, and 10% were described in other Black and Minority Ethnic group categories and 50%. Across England, these figures were 8% and 14% respectively, and 75% were White British.

19 Child death reviews: forms for reporting child deaths. Available at: https://www.gov.uk/government/publications/child-death-reviews-forms-for-reporting-child-deaths

20 Bradford City CCG, Bradford District CCG and Airedale, Wharfedale and Craven CCG

21 Data taken from the Office for National Statistics

22 Data taken from the Office for National Statistics

23 Data taken from the Office for National Statistics

24 Data taken from the Office for National Statistics

25 Data taken from the Office for National Statistics

26 Data taken from the Office for National Statistics

5. Process report, 2008/09-2015/16

The following data includes the deaths of children under 18 years of age[27], resident in Bradford District who died between April 2008 and March 2016.

Figure 2: Child deaths reported to and reviewed by CDOP, 2008/09-2015/16

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Reviewed deaths from that year	85	108	108	70	67	63	75	31
Reported deaths from that year	85	108	108	70	68	67	80	61
% of deaths reviewed	100%	100%	100%	100%	99%	94%	94%	51%

Source: Bradford CDOP notifications data and Public Health Analysis Team, City of Bradford Metropolitan District Council

A total of 607 deaths of the 647 notified deaths (94%) have been reviewed over the eight years between April 2008 and March 2016. This is an improvement on 2011/12 when only 81% of all reported deaths since April 2008 had been reviewed. This is also higher than the last publication of national estimated figures, which indicated 82% of notified deaths had been reviewed between 2009 and 2014[28]. Of the 79 deaths which were reviewed in 2015/16, 31 of the reviewed deaths occurred in 2015/16, 45 deaths occurred in 2014/15, and 3 deaths occurred in previous years. Delays due to inquests, and other investigations outside the control of CDOP, can effect the year in which a death is reviewed. There are 10 categories for cause of death (see Appendix 2).

6. Analysis of child deaths reviewed by CDOP, 2015/16

6.1 Demographics, 2015/16

Of the 79 cases reviewed between April 2015 and March 2016:

- 50 were of children less than a year old (63%)
- 29 of children over the age of one (37%)

- 43 were male (54%)
- 36 were female (46%)

- 50 were children of South Asian ethnicity (63%)
- 23 were children of White British ethnicity (29%)
- 6 were children of other ethnicities, including Eastern European and Mixed (8%)

6.2 Category of death classification, 2015/16

Of the 79 cases reviewed between April 2015 and March 2016 70% were in Category 7 or Category 8 as below:

27 Up to the 18th birthday and described as 0-17 years

28 Department for Education Statistical Release (2014). SFR21/2014 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014

- 40 deaths were categorised as chromosomal, genetic and congenital anomalies (Category 7) (51%)
- 15 deaths were categorised as perinatal/neonatal events (Category 8) (19%)
- 24 deaths fell into other categories (30%)

6.3 Modifiability classification, 2015/16 reviews

See Appendix 2 (CDOP) for the definition of modifiable factors and categories of death

Of the 79 cases reviewed between April 2015 and March 2016:

- 8 deaths were considered to have modifiable factors (10%)
- The deaths were categorised as suicide or deliberate self-inflicted harm (Category 2), acute medical or surgical condition (Category 5), and sudden unexpected or unexplained death (Category 10).

6.4 Issues highlighted, 2015/16

For individual children there may be issues identified which are not classed as modifiable factors in the child's death, but are of note and require follow up with organisations or lead clinicians. Any specific issues identified for individuals results in recommendations being produced, whereby CDOP ensures the appropriate action has been taken by the relevant agency e.g. if referral to genetic counselling was confirmed this would be followed up with the relevant clinician. The following issues are identified as risk factors:

- Smoking in pregnancy
- Obesity in pregnancy
- Diabetes in pregnancy
- Mental health issues
- Domestic abuse
- Consanguinity
- The importance of offering genetic counselling, where appropriate to parents and siblings of those affected by genetic conditions and ensuring appropriate referrals to specialist services.
- The importance of rapid, high quality clinical assessment, transfer (if necessary) and management for acutely ill children and young people in relevant setting including: primary care, secondary care, urgent care centres and ambulance services.
- The importance of post mortems in ascertaining cause of death, which may influence management of future pregnancies.
- Access to timely and appropriate bereavement support
- Access to chaplaincy services when required for parents/family
- The importance of flagging the need for early foetal anomaly scans for future pregnancies, where risk is present of congenital abnormality.
- The continued access to high quality end of life care offered by Martin House Hospice, if children are on Intensive Care Units
- Children who died abroad – in instances where a child died abroad there has been insufficient information to carry out a review
- Foetal Magnetic resonance imaging (MRI) for diaphragmatic hernia is good practice
- Early testing for Guthrie (MCADD) where possible
- The importance of ensuring other diagnoses are kept in mind in categorisation of death, where the child has died due to a head injury.

6.5 Recommendations, 2015/16

Recommendations identified in the 8 deaths with modifiable factors from 2015/ 2016 covered the following areas:

- Formalise and circulate guidance on gastroenteritis;
- Discuss actions with specialist drug and alcohol team to reduce the risk of death in vulnerable people in relation to substance misuse;

- Continue awareness of safe sleeping through multi-professional work and media work and feed into the maternity network – this included an updated e-learning package on safe sleeping and a repeat audit of all deaths due to Sudden Infant Death (SIDS)/Co-sleeping;
- Work across local organisations to understand the management of asthma in young people with additional complex health needs.

The summary Action Plan for Modifiable deaths is updated and audited regularly to ensure the actions recommended are completed in a timely manner by relevant organisations.

General recommendations arising from issues identified from the CDOP meetings in 2015/16 included:

1. To make the 'Away Day' held in May 2016 an annual event. At the 2015/16 event, the panel considered analysis, and trends for deaths reviewed in 2015/16 and the total period 2008–2016. The event also included sessions on genetic inheritance led by the Regional Genetic Service and a presentation on the recent Born in Bradford infant death research. This event will be repeated in 2017.
2. To continue to monitor key themes for modifiable child deaths to include drowning in baths, co-sleeping and Sudden Infant Death Syndrome (SIDS) road traffic accidents and clinical incidents over the next year and seek assurance organisations have addressed the key areas of concern and monitor any new similar cases arising.
3. To monitor other recurrent, issues, which may not be identified as modifiable factors for an individual child but are relevant at a population level. Examples include smoking and obesity in pregnancy which are linked to increase risk of infant death, and consanguinity which is linked to an increased risk of congenital abnormalities and in some cases infant death. CDOP will continue to seek assurance that organisations and partners are also addressing these key areas of concern.

7. Analysis of child deaths reviewed by CDOP, 2008/09 – 2015/16

This section provides an overview of all reviewed child deaths in the Bradford District from April 2008 until March 2016. The data has been collated from the deaths of children aged under 18 years of age who have been formally reported to and reviewed by the panel over the course of the eight years from April 2008 to March 2016. It must be noted that the analysis only includes deaths reviewed by the CDOP between April 2008 to March 2016; totalling 94% of all child deaths which occurred in this period.

Tables containing a full breakdown by different characteristics can be found in Appendix 4.

7.1 Demographics, 2008/09 – 2015/16

Age

Of the 607 cases reviewed between April 2008 and March 2016, 69% were infants (aged under 1 year old) and 31% were children (aged 1-17 years).

