

Review of health services for Children Looked After and Safeguarding in Bradford

Children Looked After and Safeguarding

The role of health services in Bradford

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Summary of the review

This report records the findings of the review of health services in safeguarding and looked after children services in Bradford. It focuses on the experiences and outcomes for children within the geographical boundaries of the local authority area and reports on the performance of health providers serving the area including Clinical Commissioning Groups (CCGs) and Local Area Teams (LATs).

Where the findings relate to children and families in local authority areas other than Bradford, cross-boundary arrangements have been considered and commented on. Arrangements for the health-related needs and risks for children placed out of area are also included.

About the review

The review was conducted under Section 48 of the Health and Social Care Act 2008 which permits CQC to review the provision of healthcare and the exercise of functions of NHS England and Clinical Commissioning Groups.

- The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children.
- The focus was on the experiences of looked after children and children and their families who receive safeguarding services.
- We looked at:
 - the role of healthcare providers and commissioners.
 - the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews.
 - the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services.
- We also checked whether healthcare organisations were working in accordance with their responsibilities under Section 11 of the Children Act 2004. This includes the statutory guidance, Working Together to Safeguard Children 2018.
- Where we found areas for improvement in services provided by NHS but commissioned by the local authority then we will bring these issues to the attention of the local public health team in a separate letter.

How we carried out the review

We used a range of methods to gather information both during and before the visit. This included document reviews, interviews, focus groups and visits. Where possible we met and spoke with children and young people. This approach provided us with evidence that could be checked and confirmed in several ways.

We tracked a number of individual cases where there had been safeguarding concerns about children. This included some cases where children were referred to social care and also some cases where children and families were not referred, but where they were assessed as needing early help and received it from health services. We also sampled a spread of other such cases.

Our tracking and sampling also followed the experiences of looked after children to explore the effectiveness of health services in promoting their well-being.

In total, we took into account the experiences of 129 children and young people.

Context of the review

Bradford is the sixth most populous city in Britain. The city has an increasingly youthful population, with children and young people under the age of 20 years making up approximately 28.9% of the population, compared to 23.8% nationally.

The city of Bradford is ethnically and culturally diverse. Approximately 56.7 per cent of school age children are from ethnic minority groups. This is significantly higher than the national average of 31.0%. Bradford has one of the largest South Asian communities in the country.

There are significant economic variations throughout the city of Bradford. Whilst there are some localities such as Ilkey which are thriving, there are considerable pockets of deprivation and poverty found predominantly within inner-city wards. Bradford ranks as the 19th most deprived local authority in England according to the Index of Multiple Deprivation.

The health and wellbeing of children in Bradford is generally worse compared with the England average, with higher levels of obesity, teenage pregnancy and accidental injury. Infant mortality rates in Bradford are also significantly higher than the comparative value for England. Childhood vaccination coverage is a particular area of strong performance, and the number of children in care receiving immunisations is significantly higher than the England average.

The DfE reported that Bradford had 751 looked after children that had been continuously looked after for at least 12 months as at 31 March 2018 (excluding those children in respite care). The rate of children in care in Bradford is similar to the England average.

A strengths and difficulties questionnaire (SDQ) is used to assess the emotional and behavioural health of looked after children in Bradford. The most recent SDQ score (2018) was 13.8 compared to the England value of 14.2. The average score has increased since 2015, and therefore suggests that the emotional health and wellbeing of looked after children in Bradford may be deteriorating.

Commissioning and planning of most health services for children is carried out by Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups via a shared management structure arrangement.

The majority of residents in Bradford (58.1%) are registered with a GP practice that is a member of NHS Bradford Districts Clinical Commissioning Group, whilst a further 21.3% are registered with practices that fall under Bradford City CCG. A smaller percentage are registered with other GPs that fall under other CCG's.

Acute hospital services are commissioned by Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups and are provided by Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust. Our review included visits to the emergency department (ED) at both Bradford Royal Infirmary (BRI), and Airedale General Hospital. We also visited maternity services at both Bradford Royal Infirmary and Airedale General Hospital.

Health visitor and school nursing services are commissioned by City of Bradford Metropolitan District Council Public Health department and provided by Bradford District Care NHS Foundation Trust.

Commissioning arrangements for looked-after children's health are the responsibility of Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups via a shared management structure arrangement. The looked-after children's specialist nursing team is provided by Bradford District Care NHS Foundation Trust. The Designated Nurse, Safeguarding and Looked After Children roles are employed by the CCGs, and the Designated Doctors for children looked after are based in the acute Trusts, working within the CCGs via a service-level agreement

Specialist child and adolescent mental health services (CAMHS) are provided by Bradford District Care NHS Foundation Trust. In-patient care tier 4 CAMHS is commissioned nationally by NHS England.

Perinatal and adult mental health services are provided by Bradford District Care NHS Foundation Trust.

Integrated sexual health services are commissioned by City of Bradford Council's Public Health department and provided by Locala and some GP practices.

Adult substance misuse services are commissioned by City of Bradford Council's Public Health department and provided by Change Grow Live (CGL), Bradford District Care NHS Foundation Trust and Bradford Substance Misuse Recovery Service.

Child substance misuse services are commissioned by City of Bradford Council's Public Health department and provided by Bradford Council's Children's Social Care (alcohol drugs prevention team ADEPT), Children's Social Care Problem Solving Court Team, The Bridge Young People's Specialist Substance Misuse Service and Bradford District Care NHS Foundation Trust Substance Misuse Service

The last inspection of services for children in need of help in Bradford took place in September 2018 and was carried out by Ofsted. The overall effectiveness of the safeguarding services including for looked after children was judged as **inadequate**

Progress against inspection recommendations have been considered in this review. Bradford was also subject to a Joint Targetted Area Inspection (JTAI) which focused on how effectively partners work together to provide help and protection to vulnerable families impacted by domestic abuse in 2017.

The report

This report follows the child's journey reflecting the experiences of children and young people or parents/carers to whom we spoke, or whose experiences we tracked or checked. A number of recommendations for improvement are made at the end of the report.

What people told us

One young person told us about their CAMHs worker;

They listen to me when I talk. They are also very reliable. I can message her when I am not feeling very well and she will come to see me at home or school when I need help.

