21 April 2017

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Charlie Jones, Manager, Youth Offending Team
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Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in Bradford Metropolitan District Council

Between 27 February and 3 March 2017, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to abuse and neglect in Bradford.[1] This inspection included a 'deep dive' focus on the response to children living with domestic abuse.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Bradford.

The inspectorates recognise the complexities for agencies in intervening in families where there is more than one victim and where, as a consequence, risk assessment and decision making has a number of complexities and challenges, not least that the impact on the child is sometimes not immediately apparent. A multi-agency inspection of this area of practice is more likely to highlight some of the significant challenges to partnerships in improving practice. We anticipate that each of these joint targeted area inspections (JTAIs) will identify learning for all agencies and will contribute to the debate about what 'good practice' looks like in relation to children living with domestic abuse. In a significant proportion of cases seen by inspectors,

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

there were risk factors in addition to domestic abuse, which reflects the complexity of the work.

The partnership in Bradford is well established and committed to driving improvement across services in responses to domestic abuse. There are many clear examples where joint working at a strategic and operational level is resulting in timely and effective responses to tackle domestic abuse. This provision of timely and good quality support to children and their families is reducing the risk of harm to many children.

Staff in many agencies, including the voluntary and community sector, children's social care, the police, national probation services, youth offending teams and many health services, have a strong focus on understanding domestic abuse from the perspective of the child.

Initial responses to children who witness domestic abuse are a particular strength in most agencies, with prompt information sharing and assessments of the risk to children so that the vast majority receive the help and support they need in a timely way.

This effective joint working is also in place for children subject to child protection plans, and in the vast majority of cases seen, risk was reducing and children and their families were receiving help that was making a real and positive difference to their lives. Voluntary sector providers are an integral part of service to families and include specialist workers to ensure reach to some of the 'seldom heard' communities.

Joint planning and coordination of work is not in place at each stage of children's involvement with statutory services. Once children's needs have been assessed in the Multi-Agency Safeguarding Hub (MASH) and they progress to an assessment, there is not always a well-coordinated multi-agency safety plan in place prior to them becoming subject to a child in need or child protection plan. The impact of cumulative risks of children witnessing domestic abuse is not always recognised by professionals. In in a small number of cases, this has resulted in delays in children receiving the help they need, and in particular long term coordinated support.

Not all agencies have systems in place to ensure that they can identify the risk of domestic abuse. For example, adult attenders are not always asked about parental or carer responsibility when they attend Bradford Teaching Hospital NHS Foundation Trust emergency department, and school nurse documentation does not prompt practitioners to ask direct questions and record answers about domestic abuse. Community Rehabilitation Company (CRC) staff are not consistently proactive in contacting children's social care to identify and discuss any child protection issues in

relation to perpetrators whom they are working with, including when perpetrators are due for release from custody.

Policies, procedures and protocols are not always in place to underpin effective joint working to prevent and respond to domestic abuse. For example, there is no information sharing agreement between the national probation service and the MASH, and the CRC do not have an up-to-date domestic abuse policy.

There is more to do to ensure a robust strategic overview of domestic abuse in Bradford, including the prevalence and nature of abuse and responses to domestic abuse across the Bradford district. The Domestic and Sexual Violence Board action plan does not have sufficiently clear or measurable targets to enable them to monitor progress in respect of key priorities. This means that it is difficult for leaders to plan effective commissioning of services and to develop services to meet changing needs. This is particularly critical given the recent changing demographic of the population of the Bradford district.

Key Strengths

- Leaders and partners have high aspirations for all children in Bradford. Across partners, there is commitment to continuous improvement to offer a wide range of high quality services to meet the diverse needs of children and families in the Bradford district. The determination of the partnership to tackle domestic abuse is evident in the level of resources that are committed to this end. These resources include: the wide range of services commissioned by the local authority for victims and perpetrators of domestic abuse; the range of group work available for perpetrators of domestic abuse, including those provided by the Community Rehabilitation Company; a number of innovative projects involving the police and the dedicated health domestic violence manager in the Clinical Commissioning Groups.
- There are very effective multi-agency arrangements within the MASH, particularly between the police and children's social care, with a dedicated domestic violence hub. This means that for children who have witnessed domestic abuse, agencies work together well to ensure a speedy response. All domestic abuse incidents reported to the police, where children are present, are risk assessed, and sent promptly to the MASH. When risks to children are first identified, MASH social workers and police officers act quickly to make sure that they have information from any agencies who know children and their families. This includes mostly good access to health services, especially health visitors, school nursing and the emergency departments of local hospitals. Assessments of risk in the MASH have children's needs and any risks to them as the key focus, and are based on

information gathered in a timely way due to the effective working relationships between the majority of partner agencies.