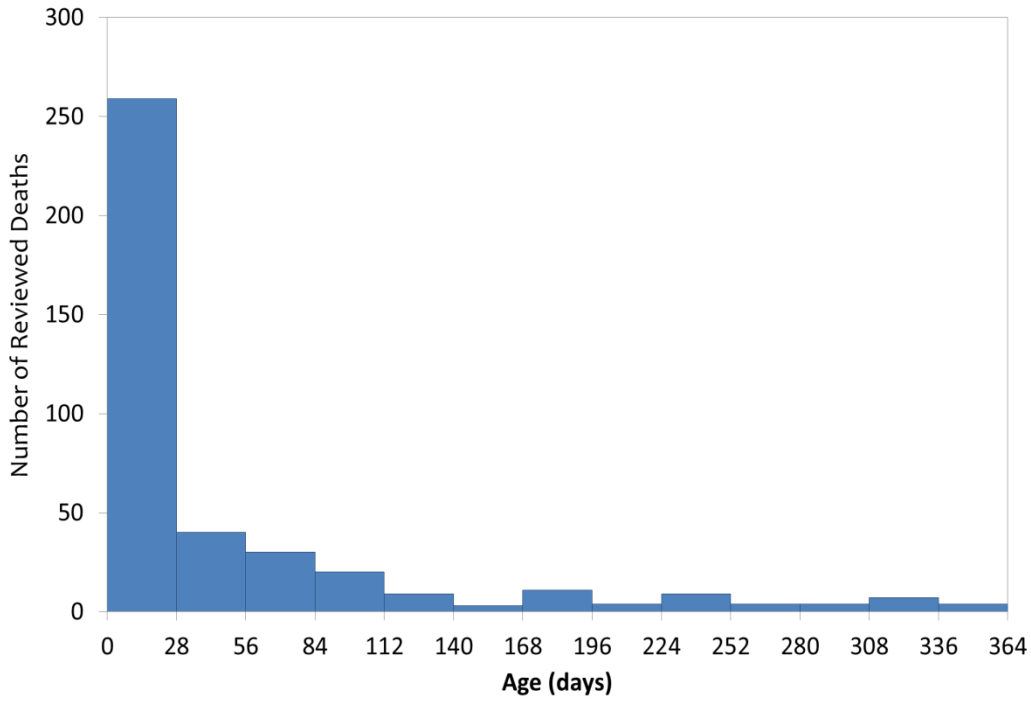


Figure 3: Age distribution for

reviewed infant deaths (<1 year old), 2008/09-2015/16

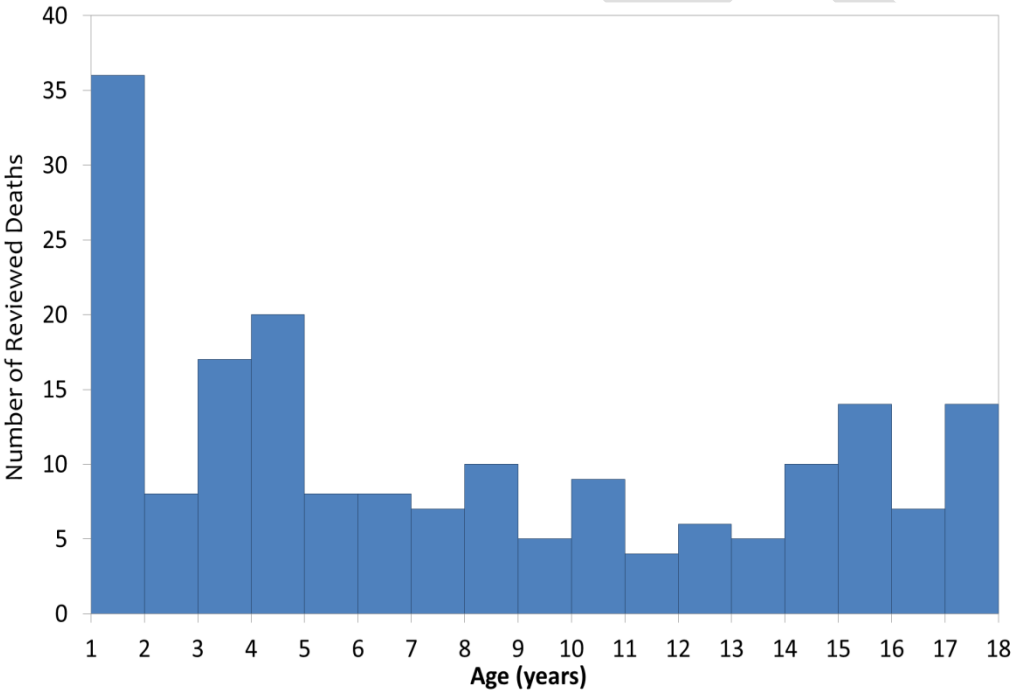
Source: Bradford CDOP review data

There were 419 cases aged under 1 year old reviewed between April 2008 and March 2016. Figure 3 shows that the majority of reviewed infant deaths (62%) were aged under 28 days old. A further 20% of the infant deaths were aged 28 days to 3 months old.

There were 188 cases aged 1-17 years reviewed between April 2008 and March 2016. Figure 4 shows there was more variation in the ages of the reviewed child deaths than there was in the infant deaths. 55% of the reviewed child deaths were aged 1-4 years old, 19% of the reviewed child deaths were aged 14-17 years old.

Figure 4: Age distribution for reviewed child deaths (1-17 years old), 2008/09-2015/16

Source: Bradford CDOP review data



Sex

Of the 607 cases reviewed between April 2008 and March 2016, 54% were male and 46% were female.

Ethnicity

Of the 607 cases reviewed between April 2008 and March 2016:

- 380 deaths were South Asian (63%)
- 184 deaths were White British or White Other (30%)
- 17 deaths were Eastern European (3%)
- 16 deaths were mixed ethnicities (3%)
- 10 deaths were other ethnicities (2%) including African, East Asian and Other

NB: Percentages may contain rounding errors

South Asian children are over–represented in the reviewed deaths compared to the comparable population in Bradford for all children under 18 years of age.

7.2 Category of death classification, 2008/09 – 2015/16

There have been 607 cases reviewed between April 2008 and March 2016 where it was possible to classify the cause of death into one of the ten categories used nationally (Appendix 2). The most common causes of death out of all the reviewed cases (children aged under 18 years old) were chromosomal, genetic and congenital anomalies (Category 7) and perinatal/neonatal events (Category 8); these two categories of cause of death accounted for 73% of all reviewed deaths 2008-2016.

Figure 5: Category of death classification for reviewed deaths by age group, 2008/09-2015/16

Source: Bradford CDOP review data

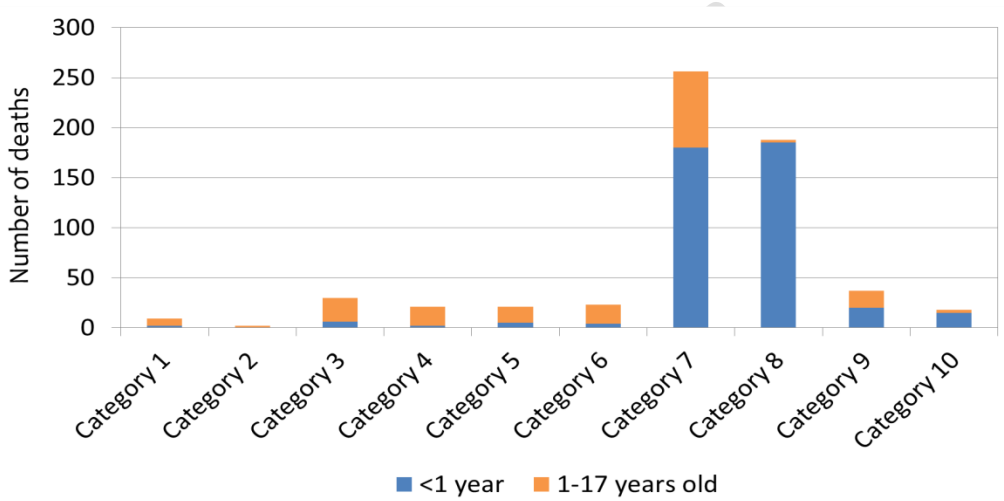


Figure 5 shows that the most common causes of death for infants (under 1 year old) were Category 7 (chromosomal, genetic and congenital anomalies) and Category 8 (perinatal/neonatal event) which accounted for 42% and 31% of the reviewed infant deaths respectively. Out of all the child deaths attributed to Category 8 (perinatal/neonatal event), 98% of the reviewed deaths were infants (under 1 year old).