One young person who had received support from the CSE team said;

I have been through a lot, but the support that I have had from the CSE hub has been brilliant. It has really helped me to move on

A parent of a child accessing support from CAMHs told us;

We are in capable hands in the care of CAMHS practitioners. They are there for me when I need help, they are great. The meetings held with me and my family are very valuable in helping build our understanding. If I could rate the service, it would get 100%

A parent who attended ED at BRI with their child told us;

“My (child) was seen very quickly. We really didn’t have to wait long which was good considering how busy it all seemed. The nurse seemed to really care about what was going on and we got good support really quickly.”

A father of a new born baby that was born at BRI said;

I always felt included by all the NHS staff, everyone always explained what they were doing and why. I know the staff are always busy but I always felt like we were the only ones on the ward. Everyone has been absolutely fantastic.

The child's journey

This section records children's experiences of health services in relation to safeguarding, child protection and being looked after.

1. Early help

1.1 Children and young people who access unscheduled care at Bradford Royal Infirmary (BRI) have limited access to dedicated paediatric ED facilities. Whilst there is a paediatric ED at BRI, children who present outside of the hours of 14:00 and midnight, are triaged in the adult ED area. Children and young people are not always fast tracked which means that vulnerable children and young people, particularly those with sensory processing and mental health needs, may experience anxiety and distress if subject to lengthy waits in busy clinical areas. Following the review we have been informed that there is a new and approved staff plan which will see an increase in nursing staff which will enable children to be triaged in ED 24 hours a day. **(Recommendation 2.1)**

1.2 Young people who are assessed in adult ED do not always have their details recorded on paediatric admissions documentation, which contain age-related safeguarding prompts. Therefore, there is too much reliance on individual clinician's professional curiosity to explore the vulnerabilities and risks of presenting young people. **(Recommendation 2.2)**

1.3 Pregnant women who do not engage in ante natal care are identified and safeguarded well. In records reviewed we saw evidence of midwives following the 'missed appointments' and the 'late booking' policy to engage with clients and take safeguarding action when required. This means that a lack of engagement with antenatal care is consistently addressed to ensure the safety and wellbeing of the pregnant woman and her unborn child.

1.4 Midwives at Airedale General Hospital are not consistently documenting their exploration of risk factors. For example, midwives told us that they do advise expectant parents on safe sleeping guidelines in the antenatal period, and that they do screen for domestic abuse and observe interactions between the new-born and care givers. However, we did not find evidence of this being consistently documented in the records reviewed. Therefore, concerns and needs that have been identified may remain unmet. **(Recommendation 3.1)**

1.5 Women attending Bradford Royal Infirmary maternity department who do not speak English benefit from the services' use of recognised interpreters. In records reviewed the use of interpreters (when required) was clearly documented. This means that the service can be assured that information is being translated correctly and understood by the service user.

1.6 Midwives at BRI are not always adopting a think family approach when completing early assessments of risk during the booking of a woman's pregnancy. We saw that there is a lack of standardised prompts in place to remind midwives to consistently enquire about substance misusing behaviours and the mental health history of both the mother and her partner. Therefore, there is too much reliance on professional curiosity and an increased likelihood of needs and vulnerabilities not being identified at the earliest opportunity. **(Recommendation 2.3)**

1.7 Communication and information sharing between maternity staff at Bradford Royal Infirmary and the Bradford District Care Foundation Trust Health Visiting team is ineffective. Health visitors are not always informed of women's additional needs and vulnerabilities identified when the woman books her pregnancy with a midwife. The health visitors told us they are not consistently provided with updates from the midwifery team during the ante-natal period. In one tracked case reviewed, one woman's initial estimated due date was incorrect. The health visiting team was not updated and therefore did not carry out the antenatal home visit. When the baby was born safeguarding issues were identified which could have been addressed prior to the baby's birth had more information been shared in a timely manner. This inconsistent sharing of information is leading to missed opportunities to provide early intervention. **(Recommendation 2.4)**

1.8 Reductions in the capacity of the health visiting service, is reducing the opportunity for women and families with vulnerabilities to receive early intervention and help. The health visiting team is achieving the key performance indicators for the healthy child programme for new birth visits but not for antenatal visits. Antenatal visits are targeted to first time mothers and families with known safeguarding concerns and vulnerabilities. Targets for completing the 6-week maternal mood check are not being met, and this means that the opportunity to provide women with perinatal mental health needs with early help and interventions is minimised. This is a significant limitation given the known high number of women reporting perinatal mental health concerns. *This has been brought to the attention of public health.* **(Recommendation 1.1 and 4.1)**

1.9 Children under 5 and their families in Bradford benefit from a health visiting service that understand and respond to the specific health needs of the local population. In records reviewed we saw that health visitors consistently gave advice on safe sleeping and accident prevention, topics which have been key themes in recent serious case reviews and published lessons learned reports. This proactive work is helping to reduce harm and accidental injuries in children under 5.

1.10 The CCG recognises that poor dental hygiene and the presence of dental caries can be indicative of neglect. Health visitors routinely provide parents with a dental health promotion pack to promote good oral hygiene, and refer to social care where there are concerns about poor oral health. The local area is supported by a paediatric dentist who is working to promote the importance of promoting good oral health across the health partnership. This means the most vulnerable children are identified and supported to access dental care which provides dentists with further opportunity to identify cases of neglect.

1.11 Routine enquiry regarding domestic abuse and maternal emotional wellbeing occurs consistently each time health visitors have contact with families in Bradford. In records reviewed there was clear documentation to state mothers were asked about their emotional health and domestic abuse at each contact when appropriate. This gives mothers the opportunity to disclose issues to a health professional and ensures that help is provided at the earliest opportunity.

1.12 The school nurse offer is not being received by children and young people equitably across Bradford. Health promotion sessions are offered to all schools; however a noteworthy proportion of schools decline this input due to faith or cultural reasons. This means that some young people who are statistically more likely to experience health inequalities are less likely to receive important health messages. *This has been brought to the attention of public health. (Recommendation 1.2 and 4.2)*

1.13 Home educated children and young people who are not accessing education receive the core offer from school nursing. This means that this cohort of young people who may have underlying health or safeguarding needs can access school nurse support, advice and intervention to address their needs.