- Children who have witnessed domestic abuse are promptly referred for the help and support they need. This includes early help support, a wide range of support from voluntary sector organisations or statutory involvement through Section 17 or Section 47 assessments. Thresholds are well understood and applied by professionals in the MASH, and managers provide effective oversight of contacts and referrals. There is also a strong dynamic system in place to ensure that children's needs are at the centre of decision making. For those children who need early help services, the police researcher working in the early help team reviews all cases to ensure that a full history is considered. This provides additional assurance, and where further risk is identified or a decision about the threshold is queried, children are referred back to the MASH for a reassessment of the risk based on the fuller picture.
- Schools in Bradford are notified within 24 hours of a child witnessing domestic abuse. Since the scheme was implemented in January 2017, 1,100 notifications have been made to schools. Early signs indicate that links between schools and targeted early help is ensuring that more children receive the support that they need at the right time. Designated police officers, linked to schools, provide safer relationship and internet safety education to pupils and receive notifications of domestic abuse that involve children who attend the schools for which they have responsibility. Police officers are therefore available to provide support and advice to schools where necessary.
- Strategy discussions in the MASH are timely and records demonstrate a clear understanding of risks and decisions agreed. Daily risk assessment meetings (DRAMs) between the police and IDVAs mean that all cases assessed as high risk are discussed within 24 hours, with evidence of good information sharing.
- Police officers within the MASH and domestic abuse team recognise risk effectively and give good consideration to the needs of children in the family. The detective sergeant in the joint investigation team based in the MASH checks all incidents that occur overnight to ensure relevant actions have been taken to keep children safe. Children at high risk of domestic abuse receive effective and sensitive responses from officers in the domestic abuse team. For example, an officer was seen to ensure alternative accommodation was found for one family experiencing domestic abuse. Timely and thorough investigations lead to the arrests of perpetrators when necessary.
- When adults attend Airedale General Hospital's emergency department, good attention is paid to identifying domestic abuse and the care arrangements and safety of children who are exposed to domestic abuse. Staff are well supported by appropriate assessment systems and documentation. A safeguarding screening checklist includes checks as to who has accompanied the child, who has parental responsibility and the nature of their interaction, and whether social

services are involved, with tight scrutiny of children and young people who have attended twice or more frequently in the previous 12 months. Checks on domestic abuse and its impact on children is routinely and clearly recorded and appropriate referrals are made promptly to the MASH.

- Community midwives in Bradford Teaching Hospital NHS Foundation Trust (BTHFT) services are knowledgeable about the risks of domestic abuse and the additional risks to unborn children. They work well with the police and children's social care to both support mothers and keep children safe, with good management oversight provided by the named midwife.
- Where GP practices in Bradford have well established vulnerable families' meetings in line with best practice, information on known or emerging vulnerabilities including domestic abuse can be shared promptly between health visiting, school nursing and primary care. This is leading to effective and timely information sharing, which results in referrals or escalations of concerns to the MASH where appropriate.
- Leaders and managers in Bradford have a good understanding of the effectiveness of the 'front door' for their services. For example, the Joint Targeted Area Inspection (JTAI) task and finish group undertook a wide ranging assessment of the 'front door' of services, which has resulted in a detailed action plan. A range of actions for the partnership are in place, including improved quality assurance arrangements and multiagency audits on a quarterly basis.
- The NPS has children's safety at the forefront of its work. It shares information in a timely way with the MASH when an offender's circumstances change, to ascertain whether the changes have any safeguarding implications, including in cases when it is possible but not clear that children are involved. Offender managers are alerted to safeguarding concerns at the earliest opportunity so they can consider the implications when they undertake assessments and make decisions about offenders. Good communication within the NPS and with children's social care means that risks to children can be managed in a coordinated way. Quality assurance systems are in place to ensure that referrals to children's services are followed through and the outcome of the referral is recorded in every case.
- The Youth Offending Team (YOT) has access to the social care database, so can easily gather information about social work involvement. Staff are vigilant in ensuring that they understand children's wider circumstances, with good communication with health and education staff and regular home visits and contact with family members. This means that when children's circumstances change, the YOT can readily assess the level of risk, including risk of domestic abuse and is able to respond appropriately.
- In Bradford, strategic partnership oversight of domestic abuse is through the Domestic and Sexual Violence Board (DSVB), which is a multi-agency board currently chaired by the local police district commander (chief superintendent),