For children (aged 1-17 years old), the most common cause of death (41% of reviewed deaths) was Category 7 (chromosomal, genetic and congenital anomalies). After this, the causes of death for children were split over more categories than for infants and included Category 3 (trauma and other factors), Category 4 (malignancy), Category 5 (acute medical or surgical condition), Category 6 (chronic medical condition) and Category 9 (infection).

When comparing reviewed deaths for 0-17 year olds in the district to National CDOP data[29,30,31,32,33,34], pooling data between 2010 to 2016 reveals that nationally 24%, of all the deaths reviewed, were in Category 7 (chromosomal,

29 Department for Education Statistical Release (2016). SFR23/2016 Tables. Available from:https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016

30 Department for Education Statistical Release (2015). SFR23/2015 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2015

31 Department for Education Statistical Release(2014). SFR21/2014 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014

32 Department for Education Statistical Release (2013). SFR26/2013 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2013

33 Department for Education Statistical Release (2012). OSR14/2012 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-completed-in-england-year-ending-31-march-2012

34 Public Health, City of Bradford Metropolitan District Council (December 2014,). Why children die in Bradford District 2008-2014: differences between local and national CDOP profiles. Presentation at the first National Network of Child Death Overview Panels' Conference on Investigating Child Deaths, Warrington.

genetic and congenital anomalies). The proportion of deaths attributable to Category 7 deaths in the District is significantly higher (43%) than the national figure (Figure 7, Appendix 4).

7.3 Expected/unexpected deaths, 2008/09 – 2015/16

Of the 607 cases reviewed between April 2008 and March 2016:

- 448 deaths were expected (74%)
- 154 deaths were unexpected (25%)
- 5 deaths were unknown (1%)

Figure 10 shows the most common cause of unexpected deaths for infant (under 1 year old) were Category 7 (chromosomal, genetic and congenital anomalies), Category 8 (perinatal/neonatal event), and Category 10 (sudden unexpected deaths), which accounted for 27%, 24%, and 20% of the reviewed infant deaths, respectively.

For children (aged 1-17 years old), the most common cause of unexpected deaths were Category 3 (trauma and other factors), Category 9 (infection), and Category 7 (chromosomal, genetic and congenital anomalies), which accounted for 23%, 19% and 17% of reviewed child deaths, respectively.

7.4 Preventability/modifiability classification, 2008/09 – 2015/16

Of the 607 cases reviewed between April 2008 and March 2016:

- 62 cases were deemed to have been preventable, or to have had modifiable factors (10%)
- 541 cases were deemed to have been not preventable or to have had modifiable factors (89%)
- 4 cases were deemed to have insufficient information to make classification (1%); this is where the child has died abroad

The classification was changed from preventable/potentially preventable to modifiable factors in April 2010 (see Appendix 2).

For the 62 cases deemed to have been preventable or to have had modifiable factors, the causes of death related to:

- deliberately inflicted injury, abuse or neglect (Category 1)
- suicide or deliberate self-inflicted harm (Category 2)
- trauma and other external factors (Category 3)
- malignancy (Category 4)
- acute medical or surgical condition (Category 5)
- chromosomal, genetic and congenital anomalies (Category 7)
- perinatal/neonatal event (Category 8)
- infection (Category 9)
- sudden unexpected or unexplained death (Category 10)

Analysis of themes and trends over time for 2008-2016 for modifiable deaths showed the following recurrent causes:

- Co-sleeping and SIDS
- Road traffic collisions[35]
- Specific clinical incidents over a range of causes
- 4 Serious Case Reviews over this period

Less common themes include:

35 No such cases reviewed in 2015/16 (One child death abroad in 2015/16, due to road traffic accident – insufficient information to review)

- Drownings in bath and death in Fires[36]
- Asthma
- Suicide in teenagers
- Swine Flu[37]

All the above have specific recommendations made and these have been monitored and audited by CDOP to seek assurance all actions have been completed.

7.5 Recommendations summary, 2008/09-2015/16

Examples of key recommended actions from the panel over the 7 year period for modifiable deaths have included the following:

- Implementation of specific Recommendations from Serious Case Reviews and Serious Clinical Incidents
- Increased clinical awareness of management of specific medical conditions
- CDOP Alerts to raise public awareness of the risks of leaving children bathing alone/supervised by another young child
- Road Safety Actions to reduce further deaths from road traffic collisions
- Swine flu vaccination programme in Special schools
- CDOP Alerts re Safe sleeping practice and update on current E learning package for Safe sleeping for babies

7.6 Risk factors

Data is collected by the CDOP on a range of risk factors that potentially influence child deaths. These include, for example, smoking, alcohol intake, obesity and domestic violence. Some of these risk factors have a clear link with poor outcomes; for example, smoking in pregnancy is known to be associated with increased low birth weight rates[38].

Further classifications have been agreed by the CDOP to describe precisely the more common causes of death in Bradford. To help investigate perinatal/neonatal events (Category 8), extreme prematurity is recorded.

For chromosomal, genetic or congenital anomalies (Category 7), since September 2011, there has been sub classification of the genetic conditions to indicate whether the deaths were due to an autosomal recessive condition, autosomal dominant condition, a sporadic genetic cause or if this information was not known. Sporadic causes are not predictable and can occur across all communities. In communities where consanguinity (marriage between cousins) is more common – such as in the Pakistani community in Bradford district - it is more likely that genes that are rare within the general population are carried by both parents. Therefore, a child born from a consanguineous relationship is at greater risk of inheriting genes which could cause congenital anomalies or chronic diseases; in some cases the conditions are fatal in childhood.

A paper published in the Lancet 2013, based on the Born in Bradford cohort, confirmed an increased risk of congenital anomalies within the South Asian population in consanguineous marriages from 3% to 6% and also increased risk of congenital anomalies for older White women[39].

36 Encouragingly it should be noted that there were no such cases reviewed in 2015/16.

37 The last case of Swine Flu was reviewed in November 2015

38 National institute for Health and Care Excellence (NICE) (2010). Quitting smoking in pregnancy and following childbirth. Available from: http://www.nice.org.uk/guidance/ph26

39 Sheridan, E. et al (2013). Risk factors for congenital anomalies in a multiethnic cohort: an analysis of the Born in Bradford study. The Lancet. Available from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61132-0/abstract

In summary, specific common risk factors noted in the issue log were obesity in pregnancy, smoking in pregnancy and consanguinity; whilst it is not possible to state specifically that these risk factors caused an individual child's death in many cases, national evidence clearly demonstrates they all increase the risk of infant death at a population level.

The CDOP panel will continue to monitor the data and information for both deaths of infants and children up to the age of 18 years and as more data becomes available over time these will inform future recommendations. The information collated at each CDOP meeting also informs the CDOP issues log. These issues lead to more general recommendations by CDOP and emerging themes worthy of being highlighted are identified and monitored. Findings from CDOP are also shared with key groups and leads such as the Every Baby Matters steering group, Road Safety Team and Maternity Network and are also shared as part of Safeguarding Week.

8. Comparison of Infant and Child Mortality Rates

There was a higher proportion of deaths due to chromosomal, genetic or congenital anomalies (Category 7) deaths in Bradford compared to national CDOP data – this difference in the profile of category of death could in part explain some of the differences between local and national infant and child mortality rates. The proportion of perinatal/neonatal events (category 8) for 2010/11-2012/13 was similar to the national CDOP data[40,41,42,43,44,45] but, overall, neonatal mortality rates are higher than regional and national averages (Figure 1, Appendix 5). This analysis indicates CDOP's focus to reduce child deaths should cover all cause of death for children but a significant focus should be on preventing deaths in Category 7 and 8.

8.1 Infant Mortality Rates (under 1 year)

Infant mortality is defined as the number of deaths in the first year of life per 1,000 live births. The latest infant mortality rate for Bradford District (5.8 per 1,000 live births) remains above the England average (4.0 per 1,000 live births) for the period 2012-2014. The rate has decreased each year for the last six years. Although the Bradford infant mortality rate remains high compared to regional and national rates, the gap is reducing. See Figures 1 and 2, Appendix 5 for more information.

The infant mortality rate in the most deprived quintile in Bradford has reduced much faster over time than the Bradford, Yorkshire and The Humber and England rates (Figure 3, Appendix 5).