1.14 Children and young people in Bradford benefit from good access to sexual health support from Locala. Careful consideration has been given to changes that can be made to service delivery to ensure that there are no barriers which might prevent young people from accessing the service. A specific young person's clinic is held weekly outside of school hours, and children and vulnerable young people who are referred from other agencies and attend the service outside of that clinic slot, are fast tracked which ensures that they do not experience lengthy waits in waiting areas also used by adults. Young people who attend at particularly busy times with identified vulnerabilities, who choose not to wait to be seen are consistently spoken to by a practitioner before they leave the clinic which encourages future engagement with the service. This child-centred practice is ensuring that the sexual health needs of children and young people are being consistently met.

1.15 Leaders cannot be assured that all young people in Bradford requiring support regarding substance misuse issues are being appropriately referred for support to meet their needs. At the time of this review, only 38 young people across Bradford were actively in treatment for substance misuse despite problematic drug and alcohol use being more prevalent in Bradford than nationally. Leaders recognise that more proactive outreach work needs to be undertaken to increase the numbers of referrals into The Bridge young person's substance misuse service to ensure that young people are in receipt of effective and timely early intervention, and that associated risks and vulnerabilities are responded to. *This has been brought to the attention of public health.*

1.16 Children and young people are able to access early help with emerging emotional health difficulties. Joint working between school nurses and primary mental health workers is effective and helping to strengthen the early help offer. A primary mental health worker is attached to each cluster of schools to help improve vigilance of the emotional and mental wellbeing of children and young people and is ensuring that early intervention is accessible to reduce the likelihood of mental health needs escalating.

1.17 At one GP practice we visited, we saw how the practice manager produces a monthly report on all children aged five years and under registered at the practice. A copy of the report is then provided to health visitors to keep them updated of registered children. A copy is also forwarded via secure email to Child health teams in Bradford and Airedale. This helps to strengthen oversight of families who have benefitted from six to eight week checks, and provides a further protective factor where families are mobile or may cross borders and may otherwise miss out on this key post-natal contact.

2. Children in need

2.1 Children and families who present at the ED at BRI have their cultural needs understood and met. Bradford Teaching Hospital's safeguarding leads have identified the importance of supporting staff to recognise and respond appropriately to the diverse cultural needs of the service user population. Staff are supported to engage effectively with families from different communities. There has been effective work carried out to help staff understand the cultural differences and additional needs of Roma and Czech families. Practitioners report that they feel more knowledgeable and better equipped to provide support to vulnerable children and families from these communities.

2.2 Arrangements in ED's at both BRI and AGH to identify and respond to the vulnerabilities of children and young people with learning disabilities and special educational needs and disabilities (SEND) are underdeveloped. Children with additional needs and disabilities are not always 'flagged' on electronic patient record systems in line with the Accessible Information Standard, which may limit clinician's ability to provide holistic and appropriate responses to risk and vulnerability. Appropriate alerts are particularly valuable when treating children who may access clinical areas which are also utilised to treat adults. **(Recommendation 2.5 and 3.2)**

2.3 Opportunities for midwives across Bradford to identify risks present in hazardous and inappropriate home environments are limited. Whilst some home visits are carried out postnatally, the absence of routine home visits during the ante-natal period reduces the opportunity to address any home safety issues and to identify factors that may indicate a risk of neglect prior to birth. **(Recommendation 1.3, 2.6 and 3.3)**

2.4 Opportunities to embed partnership working to co-ordinate care for complex and vulnerable families are being missed. Whilst midwives from AGH do consistently attend GP vulnerable family meetings, midwives from BRI do not routinely due to a lack of capacity. Whilst some midwives can read GP records, others are reliant on the GP responding to a request for information which may result in delays in obtaining important safeguarding information. In records reviewed we could not be assured that information from GP's is being consistently sought, this means midwives may not be aware of any previously identified risks at the time of booking, leading to potentially delayed or missed opportunities to safeguard vulnerable families. **(Recommendation 1.4 and 2.7)**

2.5 Midwives in both acute trusts are not using a CSE screening tool to inform their analysis of risk. The exploration and identification of CSE by midwives is therefore reliant on professional curiosity, and in records reviewed, evidence of exploration of CSE was too variable. The absence of this tool does not facilitate the effective identification of CSE and therefore young women who may have been exploited may not be in receipt of the help and protection that they need to keep them safe from abuse and harm. **(Recommendation 2.8 and 3.4)**

2.6 New arrangements in place mean that practitioners across the health partnership have been advised not to complete CSE screening tools, and if they are concerned that a child or young person is at risk of exploitation, a referral to the MASH should be made. Relevant referrals are then passed onto the CSE hub who complete CSE assessments. However, screening of MASH referrals is not carried out by a health practitioner and there is a risk that key health information which may be indicative of sexual exploitation, for example symptomology of STI's may not be understood, and referrals may not be passed to the CSE hub as appropriate.

2.7 The quality of referrals made to the MASH across the health partnership are too variable, and the lack of a standardised screening tool is likely to further exacerbate the disparity in referral content and quality. **(Recommendation 1.5)**

2.8 Pregnant women with additional needs and vulnerabilities are being appropriately safeguarded by the specialist midwife at Airedale General Hospital. Women with mental health or substance misuse issues benefit from holistic and individualised support provided by the early intervention specialist midwife. In cases reviewed, we saw evidence of the specialist midwife making good quality safeguarding referrals which captured the impact of parental behaviours on the unborn baby and included a robust analysis of risk. Safeguarding reports written by the specialist midwife contained specific, measurable, achievable and realistic actions required to safeguard and protect vulnerable woman and their babies. This means that the most vulnerable families are receiving specialist interventions tailored to their needs.

2.9 However, pregnant women who misuse substances do not receive the input of a specialist substance misuse midwife at BRI. The local area's multi-agency pre-birth assessment protocol recommends professionals assess the impact of the substance misuse on parental capacity to determine if a referral to social care is required. This means that for pregnant women who have substance misuse issues in Bradford, support provided by maternity services is not equitable due to variation in arrangements and availability of specialist support from AFT and BRI.