with good representation from a wide range of partners including the voluntary and community sector. The DSVB structure has themed subgroups, with prevention, provision, protection and prosecution representing the key priorities of the board. There are clear examples of the areas in which the work of the board is having a positive impact, for example a focused initiative by the prosecution sub-group to reduce court-based attrition rates (the rate at which cases before the court are lost or dropped). To support this, the victim journey was mapped to identify the most appropriate times for interventions and support for survivors of abuse. Carefully timed interventions with victims are resulting in a small but significant reduction in attrition rates.

- Bradford Safeguarding Children Board (BSCB) is well-sighted on domestic abuse through the recent work of the JTAI task and finish group, which has undertaken an extensive review of domestic abuse, including a multi-agency audit of cases. The board challenged agencies to provide evidence of key areas of work around domestic abuse, the impact of this work and areas for development. This has given the board good oversight of key agencies' approach to identification and response to domestic abuse, and has enabled partners to understand each other's role and, importantly, those areas where further work is needed. Outcomes from this work include a revision of the threshold document and development of joint commissioning of services where gaps are identified. One example of this is a recent funding bid to support women and girls who have experienced violence but do not meet the threshold for statutory services.
- Children and parents who experience domestic abuse have access to a wide range of services to meet differing needs. This includes a number of commissioned services (eight in total commissioned by the local authority), as well as voluntary sector organisations that offer services. Effective commissioning of their specialist skills and knowledge adds considerable value to services offered to families. The range of services is impressive, including specialist workers to meet the needs of diverse communities and services for men who are victims of domestic abuse. One mother spoke powerfully of how the group work provided by one such organisation has helped her understand the impact of domestic abuse on her son and helps her to be aware of early signs of potential abuse in new relationships.
- This range of services to meet differing needs means that early help is available when concerns about domestic abuse first arise. When cases step up or down across the threshold to social work involvement, voluntary sector services are accustomed to retaining their involvement as part of planned intervention through child in need plans or core groups. This means there is consistency for children and their families who have often built strong relationships with workers. Close working relationships with social workers means that well-trained staff in the voluntary sector are fully included partners in 'Teams around the Family' and they are confident in taking the lead professional role.