8.2 Characteristics of infant deaths reviewed by CDOP, 2008/09-2015/16

The number of infant deaths being reported each year to the CDOP has decreased from a peak of 77 deaths in 2009/10 to 39 deaths in 2015/16 (Figure 4, Appendix 5).

Using previous years' CDOP data - for which almost all infant deaths have been reviewed (99%) - a comparison can be made between 2009/10-2011/12 and 2012/13-2014/15 to look at differences over time.

There were 54 fewer infant deaths in the three year period 2012/13-2014/15 compared to 2009/10-2011/12. There were fewer reviewed deaths between the two time periods attributed to all of the ten categories of death, more

40 Department for Education Statistical Release (2016). SFR23/2016 Tables. Available from:https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2016

41 Department for Education Statistical Release (2015). SFR23/2015 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2015

42 Department for Education Statistical Release(2014). SFR21/2014 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-march-2014

43 Department for Education Statistical Release (2013). SFR26/2013 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-year-ending-31-march-2013

44 Department for Education Statistical Release (2012). OSR14/2012 Tables. Available from: https://www.gov.uk/government/statistics/child-death-reviews-completed-in-england-year-ending-31-march-2012

45 Public Health, City of Bradford Metropolitan District Council (December 2014,). Why children die in Bradford District 2008-2014: differences between local and national CDOP profiles. Presentation at the first National Network of Child Death Overview Panels' Conference on Investigating Child Deaths, Warrington.

noticeably reducing in Category 7 (chromosomal, genetic or congenital anomalies), Category 8 (perinatal/neonatal events) and category 9 (infection) (Figure 5, Appendix 5).

The proportion of deaths within each of these categories has changed between the two time periods, there was a greater proportion of deaths due to chromosomal, genetic or congenital anomalies (Category 7) and a smaller proportion of deaths due to both perinatal/neonatal events (Category 8) and infection (Category 9) (Figure 6, Appendix 5).

8.3 Child Mortality Rates (1-17 years)

Child mortality is defined as the number of deaths for children aged 1-17 years old per 100,000 population. The child mortality rate for Bradford has been consistently higher than the national rate; in 2012-14, the child mortality rate for Bradford District was 17.3 per 100,000 compared to 12.0 per 100,000 for England. The gap between the local and national rates is narrowing over time (Figures 1 and 7, Appendix 5).

8.4 Characteristics of child deaths reviewed by CDOP, 2008/09-2015/16

The number of child deaths (aged 1-17 years old) notified to the CDOP has fluctuated over time and there has been year on year variation with no discernible trend. There have been much smaller numbers compared to the number of infant deaths which makes it difficult to draw comparisons to the child mortality rate.

Using previous years' CDOP data - for which almost all child deaths have been reviewed (95%) - a comparison can be made between 2009/10-2011/12 and 2012/13-2014/15 to look at differences over time.

There were 27 fewer child deaths in 2012/13-2014/15 compared to 2009/10-2011/12.

The number of deaths in each of the ten categories varied between the two time points, and there was variation as to whether there was a greater or lesser number of deaths in each category (Figure 8, Appendix 5).

The proportion of deaths within each of the categories has also changed between the two time periods, and shows variation as to whether there was a greater or lesser proportion of deaths in each category. Notably however, there was a greater proportion of deaths due to chromosomal, genetic or congenital anomalies (Category 7) and a smaller proportion of deaths due to chronic medical condition (Category 6) between the two time periods (Figure 9, Appendix 5).

9. Actions to reduce infant and child mortality

There are a range of strategies across the district to reduce infant and child deaths.

The very high rate of infant mortality in 2000-2002 initiated an independent Infant Mortality Commission in Bradford District in 2004-2006. The Commission investigated why some babies born in the District die during their first year of life and a key report was produced which demonstrated that infant mortality is linked with poverty and deprivation as well as other risk factors such as smoking, alcohol and substance misuse, young motherhood and consanguinity[40]. Young motherhood, smoking, alcohol and substance misuse are significantly higher risk factors within the White population of the District and consanguinity, which is linked to an increased risk of congenital anomalies, is common in the South Asian community – around 60% of marriages within the Pakistani population in Bradford District are consanguineous[46,47,48].

46 Sheridan, E. et al (2013). Risk factors for congenital anomalies in a multiethnic cohort: an analysis of the Born in Bradford study. The Lancet. Available from:

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61132-0/abstract

The work of the Commission and further in depth analysis of data on infant deaths continues as part of the Every Baby Matters Steering Group agenda; the current Strategy and Action Plan focuses on the 10 recommendations within the original report to continue to reduce infant mortality rates[41,49]:

- Recommendation 1a – To reduce poverty in families in Bradford
- Recommendation 1b – To reduce unemployment in families in Bradford
- Recommendation 2 – To improve the availability of good quality and affordable housing for families
- Recommendation 3a – To improve the health and nutrition of women, before and during pregnancy, and their babies
- Recommendation 3b – To increase breastfeeding rates
- Recommendation 4 – To ensure equal access to all aspects of pre-conception, maternal and infant health care
- Recommendation 5 – To improve social and emotional support for vulnerable parents
- Recommendation 6a – To reduce smoking rates in the district with a focus on women during pregnancy
- Recommendation 6b – To reduce high levels of alcohol and/or non-prescribed drugs in pregnancy
- Recommendation 7 – To increase community understanding of genetically inherited congenital anomalies
- Recommendation 8 – To ensure these recommendations are shared widely
- Recommendation 9 – To develop further data collection and monitoring procedures
- Recommendation 10 – To conduct future research to understand causes of death

To reduce the risks of child death, some of the strategies and action plans in place across the District include the following:

- Accident Prevention work across the district
- Road Safety Plan
- Bradford Children Safeguarding Board – Serious Case Reviews and Learning Lessons Reviews
- Implementation of Recommendations from Serious Clinical Incidents
- Alerts re risks of drowning in baths
- Increased awareness amongst clinicians regarding management of specific clinical conditions

10. Conclusion

10.1 Specific Recommendations

The focus of this report is on the recommendations for 2015/16. These were identified in the 8 deaths with modifiable factors reviewed in 2015/ 2016 which covered the following areas:

- Specific actions with Out of Hours provider regarding use of gastro-enteritis pathway and also highlighted with all clinicians across the district
- Risk of suicide with drugs highlighted with Substance Misuse and Alcohol team working with young people and fed into district wide work on Suicide Prevention

47 Bradford District Infant Mortality Commission (2006). Summary report. Available from: https://www.bradford.gov.uk/media/1881/infant_mortality_report.pdf

48 Born in Bradford (BiB) (2012). The Born in Bradford (BiB) cohort study: Summary statistics by ethnic group. Available from:

http://www.borninbradford.nhs.uk/uploads/downloads/research_and_scientific/cohort_information/Baseline%20Summary%20Factsheet%20BiB.pdf

49 Every Baby Matters Strategy and Action Plan Bradford District. Available from: https://www.bradford.gov.uk/health/improve-your-childs-health/every-baby-matters/

- Alerts with regard to safe sleeping for babies based on latest evidence sent by CDOP to key organisations and staff in the district , update on E learning package on safe sleeping is underway and a repeat audit of all deaths due to SIDS/Co-sleeping is due for completion in Sept 2016
- Recommendations made with regard to management of asthma in young people with additional complex health needs and shared with key organisations

The summary Action Plan for Modifiable deaths is updated and regularly audited to ensure the actions recommended are completed in a timely manner by relevant organisations. In addition, CDOP provides a valuable opportunity to review all causes of death in detail and hence every year the updated analysis for 2008-2016 is also reviewed. This information is fed into key networks, groups and safeguarding week to inform plans to reduce the risk of child deaths in the future.