(Recommendation 2.3)

2.10 Whilst BDCFT informed us that perinatal plans are provided to midwives for every woman that the perinatal mental health team are supporting, we did not see evidence of plans on the records we reviewed. Practitioners we spoke with did not refer to a perinatal mental health pathway or provide any evidence to show the efficacy of this, despite the trust stating that a formalised pathway has been in place since 2015. ***(Recommendation 1.6 and 2.19)***

2.11 Children and young people with the most complex additional needs who attend special schools in Bradford benefit from a strong core offer from the special school nursing team. The nurses attend all safeguarding meetings and jointly conduct home visits with school staff when the child starts school. This means that the most vulnerable children receive coordinated interventions from health, education and social care.

2.12 Whilst there has been a recent revision of systems and processes to ensure that school nursing teams have good oversight of children and young people's attendances at unscheduled care settings, we were told that there is still a considerable backlog of ED notifications that have not yet been uploaded onto the electronic patient record system by the school nursing team. Delays in notifications being uploaded and visible to practitioners lead to incomplete records which hinders effective safeguarding and identification of emerging vulnerability and need. *This has been brought to the attention of public health.* ***(Recommendation 2.10, 3.5 and 4.3)***

2.13 Joint working between CAMHS and adult mental health services has been strengthened to ensure a flexible response to meeting the needs of young people who continue to require specialist mental health support in adulthood. An improved focus on the mental health needs of children and young people 16-25 is evident, including those with suspected personality disorders, with professionals actively sharing their knowledge and skills to help achieve a seamless transition and better outcomes.

2.14 CAMHs are working proactively with multi-agency partners to ensure that children and young people with mental health needs who are particularly vulnerable to risk and exploitation are well safeguarded. In one record reviewed, the CAMH practitioners identified that a young woman was at high risk of CSE. It was noted that she had established a good rapport with her social worker and had voiced that she did not want to engage with mental health services. The CAMH practitioner worked alongside the social worker which facilitated monitoring and oversight of her mental health and risk and ensured that the young woman was supported to help manage her mental health condition.

2.15 Practitioners from the Locala sexual health service are holistically responding to the individual and diverse needs of children and young people who attend the service for support. In records reviewed, practitioners clearly considered the potential safeguarding risk factors posed to vulnerable young people with learning difficulties and mental health concerns, and also had a good awareness of the impact of cultural and diversity issues. This informed and sensitive approach ensures that vulnerable young people with emerging or additional needs are safeguarded effectively.

2.16 Proactive attempts are made to contact and engage children and young people who do not attend scheduled appointments with the Locala sexual health service. In all records reviewed, practitioners made numerous attempts to contact young people via a variety of methods and liaised with the referrer, GP and other involved professionals where appropriate. This means that children and young people are supported to access services to ensure that their sexual health needs are appropriately met.

2.17 Despite the very real link between substance misuse and child sexual exploitation, communication and information sharing between the CSE hub and the young person's substance misuse service "The Bridge" is inconsistent. Information is not always shared directly with the health practitioner. There is an assumption that information shared with the lead social worker will in turn be shared with the health practitioner in the CSE hub. This means that there may be unnecessary delays in pertinent information and intelligence held by the substance misuse services being shared and used to inform the robust analysis of risk and appropriate decision making. *This has been brought to the attention of public health. (Recommendation 1.7 and 6.1)*

2.18 The absence of a formalised transitional pathway between the New Directions adult substance misuse service and The Bridge young person's substance misuse team, means that young people who require ongoing support for substance misuse issues are not benefiting from care continuity. The lack of effective formalised transitional arrangements means that there is an increased propensity for young people to discontinue their engagement with services despite the need for continued intervention and risk management. *This has been brought to the attention of public health. (Recommendation 6.2)*

2.19 The GP's we visited in Bradford are pro-active in ensuring that children who are not brought to appointments are appropriately safeguarded and in receipt of support which meets their health needs. One GP practice that we visited, provides routine six-to-eight-week developmental checks for babies registered with their practice. We heard that if a child is not brought to a health appointment on two or more occasions, the GP liaises with the health visiting team to prompt them to carry out their own enquiries and checks with the family. Furthermore, children who have consistently not been brought to health appointments are flagged and subject to further discussion at vulnerable families' meetings. These meetings ensure that health professionals have good oversight of children and families who may be in need of additional support and intervention.

2.20 GPs recognise the impact that socio-economic factors such as financial deprivation may have on the well-being and safety of vulnerable families and will make onward referrals to multi-agency partners accordingly.

Case Example from GP

In one case reviewed, a young pregnant woman went to see her GP and disclosed that she was in financial distress which was impacting on her mental health. The GP recognised the impact that ill mental health may have on the unborn child and referred the woman to independent counselling services. The GP also promptly liaised with the health visiting team to ensure that additional help and support is provided to address the needs and vulnerabilities of the family.

3. Child protection

3.1 Specialist safeguarding practitioners at BRI paediatric ED are consistently tenacious and diligent in carrying out checks to identify children associated with adults who attend the ED. We saw evidence of additional checks and enquiries being carried to identify associated children and dependants, when patients do not disclose that they have parental responsibility. The effective use of electronic systems is ensuring that otherwise hidden children are being identified and appropriate referrals then made to ensure their safety.

3.2 Children and young people who frequently attend ED are well safeguarded. Individualised risk management plans are in place to protect vulnerable children and young people who have had multiple attendances to the ED at both BRI and AGH. We saw robust identification and exploration of risk in management plans, and the voice and preferences of the child were clearly documented.

3.3 Effective arrangements are in place in both acute trusts to identify and support women and children who are vulnerable to FGM. Where survivors of FGM have been identified, and it has been ascertained that the woman has carer or parental responsibilities, referrals to children's social care are made to ensure that measures to protect children from FGM are in place.

3.4 The Child Protection Information System (CP-IS) is now in place at both AGH and BRI, and is alerting clinicians and staff to children who are looked after or the subject of a child protection plan. The introduction of CP-IS has strengthened clinician's safeguarding work with vulnerable and transient young people who present at unscheduled care settings. Clear alerts ensure that clinicians and staff are aware of the most up to date safeguarding intelligence and information and enables them to tailor their interactions with young people accordingly to ensure that they are well supported and protected.