- Leadership within children's social care is effective, and senior managers are creating a healthy environment in Bradford for effective social work to flourish. The Strategic Director Children's Services (DCS) is focused on 'getting the basics right' in social work practice but also in innovating and using external sources of funding and expertise to drive new developments and approaches to providing effective support for children and young people.
- Frontline managers have good, timely access to performance information, enabling them to identify good performance, as well as areas where improvement is needed and trends in each team. Performance against key indicators is strong at the 'front door', demonstrating that when children are referred with concerns related to domestic abuse, these are responded to in a timely way. Managers have close oversight of work, which is effectively monitored to ensure that children get the right services at the right time, including services to protect them from further abuse.
- Social workers are well supported to enable them to work effectively with families. Caseloads are manageable and workers receive regular supervision. All social workers have had 'Signs of Safety' training and this is seen to be having a positive impact on practice, promoting a clear focus on risks and protective factors in many cases. Good engagement with children means that children's experiences are understood by social workers and central to their interventions to ensure that children are safe and their needs met.
- The council has made a significant investment in 'Signs of Safety' training across agencies, rather than just children's social care. This includes training frontline staff and senior managers across the partnership. All members of the BSCB have undertaken training, as has the Strategic Director Children's Services (DCS). While training is ongoing, the early benefits of this approach are apparent, particularly at the front door: there are many examples of a shared understanding of risk and the approaches to the assessment of risk between agencies that result in a coordinated response to families.
- Both the lead member and the chief executive of Bradford council are very well informed about the diverse needs of children in Bradford and the quality of services to children in need of help and protection. Both regularly visit frontline services, including the MASH, and the lead member meets weekly with DCS and regularly with the police superintendent with responsibility for safeguarding. The 'Young Lives' organisation coordinates children's attendance at the children and Young People's Scrutiny committee, ensuring elected members are kept in touch with children's views and experiences. There is effective and appropriate challenge from the lead member, chief executive and the scrutiny committee to officers to ensure that children's needs are met.
- There are clearly defined police structures for dealing with domestic abuse, which have been supported by an investment of staff within the local police safeguarding teams, and in the MASH. Police are well engaged at a strategic and

operational level, with many examples of innovative practice to improve reporting of domestic abuse and build confidence in the police across diverse ethnic groups. The local police have a culture of seeking improvement and learning, which is supported by a safeguarding central governance unit. This unit undertakes auditing and also commissions peer reviews into domestic abuse to better understand police responses to abuse. Learning from a recent audit has resulted in the improved management oversight of open domestic abuse incidents. These are now reviewed within 24 hours so that decisions can be assured by a manager.

- The NPS is committed to supporting local developments. For example, probation managers have undertaken 'Signs of Safety' training and have been involved in the development of the pilot of early help work in Keighley. The NPS is well represented at the LSCB and DSVB. Training in the use of the domestic abuse screening tool has been extended to probation service officers, who undertake much of the court work.
- YOT is an active participant of the BSCB and has undertaken 'Signs of Safety' training. There is strong representation from health in the service and access to CAMHS consultancy for higher risk young people. There are strong links with the police Integrated Offender Management (IOM) team, which assists with surveillance and disruption of persistent offenders, including domestic abuse perpetrators. Practitioners showed a personal commitment to young people and a strong value base. Management oversight was effective and practitioners described their supervision with managers as achieving an appropriate balance between compliance with process and reflective conversations about practice.
- Overall, the health service's leadership, management and strategic governance of safeguarding practice, including identifying and responding to domestic abuse, is good. Health leaders make a significant contribution to partnership working across Bradford to identify, support and protect children living with domestic abuse as they are well engaged with the BSCB and DSVB. There is some improvement needed in the frontline services' operational governance.
- The formation of the CCG collaborative for those three CCGS with only a single designated nurse for safeguarding is a strength as this has facilitated consistent and effective engagement of the health economy with the partnership arrangements through a single organisational interface. The designated nurse provides effective challenge to the health provider trusts through regular performance monitoring and scrutiny of safeguarding performance.
- The appointment of a dedicated health domestic violence manager to the CCG collaborative is innovative and a real strength for Bradford. The post gives flexible developmental capacity across the local domestic abuse and sexual violence partnership, bringing a health perspective to a range of different work streams that encompass health, social care and the voluntary sector. The role has a particular focus in driving improvement across primary care.