General Recommendations for 2016/17

- CDOP's 'Away Day' in May 2017 will consider all key analysis, trends for deaths for 2016/17 and the total period 2008-2017
- CDOP will review its criteria for modifiability of deaths in discussion with partners in the national CDOP network as the percentage of modifiable deaths in Bradford and District is well below the national average.
- CDOP will continue to monitor key themes for modifiable child deaths to include co-sleeping and Sudden Infant Death Syndrome (SIDS), road traffic accidents and clinical incidents over the next year, and will seek assurance organisations have addressed the key areas of concern and monitor any new similar cases arising.
- CDOP will continue to identify and monitor recurrent issues, which may not be considered 'modifiable' factors for an individual child, but are relevant at a population level. Examples include smoking and obesity in pregnancy which are linked to an increased risk of infant death, and consanguinity, which is linked to an increased risk of congenital abnormalities and in some cases death in childhood. CDOP will continue to seek assurance from organisations and partners that they are addressing these key areas of concern.

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September 2016

Appendix 1 (CDOP): Terms of Reference

1 Purpose

The purpose of the Child Death Overview Panel is to:

a) Collect and analyse information about each child's death with a view to identifying:

i) any case giving rise to the need for a serious case review

ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and

iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area

b) Put in place procedures for ensuring that there is a coordinated response by professionals to an unexpected death.

The Panel will review deaths of all children aged 0-17 (excluding stillbirths) normally resident in the Local Authority area of the BSCB. Where the Panel is made aware of the death of a child in their area who would normally be resident in another Local Authority area, or vice versa the Child Death Review Administrator will liaise with his/her opposite number in the other Local Authority area to ensure both Panels are notified of the death and to determine which Panel is best placed to carry out a review of that child's death. Where possible it is advised that the panel in the child's area of residence takes responsibility for the review although it is recognised that circumstances will dictate the most appropriate outcome.

2 Functions

The Child Death Overview Panel:

- Meet regularly to complete a multi-agency evaluation of all child deaths in their area;
- Where appropriate undertake a detailed and in-depth evaluation into specific cases, including all unexpected deaths, assessing all relevant social, environmental, health and cultural aspects, or systemic or structural factors of the death, along with the appropriateness of the professionals' responses to the death and involvement before the death, in order to complete a thorough consideration of whether and how such deaths might be prevented in future;
- Collect and collate information using the agreed templates and where relevant seek further information from professionals and family members;
- Identify local lessons and issues of concern, requiring effective inter-agency working;
- Identify and report any local Public Health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both the provision of services and for training;
- Identify and advocate for needed changes in legislation, policy and practices, or public awareness, to promote child health and safety and to prevent child deaths;
- Ensure concerns of a criminal or child protection nature are shared with the police, children's social care and the coroner;
- Ensure any case identified as meeting criteria for a Serious Case Review are referred to the chair of the BSCB;
- Provide information to professionals involved with families so that this can be passed on in a sensitive and timely manner;
- Implement, review and monitor the local procedures for rapid response arrangements in line with Working Together;
- Monitor the quality of information, support and assessment services to families of children who have died;
- Co-operate with any regional and national initiatives in order to identify lessons on the prevention of child deaths.

3 Accountability

- The Child Death Overview Panel will be responsible, through its chair, to the chair of the BSCB. The Panel will provide to the BSCB and all constituent agencies, an annual report (in which all information should be aggregated and anonymised) which shall be a public document. In addition, the Panel will report to the BSCB any matters of concern arising from the course of its work as set out above.

- The BSCB will take responsibility for disseminating the lessons to be learned to all relevant organisations; ensuring that relevant findings inform the Children and Young People's Plan; and acting on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

- The BSCB will supply data regularly on every child death, as required by the Department for Education, to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

Appendix 2 (CDOP): Definition of Preventable and Modifiable Deaths and 10 Categories for Cause of Death

Definitions Used as cited in Statistical Release for Child Death Reviews: year ending March 2011 Dept for Education July 2011:

1. Preventable/Potentially preventable death: Definition used from April 2008 to March 2010

Preventable - A preventable child death is defined as events, actions or omissions contributing to the death of a child or a sub-standard care of a child who died, and which, by means of national or locally achievable interventions, can be modified.

Potentially preventable - A potentially preventable death with same definition as above.

2. Modifiable death: Definition changed from April 2010 onwards

A modifiable death is defined as "The Panel have identified one or more factors, in any domain, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths".

10 Categories for Cause of Death

Category 1 – Deliberately inflicted injury, abuse or neglect: this includes suffocation, shaking injury, knifing, shooting, poisoning and other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes sever neglect leading to death

Category 2 – Suicide or deliberate self-inflicted harm: this includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger people.

Category 3 – Trauma and other external factors: this includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis and other extrinsic factors. Excludes deliberately inflicted injury, abuse or neglect (Category 1).

Category 4 – Malignancy; solid tumours, leukaemias and lymphomas and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.

Category 5 – Acute medical or surgical condition; for example Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.

Category 6 – Chronic medical condition; for example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. Includes cerebral palsy with clear post-perinatal cause.

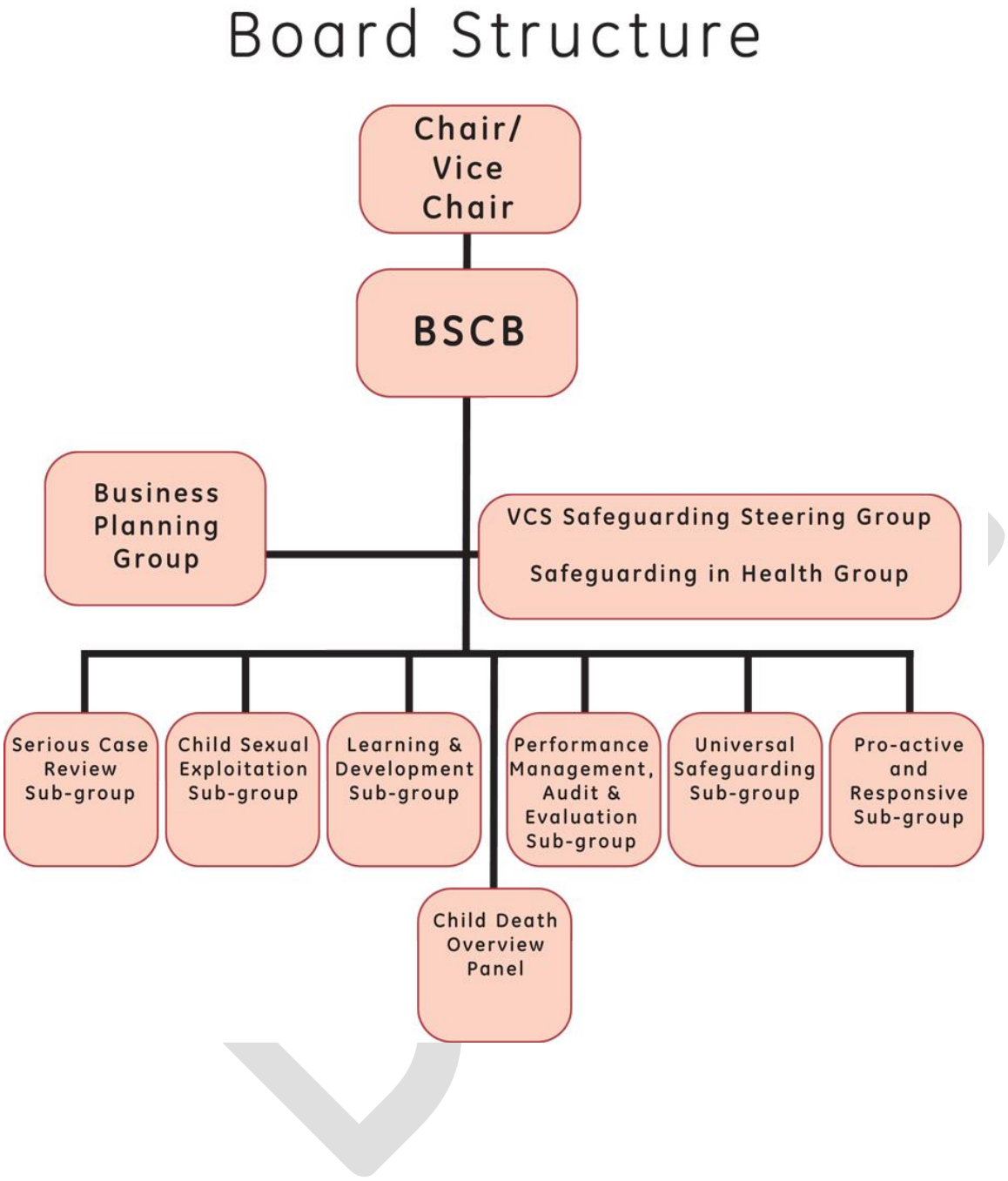
Category 7 – Chromosomal, genetic and congenital anomalies; Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis and other congenital anomalies including cardiac.