3.5 In addition to the introduction of CP-IS, there are robust arrangements in place to ensure that all paediatric attendances at both AGH and BRI are screened by specialist health practitioners. Paediatric liaison at AGH, and specialist safeguarding practitioners at BRI, screen attendances daily to ensure that staff assess each attendance appropriately for any safeguarding concerns. Where information is missed, such as an opportunity to make a referral to children's social care, the clinician is provided with additional support and training if required. The scrutiny of attendances ensures that required actions have been carried out in a timely way to safeguard vulnerable children and young people.

3.6 Processes are in place to keep children and young people who exhibit aggressive behaviour whilst attending ED at AGH, safe. The 'Restrictive Physical Intervention and Therapeutic Holding' policy has been specifically designed to support staff when they have to manage sometimes physically aggressive children and young people who are, for example, experiencing mental health distress or drug induced psychosis.

3.7 However, at the time of the review we were told that there was no physical restraint policy or guidance in place at BRI. This means that staff and clinicians that may have to use restraint in order to protect a child or young person from causing injury to themselves or others, may be unclear of how to apply safe and proportionate restraint. Leaders identify that the absence of clear guidance is a gap. **(Recommendation 2.11)**

3.8 Effective systems are in place to share safeguarding referrals completed by midwives from AGH with GP's and HV's. Practitioners can select to 'task' the GP and Health Visitors which alerts them when a referral to children's social care has been made. This means information sharing is completed immediately, and community health partners are well informed of presenting and emerging vulnerabilities and risk.

3.9 Midwives contribution to the safeguarding process is not equitable across Bradford. Whilst midwives from AGH actively participate in the safeguarding process and told us that attending meetings and submitting child protection reports is a priority, midwives from BRI are not consistently attending multiagency meetings or submitting reports to child protection conferences. This means that in too many cases, the midwives unique and valuable knowledge of the family and the health of the unborn baby is not being used effectively to inform safety planning and decision making. **(Recommendation 2.12)**

3.10 Pre-discharge planning meetings for babies who are subject to a child protection plan are not consistently being held before babies are discharged home. We were told that capacity issues prevent social workers from attending meetings. Effective discharge planning between key professionals when there are safeguarding concerns is critical to ensure that there is a child-centred, co-ordinated and robust plan in place to safeguard babies and associated siblings in their home environment. The absence of discharge planning meetings is unsafe. **(Recommendation 1.8)**

3.11 Arrangements to prevent the abduction of babies from hospital are robust in BRI. We saw evidence of an effective, in date baby abduction policy in place, and midwives demonstrated that they had a good understanding of processes to keep babies safe when on the ward. The lay out of the post-natal ward is in the process of being altered to ensure that midwives have greater observation and surveillance of who is entering and leaving the ward which will further safeguard vulnerable babies and new mothers.

3.12 There are effective processes in place to ensure that the most vulnerable and transient families safe. The 'missing from care' pathway has been developed by BDCFT in response to the high number of families which frequently leave and re-enter the UK. When a child has been identified as missing, an alert is placed onto the front page of the child's systmOne electronic patient record. This effectively alerts clinicians who have appropriate access, such as health visitors and GP's. This is effective communication practice.

3.13 The 'Think Family' approach is not sufficiently embedded in the health visiting service, and this means that some health visitors are not considering the risks that may be posed by adults who form part of wider family structures. In records reviewed, whilst health visitors routinely considered the risks and vulnerabilities of the child's mother and female care givers, there was inconsistent recognition of the fact that family structures are dynamic and an insufficient exploration of the risks that may be posed by fathers, non-blood relatives and new partners. Health visitors we spoke with told us that with the introduction of GDPR they should not record information about fathers and other adults associated with the home without gaining consent to do so. We were told that health visitors are encouraged to write in the mother's and child's record details of risk posed to them by any adult, and to detail strategies and actions undertaken to provide support and protection. Therefore inspectors remain concerned that adults who live in, or who have links with the family home and who may pose a risk to children may be overlooked. *This has been brought to the attention of public health.*
(Recommendation 4.4)

3.14 Health visitors are not routinely using chronologies or genograms to facilitate practitioners understanding of complex family compositions. Work with large South Asian, Czech and Roma families where there are multiple adults and children within the family home, would be particularly strengthened by the use of chronologies and genograms, particularly as the health visiting service operates a corporate caseload model, which means that health visitors may not have detailed knowledge and longitudinal oversight of families. Findings from Serious Case Reviews nationally have concluded that chronologies play an important role in facilitating the early identification of risks to children and vulnerable adults. *This has been brought to the attention of public health.* **(Recommendation 4.5)**

3.15 School nurses across Bradford are effectively championing the safety of children and young people. The school nursing team is fully conversant with the local areas safeguarding thresholds, policies and procedures, and we saw in a number of records reviewed, examples of school nurses making effective use of the local professional disagreement and escalation policy when practitioners did not feel that the children's social care had adequately responded to the risks that they had identified. Referrals made by the school nursing team to children's social care were consistently appropriate, contained clear analysis of risk and made explicit requests for action.

3.16 Observations and findings from assessments completed by school nurses are clearly documented in reports that are prepared for child protection conferences. Reports reviewed were of a consistently high standard, and successfully captured the voice, wishes and feelings of the child. Reports provided for both initial and review conferences are being consistently uploaded onto the child's health record which enables practitioners to maintain oversight of risks and progress against agreed actions which need to be undertaken to maintain the child's safety and wellbeing.

3.17 The Locala sexual health service has rigorous arrangements in place to safeguard the children and young people who access support for their sexual health needs. Records reviewed demonstrated good professional curiosity and exploration regarding the adults who accompany children to appointments.

Case example from the Locala Sexual Health Service

A child attended an appointment with an adult who staff felt was behaving inappropriately whilst in the waiting area. This observation prompted staff to identify who the adult was and the relationship they had with the child. It was ascertained that the accompanying adult was a professional who was supporting the child to have their health needs met. Their inappropriate behaviour was immediately flagged to the Local Authority Designated Officer (LADO). The role of the LADO is to support staff across all organisations who work with children and young people if any concerns arise regarding any practitioner's conduct. The LADO ensured that their employer was made aware of the lack of professional boundaries and inappropriate conduct, and ensured that vulnerable children the professional had contact with were safe.