- Training across health agencies increasingly includes domestic abuse components, such as coercive control. Training recently delivered by Bradford District Care NHS Foundation Trust (BDCFT) included raising practitioners' awareness of diversity issues, such as men as victims and domestic abuse in LGBT relationships. There are sound safeguarding supervision arrangements across the health economy.
- Managers across health services are well sighted on cases held by their service in which there are known risks and vulnerabilities. Operational managers in the BDCFT, including those in adult services, understand the cohorts of children in need and child protection cases and the prevalence of domestic abuse cases within service caseloads. Health service leaders have a good awareness of the cultural diversity of the city's population and of how different cultural perspectives of domestic abuse can affect victim's ability to access support services.
- As a result of the above, managers have prioritised raising awareness across primary care and other health services of the need to reach out to different community groups. Health visitors are linked to specific community projects in order to 'bring health' to the community, to promote the healthy child programme and raise awareness of how to access support. This includes promoting the domestic abuse 'freedom programme'. Good use is made of local interpreters to ensure that health professionals can communicate properly, including with very vulnerable parents.
- Health visitors' records show good observation of children at homes where there is a risk of domestic abuse. This includes consideration of the impact on non-verbal children or those who may not be able to vocalise their feelings, therefore ensuring they can recognise and respond appropriately to the impact of domestic abuse.
- Most social work assessments are completed to a high standard. Extensive information gathering from partners and effective identification of historical factors lead to comprehensive assessments. Children's and parents' views are strongly represented and influence the focus of plans for them, and social workers take the time to get to know the children they work with. Assessments are routinely updated following review child protection conferences and this is good practice. Customary use of 'Signs of Safety' methodology means that in most cases seen, assessment information was drawn together into a clear and comprehensive analysis of risk and protective factors, and this supports sound decision making and planning.
- Outcomes for children and their non-abusive parents were improving in the vast majority of cases seen. This was as a result of effective joint working so that children and parents were getting help that was making a real and positive difference to their lives. Feedback from parents spoken to was mostly positive. One mother who had experienced domestic abuse talked very positively of the involvement of most agencies but in particular about social workers, school and

some health professionals. In talking about how the social workers have helped the family, the mother said, 'They've been really supportive. They have listened to me and involved me in plans about my children. My children now feel more secure and I can get hold of professionals when I need them'.'

- Children and Family Court Advisory and Support Service (Cafcass) cases reviewed were thorough and comprehensive and evidenced analysis of risks to children. Recommendations made in each section 7 report were appropriate and reflected a fair and balanced approach.

Case study: highly effective practice

There is a range of positive activities being undertaken by the police in Bradford as a single agency, together with partners, to support victims and also work with perpetrators. Examples include:

There is direct engagement with specific diverse communities or groups by the police to improve domestic abuse reporting, including seldom-heard groups. Examples include the local domestic abuse partnership inspector hosting a meeting in January with dedicated LGBT support workers from Bradford Women's Aid and Staying Put, as well as a transgender support service in Bradford, discussing ways to improve the support services for LGBT victims, and raising awareness amongst frontline workers who deal with abuse in LGBT households. There is also a dedicated Honour Based Violence and Female Genital Mutilation officer, who oversees all reported cases and liaises with other agencies, including Karma Nirvana. The partnership's chief inspector sits on a support group called 'Men Standing Up', which is a bespoke support service for male victims.

The police are facilitating cell interventions with those domestic abuse perpetrators detained in custody for cases assessed as standard and medium risk. Those detained are offered access to a domestic abuse perpetrator service (Choices) which provides support to better understand the causes and impacts of their behaviour. This voluntary service is co-located in the police station (three days a week). They have delivered 44 cell interventions, resulting in 14 people having accepted support, and three have been referred onto other agencies (Fresh Start, MSU, and First Response).

The police, together with local independent domestic violence advisor (IDVA), have commenced an innovative multi-agency response to high risk domestic abuse cases. Two police cars, staffed with a police officer and IDVA, provide a secondary response to domestic abuse incidents on Friday, Saturday and Sunday evenings. Reported early outcomes are: better engagement of victims and immediacy of safety planning. In one example, an IDVA was able to offer a change of locks, panic alarm and next day appointment with a solicitor, all prior to the release of the suspect. The joint working also provides an environment which enables the two agencies to understand their different roles, and how their joint services improve engagement, and the responsiveness of victims.