Category 8 – Perinatal/neonatal event; Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It includes cerebral pals without evidence of cause, and includes congenital or early-onset bacterial infection (onset in the first postnatal week).

Category 9 – Infection; Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.

Category 10 – Sudden unexpected death; where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. Excludes Sudden unexpected death with epilepsy (Category 5)

Appendix 3 (CDOP)



Appendix 4 (CDOP): Characteristics of deaths reviewed by CDOP

Characteristics of the child deaths reviewed between April 2008 and March 2016.

NB: Percentages may contain rounding errors

Age

Figure 1: Age distribution of all reviewed deaths, 2008/09-2015/16

	Number	Percentage
Under 1 year	419	69%
1-17 years old	188	31%
TOTAL	**607**	**100%**

Source: Bradford CDOP review data

Figure 2: Age distribution of all reviewed infant deaths, 2008/09-2015/16

	Number	Percentage
Under 28 days	260	62%
28 days to 2 months	82	20%
3 months to 1 year	77	18%
TOTAL	**419**	**100%**

Source: Bradford CDOP review data

Figure 3: Age distribution of all reviewed child deaths, 2008/09-2015/16

	Number	Percentage
1-4 years old	104	55%
5-13 years old	49	26%
14-17 years old	35	19%
TOTAL	**188**	**100%**

Source: Bradford CDOP review data

Sex

Figure 4: Sex distribution of all reviewed deaths, 2008/09-2015/16

	Number	Percentage
Male	326	54%
Female	281	46%
TOTAL	**607**	**100%**

Source: Bradford CDOP review data

Ethnicity

Figure 5: Ethnicity distribution of all reviewed deaths, 2008/09-2015/16

	Number	Percentage
South Asian	380	63%
White British or White Other	184	30%
Eastern European	17	3%
Mixed ethnicities	16	3%
Other ethnicities including African, East Asian and Other	10	1%
TOTAL	**607**	**100%**

Source: Bradford CDOP review data

Category of death

Figure 6: Category of death distribution of all reviewed deaths, 2008/09-2015/16

	Number	Percentage
Category 1	9	1%
Category 2	2	0%
Category 3	30	5%
Category 4	21	3%
Category 5	21	3%
Category 6	23	4%
Category 7	256	42%

Category 8	188	31%
Category 9	37	6%
Category 10	18	3%
No category	2	0%
TOTAL	**607**	**100%**

Source: Bradford CDOP review data

Figure 7: Comparison to national CDOP data: proportion of reviewed deaths by category of death, 2010/11 – 2015/16

Source: National CDOP review data, and Bradford CDOP review data

Modifiability

Figure 8: Modifiability classification of all reviewed deaths, 2008/09-2015/16

	Number	**Percentage**
Preventability/potentially preventable/modifiable	62	10%
Not modifiable	541	89%
Inadequate information	4	1%

Proportion of reviewed deaths by category of death, 2010/11-2015/16		**Bradford**	**National**	**Difference**
Cat 1:	Deliberately inflicted injury, abuse or neglect	2%	1%	0%
Cat 2:	Suicide or deliberately inflicted self-harm	0%	2%	-2%
Cat 3:	Trauma and other external factors	5%	6%	0%
Cat 4:	Malignancy	3%	7%	-4%
Cat 5:	Acute medical or surgical condition	3%	6%	-2%
Cat 6:	Chronic medical condition	3%	5%	-2%
Cat 7:	**Chromosomal, genetic and congenital anomalies**	**43%**	**24%**	**18%**
Cat 8:	Perinatal/neonatal event	31%	35%	-4%
Cat 9:	Infection	6%	6%	0%
Cat 10:	SUDI	3%	8%	-5%

TOTAL	**607**	**100%**

Source: Bradford CDOP review data

Expected/unexpected deaths

Figure 9: Expected/unexpected classification of all reviewed deaths, 2008/09-2015/16

	Number	**Percentage**
Expected	448	74%
Unexpected	154	25%
Unknown	5	1%
TOTAL	**607**	**100%**

Source: Bradford CDOP review data

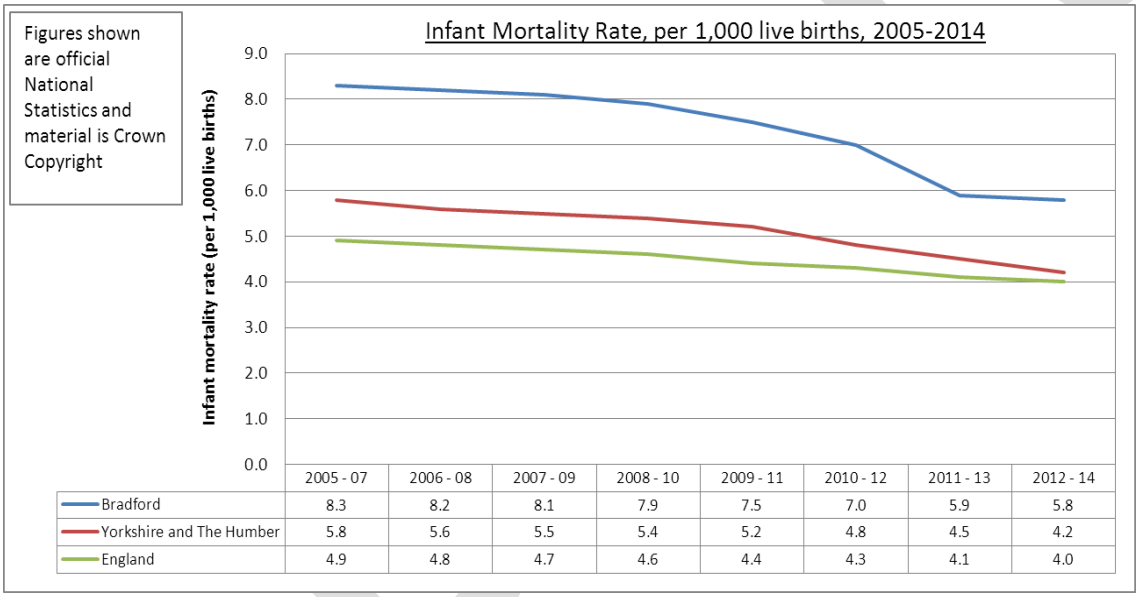
Appendix 5 (CDOP): Infant and child mortality rates

Figure 1: Mortality rates, 2012 – 2014

	Neonatal (<28 days) mortality rate, per 1,000 live births	Infant (<1 year) mortality rate, per 1,000 live births	Child (1-17 years) mortality rate, per 10,000 population
Bradford	3.8	5.8	17.3
Yorkshire and The Humber	2.8	4.2	13.3
England	2.8	4.0	12.0

Sources: Health & Social Care Information Centre Indicator Portal, and Child Health Profile 2016, ChiMat

Figure 2: Infant Mortality Rates for Bradford District vs England and Yorkshire and The Humber, 2005-07 to 2012-14



Source: Office for National Statistics (ONS) data

Figure 3: Infant mortality rates in the most deprived quintiles

Bradford District, Region and England during 2007-09 to 2012-

2014

Year	Bradford's most deprived quintile	Bradford	Yorkshire and the Humber	England
2007-2009	10.6	7.9	5.3	4.6
2008-2010	10.2	7.9	5.2	4.4
2009-2011	9.0	7.5	5.0	4.3
2010-2012	7.8	7.0	4.6	4.1
2011-2013	6.9	5.9	4.5	4.1
2012-2014	6.6	5.8	4.2	4.0
% Change between 2007-2009 and 2012-2014	**-39.2%**	**-26.6%**	**-20.4%**	**-13.0%**