3.18 Effective processes are in place in CAMHs to ensure that children and young people who are engaged with the service are appropriately safeguarded. CAMHS practitioners are consistently invited to child protection conferences and are providing high quality, detailed reports which use the 'signs of safety' model to facilitate the clear articulation of risk. We saw evidence of staff providing clear, detailed reports which help facilitate multi-agency partners to understand how factors relating to mental health and or emotional wellbeing impact on children and young people's levels of risk and vulnerability.

3.19 CAMHs practitioners effectively flag and follow up children and young people who are not brought to scheduled clinic appointments. We saw evidence in records reviewed of practitioners assessing the risk to children and young people who miss appointments. This is an area of good safeguarding practice, as learning from serious case reviews and domestic homicide reviews nationally, demonstrate that non-attendance at health appointments is often a precursor for neglect and serious child abuse.

3.20 Adult Mental Health practitioners were able to demonstrate an awareness of pathways and processes for the identification and reporting of domestic abuse. The safeguarding team provides relevant feedback of the outcome of MARAC discussions which is effectively informing ongoing clinical work and safeguarding activity with families.

3.21 Adult Mental Health practitioners give priority to attend child safeguarding multi agency meetings. The Child Protection plans we reviewed, consistently included information regarding adult relapse indicators and explored the risk that relapse may pose to the child. The sharing of this information is helping multi-agency partners to be aware of the relevant signs and symptoms which may indicate a reduction in parental capacity and increased risk to them or their children

3.22 The quality of record keeping in the Adult Mental Health service is too variable. In some records reviewed, there were significant gaps in documentation and some key documents had not been uploaded onto the patient record or were not easy to find which means that practitioners may not be aware of emerging or escalating risks. Whilst we saw good exploration of risks which may occur as a result of ill mental health in child protection plans reviewed, in some case records seen, there was a lack of wider 'Think Family' review of how identified risks and the patient's behaviours may impact on the wellbeing and safety of other family members. **(Recommendation 4.4 and 4.6)**

Case example from the Adult Mental Health Service

Concerns had been raised regarding a 19 year old male who exhibited threatening behaviour towards his younger siblings and parent. The AMH First Response team carried out a swift assessment which focused on reviewing his medication, however the assessment did not explore the young person's home environment or current familial arrangements. There was also a lack of exploration and consideration of the needs and vulnerabilities of his younger siblings and if they were potentially at risk of harm.

3.23 Children associated with adults who misuse substances in Bradford are not adequately identified and safeguarded by practitioners of the New Directions adult substance misuse service. Leaders were unable to tell us how many clients have parental responsibility or regular access to children, and were not able to track how many of their clients have historical or current involvement with statutory child protection services. Therefore the "Think Family" agenda is not sufficiently embedded in the adult substance misuse service. *This has been brought to the attention of public health.* **(Recommendation 6.3)**

3.24 Practitioners across New Directions adult substance misuse service have good oversight of client's emerging risks and safeguarding concerns. Daily 'flash' meetings are held where clients whose circumstances and presentation has resulted in an escalation of their risk status are discussed. Meetings are minuted and shared across the various sites which means that if clients present at the various bases that are placed across the city, practitioners are well placed to appropriately and proactively respond to risk.

3.25 GPs are proactive in safeguarding vulnerable patients and have mature and well-established relationships with multi-agency and health partners. Partnership working with GP's and some health visiting teams are particularly effective in keeping children safe. One GP practice we visited holds 'Vulnerable Families' meetings every six weeks. Health visitors are contributing to the meeting and are sharing important information regarding vulnerable families including the risks posed by adults in the home where there are children aged 0-5. However, due to capacity, not all health visiting teams are participating in vulnerable families' meetings. School nurses do not contribute to this forum, which means that risks posed to children aged 5 and over may not be so readily identified. *This has been brought to the attention of public health. (Recommendation 4.7)*

4. Looked after children

4.1 There are too many looked after children (LAC) in Bradford who are experiencing lengthy waits to receive medical examinations when they enter care. There has been significant increases in the numbers of children and young people entering care, yet despite this, there has been no increase in the LAC health nursing service to account for the growing numbers of looked after children. We saw evidence of considerable backlog and delay, with some children and young people waiting for up to 6-7 months to receive an initial health assessment (IHA). Statutory guidance requires such medical examinations to be undertaken within twenty eight days of coming into care. Waits are further exacerbated by delays in the LAC health team being notified by the local authority when children enter care. This is resulting in a growing number of looked after children not having their needs, vulnerabilities and health inequalities identified and met at the earliest opportunity. **(Recommendation 1.9)**

4.2 LAC specialist nurse team caseloads have significantly increased over the past 12 months, with average caseloads being consistently higher than levels proposed by current intercollegiate guidance. Therefore, the sustainability of good performance and service delivery may be an area of risk. **(Recommendation 4.10)**

4.3 Children and young people who have had their initial health assessment completed, are not always benefiting from the findings from their assessment being shared in a timely manner with relevant professionals to support holistic, joined up care planning. We saw evidence of IHAs which were completed by paediatricians seven months ago still not being received by the LAC Health team. This restricts the team's ability to ensure all health needs have been identified and responded to appropriately to effectively inform future Review Health Assessments (RHAs) and care planning for these children and young people. **(Recommendation 1.10 and 4.8)**

4.4 Strengths and Difficulties questionnaires (SDQs) and scores do not actively inform looked after children's health assessments and reviews. This means that the LAC specialist nurses are not effectively using such data to inform a holistic review of the needs of each child including analysis of whether their outcomes are improving. This also means that the child's care plan may not be suitably adapted to ensure that their needs are best met. **(Recommendation 4.9)**

4.5 Looked after children in Bradford who require support for emotional and mental health issues benefit from a LAC specialist CAMH team. However, the capacity of the LAC specialist CAMHS team is under significant strain and some young people are waiting over a year for specific therapeutic support. The risk of not being able to respond in a timely way to the current and future mental health needs of children looked after is a significant concern given the high levels of neglect and trauma children have experienced at the point of entering care combined with the impact of further placement moves on their emotional and mental wellbeing. **(Recommendation 1.19 and 4.12)**

LAC Case Example

The Review Health Assessment of a 9 year old boy in a foster placement documented that there were some concerns regarding his emotional health and wellbeing, and that he 'masks his feelings'. There was no inclusion of SDQ information, and therefore the RHA did not provide a clear picture of emerging or escalating risks, or the progress that had been made during the time he had been in care. Gaps in the holistic assessment of the child's emotional and mental health needs resulted due to not making use of the relevant concerns reflected in completed SDQ's.