Areas for improvement

Identifying and managing risk of harm at the 'front door'

- There has been no dedicated health professional in the MASH for the past 12 months. While arrangements to access information from health visitors, school nurses and the emergency departments at Airedale General Hospital and Bradford Royal Infirmary work well, information gathering from adult mental health, CAMHS and adult substance misuse is less well secured. Health participation in strategy discussions is inconsistent and may not always ensure that relevant information is shared and used to identify needs and analyse risk or assure compliance with Working Together 2015. The CCG collaborative and the provider trusts are in the process of determining their preferred model of MASH health presence and exploring resourcing options, but with no specified timescale, it is unclear when this will be resolved.
- Although there is good information sharing at the DRAMs, the actions raised are not always clearly recorded so that the outcome of the meeting, including the actions to be taken, is not routinely clear.
- In the Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment, the police record the demeanour of children who are present or in the house when there is domestic abuse, but there is limited recording of officers speaking to children. This means that the impact of domestic abuse on the child is not always as complete as it could be in the initial risk assessment that goes to partner agencies.
- Although the MASH and other children's services teams routinely make checks with NPS for their involvement with adults linked to children, these processes are not supported by policy and procedure or an information sharing agreement. This means that actions taken to gather relevant information are dependent on the skill and knowledge of the individual worker.
- Adults who attend the BTHFT emergency department are not always asked about their parental or carer responsibility, including when domestic abuse is indicated. This means that risks to children may not be identified or understood, and in one case seen this resulted in children being left in the care of a perpetrator who had seriously attacked the children's mother.
- In BDCFT, there is no robust process of quality assurance of the written referrals being made into the MASH and this means that the trust cannot be sure that all referrals contain the necessary detail for social workers to make clear assessments of risk. This is recognised as an area for improvement by the trust's safeguarding team.
- School nurse assessment documentation does not prompt practitioners to ask direct questions and record answers in relation to domestic abuse. There is an over reliance on staff's professional curiosity to ask these questions but this was

not evident in cases seen. School nurse records are not always up to date due to administrative delays in scanning and uploading key documents, such as core group minutes and other child protection documentation. As a result, the school nurse team might not be aware of key information to guide their interactions with children and young people, particularly when domestic abuse might be indicated.

Response to children living with domestic abuse

- During the early stage of social work intervention, and after children's needs have been assessed in the MASH, cases progress for an assessment and further information is gathered. In some cases, there was not a clear multi-agency safety plan in place at this stage, prior to a child in need or child protection plan being agreed and put in place. A clear outcome-based plan for the child, with an identified key worker and core group, results from the initial child protection conference, but prior to this not all children benefit from an interim safety plan. In a small number of cases, this resulted in gaps in clear and coordinated safety planning to protect children at the early stages of engagement with the family.
- Not all records of management decisions in children's social care to undertake a Section 17 assessment of a child who is at risk of domestic abuse include a clear rationale for the decision.
- The impact of cumulative risks to children who are frequently witnessing domestic abuse is not always recognised by all professionals. For example, police officers effectively respond to immediate calls from victims of domestic abuse, ensuring that the victim and children are safe and those suspected of domestic abuse arrested. Frontline officers then complete their assessment (DASH). In a small number of cases, these officers did not identify the impact of cumulative risk when completing the DASH, which then had an impact on the level of response from agencies. In some cases, this meat there were delays in children receiving the long-term coordinated support from agencies that they needed. In addition, in a small number of cases, cumulative risks did not result in referral to the DRAM, and this is a missed opportunity to consider the impact of cumulative domestic abuse incidents.
- There is little evidence of joint investigations between the police and children's social care when the domestic abuse team is dealing with an investigation, as opposed to the child protection police team. While police do respond to incidents of domestic abuse, there are examples of missed opportunities for joint investigations. Although agencies work with the family with the primary intention of safeguarding the victim and the child and to share information, the opportunity for effective joint planning is sometimes lost due to a lack of joint investigations.
- The CRC is not consistently proactive in contacting children's services at an appropriate stage, from the case being allocated or prior to the release of a perpetrator from custody, to consider any safeguarding concerns. In a small

number of cases seen, this meant that risks to children were not considered and a coordinated response to manage risk was not in place.

- Chronologies of significant events in children's lives in health visiting and school nursing are not always up to date and therefore limit their use in providing a clear overview of the child's experiences. Social work chronologies are inconsistent in their inclusion of incidents of domestic abuse as significant events and so are of limited value when identifying historical patterns, and understanding the cumulative patterns of domestic abuse that a child may be experiencing. Written child protection plans do not set clear timescales so that core groups can set milestones to achieve identified outcomes.