Source: Public Health Analysis Team City of Bradford Metropolitan

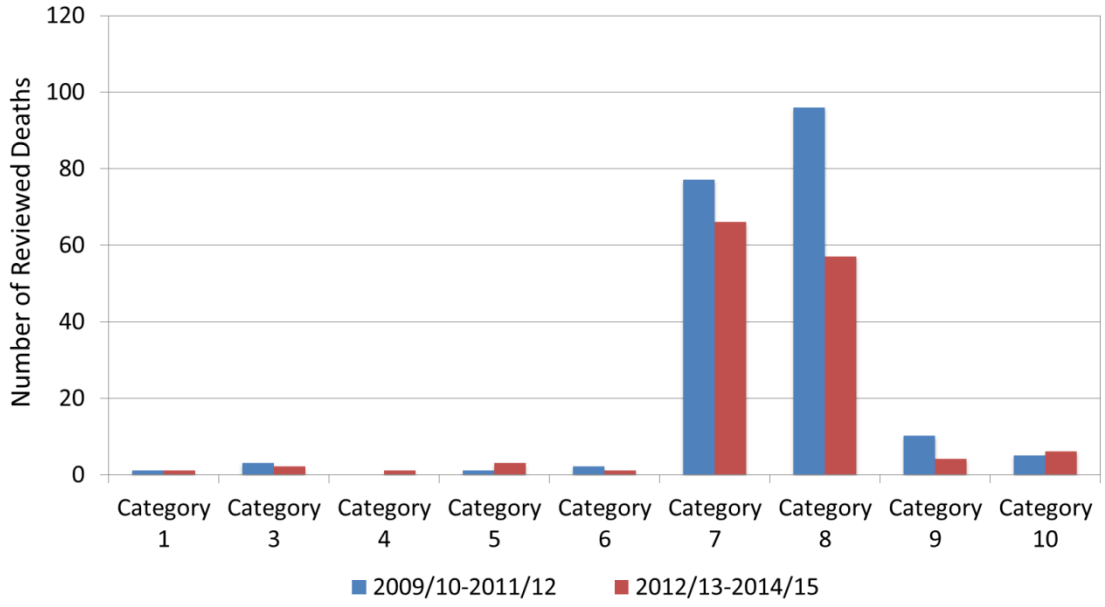
District Council, based on ONS data

Figure 4: Numbers of deaths notified to the CDOP by age category and year of death, 2008/09 to 2015/16

	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Under 1 year	63	77	74	44	45	48	50	39
1-17 year old	22	31	34	26	23	19	30	22
No date of death in notification	85	108	108	70	68	67	80	61
TOTAL	**170**	**216**	**216**	**140**	**136**	**134**	**160**	**122**

Source: Bradford CDOP notifications data

Figure 5: Numbers of reviewed infant deaths in each category of death, 2009/10-2011/12 compared to 2012/13-2014/15



Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis

Figure 6: Proportion of reviewed infant deaths in each category of death, 2009/10-2011/12 compared to 2012/13-2014/15

Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis

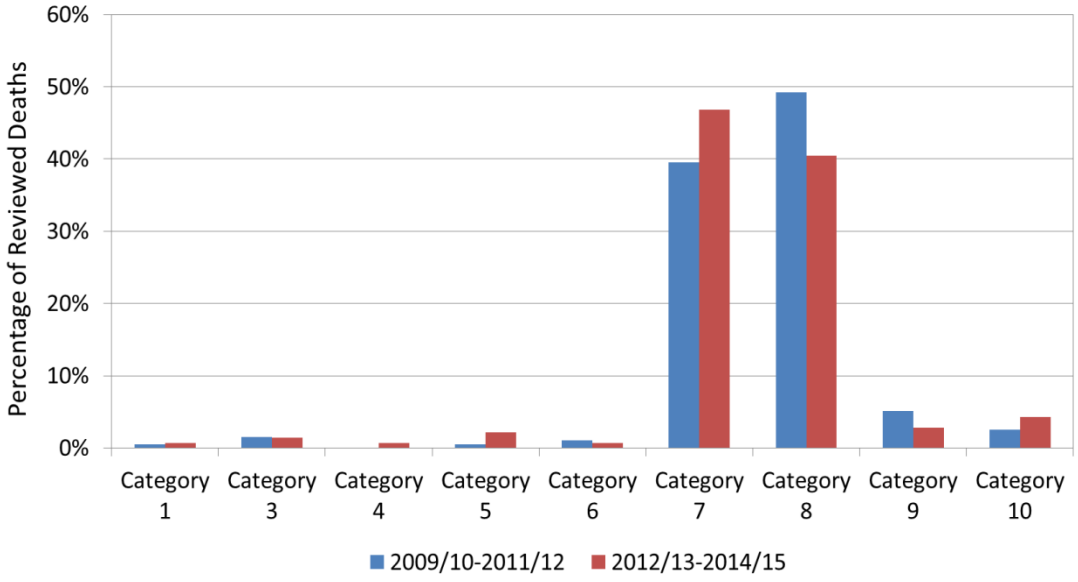
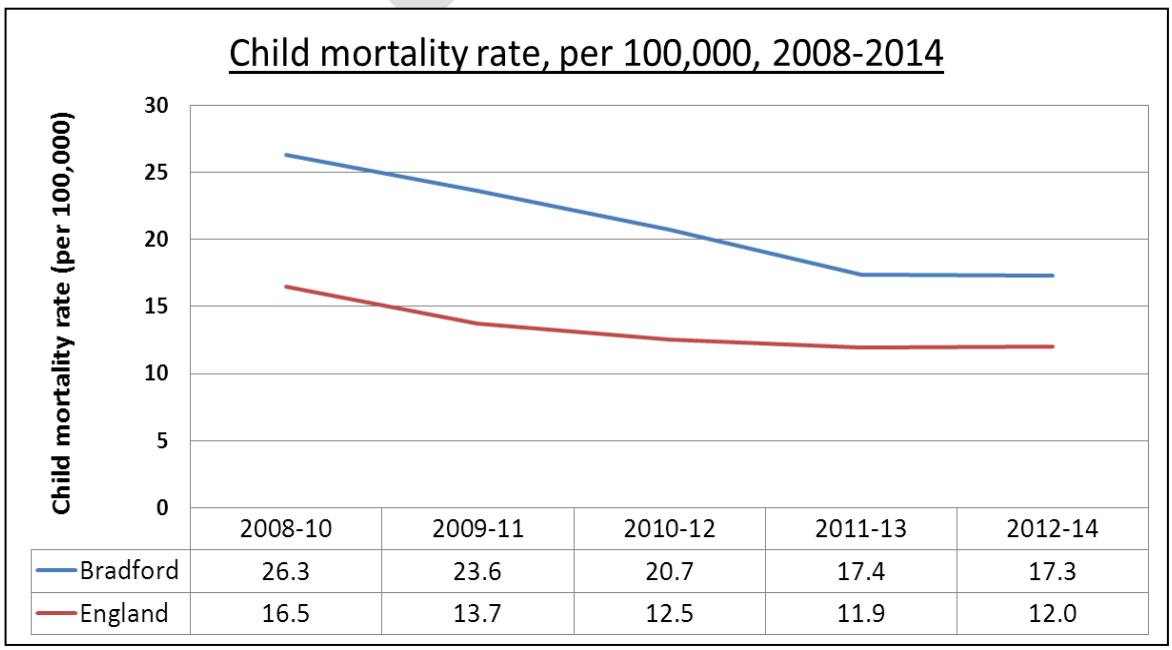
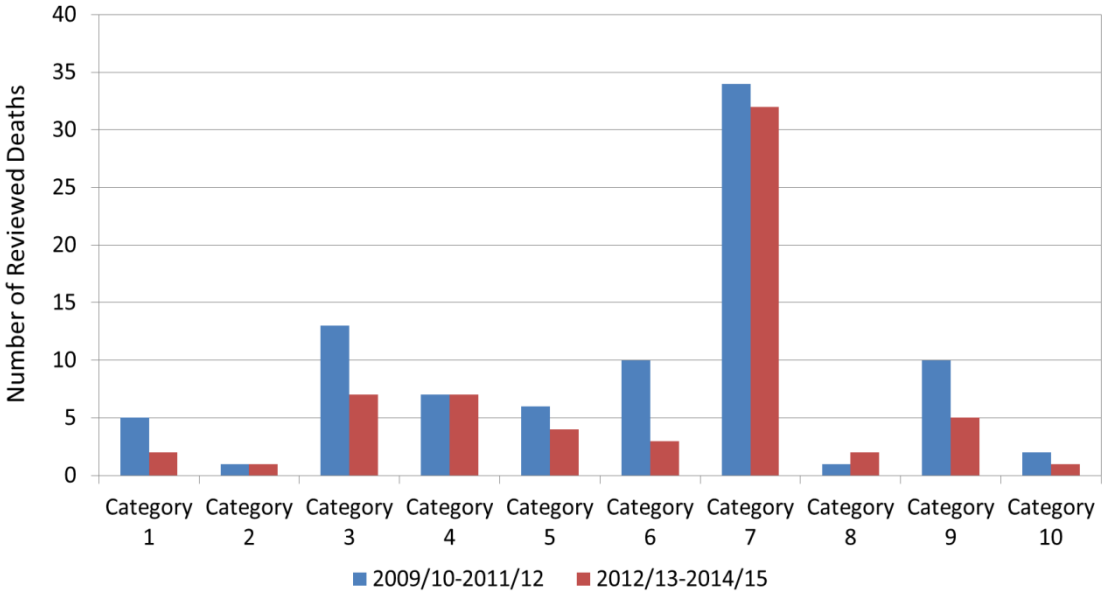