4.6 Current capacity challenges in the LAC health service has led to some previous partnership activity being placed on hold. This includes the offer of training about the health needs of children looked after to foster carers and residential care staff. Effective training to facilitate the understanding of looked after children's needs can play an important role in improvement and sustainability of placements for children who are in care. **(Recommendation 1.11 and 4.11)**

4.7 The LAC health team has recognised the need to improve oversight of children and young people with the most complex needs. A 'weighting score system' has been introduced to identify the children who are most at risk, and the most high-risk cases are discussed at twice weekly safety huddle meetings. This practice is helping to improve the LAC health team's oversight of those children where concerns regarding their wellbeing and safety are escalating. This system has only recently been introduced and therefore at the time of this review, we were unable to have a clear picture of improvements and impact.

4.8 The voices, wishes, and lived experiences of looked after children were consistently captured and documented in records reviewed. The use of 'signs of safety' is embedded in LAC health review documentation and is helping to provide a balanced, accurate and holistic picture of the child's protective factors and risks.

4.9 Children and young people are benefitting from having their health assessments completed in their homes, or at venues where they feel most comfortable, and are provided with opportunities to be spoken to alone. This child-centred approach promotes and encourages continued engagement with health services.

4.10 The numbers of children in care and care leavers who are pregnant have significantly increased during the last year. The reasons for this increase is not yet clear. It is recognised that potential sources of support for young parents have reduced with the de-commissioning of the Family Nurse Partnership. A task and finish group led by the Council's Department of Public Health (DPH), has been established to improve scrutiny of teenage pregnancy trends and of the effectiveness of preventative approaches. **(Recommendation 1.12)**

4.11 Care leavers are benefitting from effective ongoing support and outreach provided by the 'Through Care' specialist nurses. Weekly drop in clinics are well attended, and enable care leavers to maintain contact with specialist nurses who support young people to manage their ongoing health needs. The drop-in clinics also provide the 'Through Care' specialist nurses with the opportunity to continually monitor the risks and vulnerability of care leavers who are living independently or in supported housing. This service is being continually developed and changes to the service offer are influenced by the feedback of young people and care-leavers. One example of this is the move away from paper based health passports to an app which would facilitate easier access to health records. The app is planned to be in place by July 2019.

Management

This section records our findings about how well led the health services are in relation to safeguarding and looked after children.

5.1 Leadership and management

5.1.1 The three local CCG's Bradford City, Bradford Districts and Airedale, Wharfedale and Craven, work in effective collaboration to safeguard children, young people and vulnerable families living in Bradford and neighbouring districts. The collaborative arrangement means that there is an established shared safeguarding team which works across the three CCG's who provide visible and active leadership across Bradford's health economy.

5.1.2 There is a good culture of learning across the health partnership and we saw evidence of improvements to safeguarding practice and policy being made as a result of serious case reviews and previous inspections. Following the Joint Targeted Area Inspection (JTAI) that was carried out in 2017, and in response to recommendations made in the report, a health practitioner has been placed within the MASH which has helped to secure a health contribution to strategy discussions and decision making.

5.1.3 Whilst having a health representative in the MASH is a positive step in strengthening partnership working, the current practitioner is only part time and therefore has limited capacity and availability. The CCG acknowledge the fragility of current arrangements and have secured funding for an additional health practitioner post to ensure that there is an increase in capacity and to secure continuity of health input.

5.1.4 The role of the health practitioner in the CSE hub is highly effective in identifying risk and co-ordinating multi-agency responses to provide protection for children at risk of CSE, however no additional staffing is provided to cover planned or unplanned absences and to secure continuity of health input. We were not informed of any plans to provide additional staffing and resource, despite hearing that there has been an increase of referrals being made to the CSE hub, and an increase in the volume of complex cases. The lack of screening tools being used across the health partnership may also limit the identification of CSE and the number of cases being appropriately referred to the CSE hub. **(Recommendation 1.13)**

5.1.5 There is an embedded ethos of 'teamwork' across the health economy. Practitioners we spoke with, from senior managers to front line professionals, consistently told us that they felt part of a strong, non-hierarchical team who supported each other to provide a safe environment for children and young people.

5.1.6 The current capacity issues of the LAC health service, which is also being impacted adversely by high rates of staff sickness absence, is also resulting in significant numbers of Review Health Assessments (RHA's) not being completed within statutory timescales. The provider trust, BDCFT, clearly acknowledges the limitations of the current service model, and the capacity issues of the LAC health service are flagged on the trust's risk register. BDCFT, the CCG with the support of the two local acute trusts and other key health partners, are carrying out a review of the LAC health service. However, a clear, agreed recovery plan is yet to be developed, which means that roles, accountabilities and care pathways have yet to be formally agreed and updated to enable best use to be made of available resources. Whilst some actions that have been put in place to mitigate the recognised risk around the capacity to complete health assessments in a timely way, there has not been any sustained improvements in performance.

5.1.7 Bradford Teaching Hospital Foundation Trust have recognised the increased volume of vulnerable children and families that are requiring treatment and support, and recognise the increase in complex safeguarding cases. In response to this, there has been significant additional investment in the safeguarding team, which include two full-time 'specialist practitioners' that are now employed within the BRI Paediatric Emergency and Accident Department (EAD) undertaking roles similar to the previously employed paediatric liaison.

5.1.8 The safeguarding team at BTHFT have worked in effective collaboration with West Yorkshire Police on "Operation Lilac", to develop clinical procedures and protocols which assist the police to be able to use products of conception as evidence for criminal investigations. The established Lilac clinic supports children and young people who decide to terminate and uses a specific proforma for assessing under 18s for safeguarding risks/CSE. Evidence gathered from the termination of pregnancies are now able to be used as forensic evidence to assist with prosecution of offenders. This also avoids the need for victims to attend court, minimising further trauma and distress. There has been national interest in this innovative project, and the BTHFT safeguarding team have recently been nominated to receive an award in the West Yorkshire Policing Awards 2019 in recognition of their work to support Operation Lilac.