Leadership and management

- While a wide range of positive work that has a real impact has been undertaken by the Domestic and Sexual Violence Board, there is more to do to ensure a robust strategic overview of the responses to domestic abuse across Bradford. The board has yet to identify clear targets and success measures to monitor the impact of their work and the action plan is still in draft. A clear and SMART action plan would improve the focus of the board in identifying some measurable targets, a baseline for the activity of the board and effective monitoring of progress in respect of key priorities.
- Although some work is in place to map the range of support on offer to children and families in Bradford who are subject to domestic abuse, there is not currently a clear strategic overview of what is available, or where and how many children and families are receiving support. This means that it is difficult for leaders to identify gaps in service and plan effective commissioning of services or to develop services to meet changing needs. There is a need to strengthen joint and single agency commissioning arrangements to ensure that these are based on a comprehensive understanding and analysis of prevalence patterns and trends of domestic abuse in the local area. This is particularly relevant given the recent changing demographic of the city and the high number of recent migrants.
- Despite clearly defined police structures for dealing with domestic abuse, further work is required to ensure that the processes, connectivity and planning between the DRAM and MARAC provide appropriate and timely safeguarding activity. The community safety partnership has identified funding to commission an external review of both the DRAM and MARAC.
- Some practitioners in children's social care and in CRC are not aware of how to refer to the MARAC, and minutes of MARAC meetings do not always evidence robust consideration of risks to children. MARAC minutes seen lacked clarity as to the actions that need to be in place to ensure that children are safe.

- There is good use of non-molestation and restraining orders within Bradford to support the protection of victims. However, the enforcement of those orders by officers is inconsistent.
- Although the CRC has a current child protection policy, its broader public protection policies, including domestic abuse policy, are considerably out of date. In addition, management oversight of practice is inconsistent, so that risks to children are not always understood and information not consistently shared to ensure that risks are managed. Staff have not all received adequate training to ensure that they are clear about child protection procedures.
- Not all GP practices in Bradford hold vulnerable families meetings where information on known or emerging vulnerabilities, including domestic abuse, can be shared between health visiting, school nursing and primary care. As a result, some GP practices may be less aware and less well sighted on families with children living with domestic abuse than others. This was evident in one example where the GP had been less aware of risks to a child; in this practice, vulnerable family meetings were not in place
- Different information systems and information governance arrangements across the health community and in particular in BDCFT result in potentially key information not always being easily accessible to practitioners and managers within services. This, in turn, may not best facilitate effective multi-agency working. In the BDCFT adult substance misuse service, child in need and child protection plans and minutes of meetings and case conferences are held in separate paper files rather than being uploaded and properly secured on the electronic case record. This approach is creating fragmented case records.

Case study: area(s) for improvement

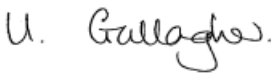
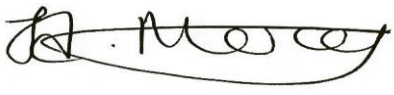
Multi-agency working is not always robust enough to ensure the full involvement of the Community Rehabilitation Company (CRC). Offender managers in the CRC do not always fully assess risks to children and take full account of historical information in deciding when to contact children's social care. High caseloads within the service impact on staff's ability to effectively manage cases when there are concerns about domestic abuse. Offender managers are required to attend mandatory domestic abuse and safeguarding training. However, there are gaps in their knowledge of processes for making referrals in relation to MARAC and where there are child protection concerns. In one case, an offender manager failed to recognise potential risks when an offender announced his intention, on release from custody, to spend time at the home of his new partner and baby. The reasoning given was that there had been no incidents of domestic violence reported to the police in respect of the couple. However, the history of domestic abuse perpetrated by the offender when he was in previous relationships was not taken into account. The offender manager was focused solely on working with the offender and not engaged with any other professionals or the family or new partner.

Next steps

The Director of Children's Services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving Cafcass, NPS, CRC, Clinical Commission Group and Health Providers in Bradford and West Yorkshire Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The local authority should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 24 July 2017. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Eleanor Schooling National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Helen Mercer Assistant Chief Inspector

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.