Figure 7: Child mortality rates over time, 2008-10 to 2012-14



Source: Child Health Profiles, ChiMat

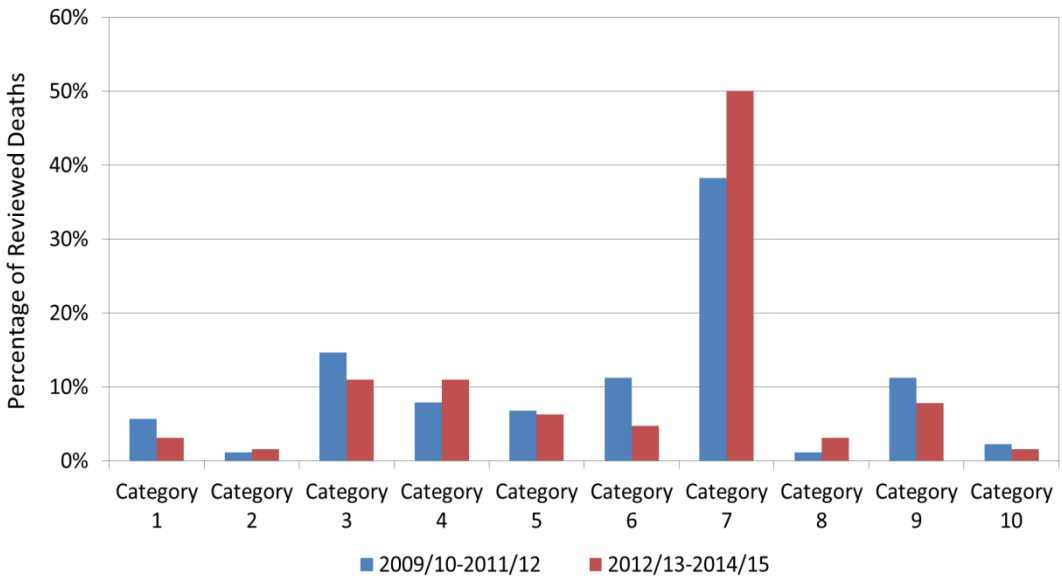
Figure 8: Numbers of reviewed child deaths (1-17 years old) in each category of death, 2009/10-2011/12 compared to 2012/13-2014/15



Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis

Figure 9: Proportion of reviewed child deaths (aged 1-17 years old) in each category of death, 2008/09-2010/11 compared to 2011/12-2013/14

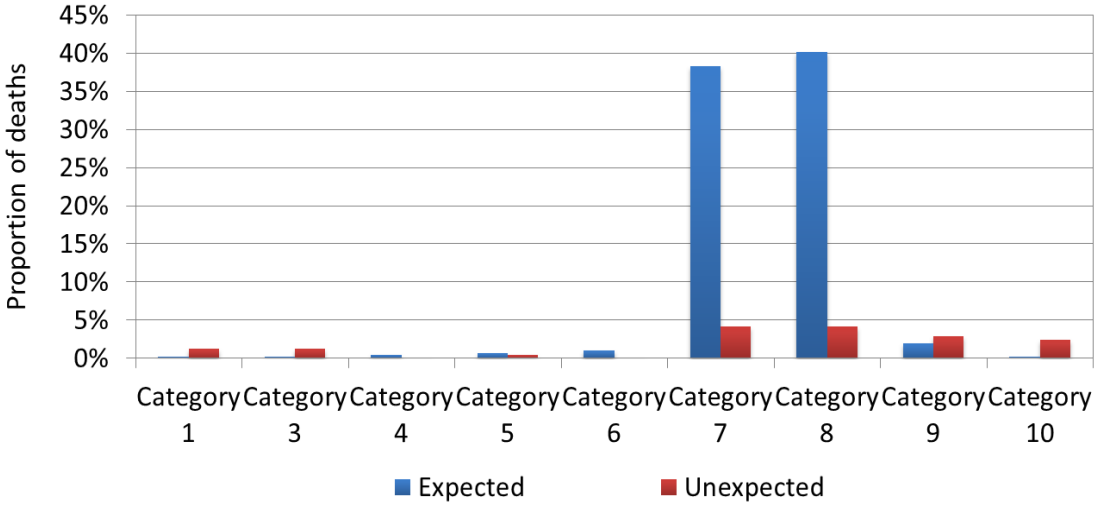


Source: Bradford CDOP review data

NB: The deaths with inadequate information to make a category of death classification were removed from the analysis

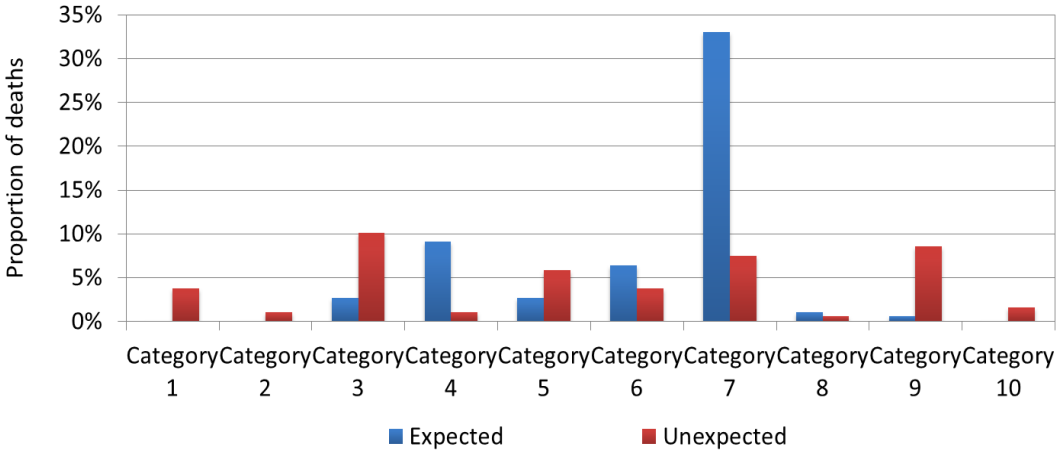
Figure 10: Proportion of expected/unexpected infant deaths in each category of death, 2008-2016

Source: Bradford CDOP review data



NB: The deaths with inadequate information to make a category of death classification were removed from the analysis

Figure 11: Proportion of expected/unexpected child deaths in each category of death, 2008-2016



Source: Bradford CDOP review data