5.1.9 Partnership working with the CCG and Bradford Children's Safeguarding Board (BSCB) is effective. BSCB is a multi-agency body which has a strategic role in protecting and children and young people in Bradford. Senior health representation at BSCB is consistent. The Director of Nursing and Quality is the vice- chair of the BSCB, whilst the Designated Nurse and Designated Doctors chair several sub-groups. This strong and consistent health representation is ensuring that the health and wellbeing of Bradford's children and young people remain an integral part of the safeguarding agenda.

5.1.10 The designated nurse for safeguarding children now chairs the Serious Case Review (SCR) subgroup, and we saw examples of how learning from SCRs is being cascaded from a strategic level to inform and improve front line practice. For example, some of the front-line practitioners that we spoke with told us that they had received training to enhance their awareness of the role that social media may play in the grooming and exploitation of children and young people, and that this training had been rolled out following the publication of a recent SCR.

5.1.11 Named and Designated professionals work in a co-ordinated way to agree on shared safeguarding priorities and actions. The effective inter-face between named and designated roles enables Named professionals to support the strategic development of the safeguarding children's agenda across Bradford.

5.1.12 The CCG's safeguarding team have also established relationships and links with designated professionals from neighbouring local authority areas. For example, members from the safeguarding team attend and contribute to Yorkshire and Humber Safeguarding forums for both children and adults, sharing learning with other providers, as appropriate at the relevant forums. Similarly, the Named Nurse network meet regionally bi-annually. This practice, as well as regular meetings between the Bradford safeguarding children team and the Designated Nurses in North Yorkshire, is improving the understanding of cross border issues, such as serious organised crime and criminal exploitation which may impact upon vulnerable children, young people and transient families.

5.1.13 Partnership working with the Local Authority is also effective. There have been notable and numerous changes to Local Authority leadership and staffing over the past 18 months, however the CCG and wider health partners have managed to circumvent any challenges that may result from inconsistencies in staffing. The introduction of the Health and Social Care Meeting, which is attended by leaders from the social care teams, health providers and Designated and Named professionals, has provided an effective forum to discuss collaborative working issues and complex cases which would benefit from a multi-agency response to identified risks.

5.1.14 There are some capacity issues within the Named and Designated professional network. There is currently no Named Doctor for LAC in post, and no professional is carrying out the important quality assurance and performance monitoring responsibilities and functions of the Named Doctor role. The Designated nurse for LAC is also fulfilling the role of designated nurse for safeguarding children. Whilst she has good oversight of the LAC health service, is supported by a deputy, and is an active and visible member of the CCG's safeguarding team, this arrangement is not compliant with the position statement issued by the Royal College of Nursing which stipulates that the Designated Nurse for safeguarding children should be distinct and not be combined with any other Designated Nurse roles or functions. (**Recommendation 1.14**)

5.1.15 There are three named GPs for safeguarding children across Bradford, who work in effective collaboration to drive forward agreed work streams to improve safeguarding practice across primary care. Named GP's have worked closely with Designated professionals to develop a Primary Care self-assessment which will provide the CCG with greater assurances about the safeguarding activities within general practice. GP practices are also being provided with robust safeguarding policies which will result in improved continuity and equitability of care for children and vulnerable families in Bradford.

5.1.16 The CCG's have a real ambition to ensure that primary care services across Bradford are equipped to effectively safeguard children, young people and vulnerable families. GPs in Bradford have access to the "Duty Advice Line" which is provided by Named and Designated Safeguarding Professionals Monday to Friday. This enables GPs and practice staff working with more complex cases to access advice, guidance and support. The Named GPs are planning to complete an audit of the content of the calls made to the Duty Line which will in turn provide some information about emerging themes and areas where GPs might benefit from additional training and professional development.

5.1.17 There have been several recent changes in the commissioning landscape across the health partnership. Changes in commissioning arrangements now mean that children under 13 years old cannot readily access screening for sexual transmitted infections, including those who may require follow up screening after initial treatment via the Sexual Assault Referral Centre (SARC). In one case reviewed, a 12-year-old child attended the GP, who signposted to Locala sexual health service to be screened for STI's. However, Locala were also unable to provide screening. Locala appropriately liaised with the West Yorkshire SARC and relevant paediatricians but neither were able to support with this child, whose sexual health needs remain unmet. Designated professionals identify that this is a considerable gap in health care provision, and that the limitations of current commissioning arrangements pose a significant risk to children and young people who may not have their health needs, risks and vulnerabilities appropriately met. Commissioners have been made aware of these issues and this gap has been flagged on the BSCB's risk register. **(Recommendation 1.15)**

5.1.18 A strong shared ambition to improve the health, wellbeing and life chances of children and young people living in Bradford is driving forward work to transform emotional and mental health services. New care models are emerging that are helping to improve the local areas crisis response and to avoid unnecessary inpatient admissions. These improvements to service delivery have been informed by a recent review which demonstrated that some admissions to in-patient facilities could have been avoided through expanding the contribution of community teams.

5.1.19 The Child Death Overview Panel Annual Report 2017-18 clearly states that children from South Asian Communities are over-represented in child death statistics, and that consanguinity is causal factor in a number of child deaths. Consanguinity occurs when children are born to parents who have common ancestors and have an increased propensity of inheriting genetic conditions or being born with congenital defects. Whilst work is being undertaken by the local area to address actions and lessons learnt highlighted in the report, for example there has been focus on promoting the risks of co-sleeping, work to reduce deaths from consanguinity is weak in Bradford, and we have not been made aware of any work or campaigns to address this topic. **(Recommendation 1.16)**

5.2 Governance

5.2.1 The BCSB is making good progress to transition to the new partnership arrangements as required by amendments to the Children and Social Work Act 2007 and Working Together 2018. An options paper has been sent to primary partners and the new model of working has been agreed to ensure that approaches to safeguarding are consistent and effective both during and post the transitional period.

5.2.2 CP-IS has been launched in ED's at both Bradford Royal Infirmary and Airedale General Hospital. The launch of this system is enabling practitioners and clinicians working in the acute trusts to identify and respond to risks with more accuracy and consistency. Senior leaders in both the acute trusts have welcomed the implementation of this system, however have identified that systems and processes need to be in place for those children and young people with emerging risks and vulnerabilities, and as we have mentioned earlier in this report, have ensured that there are robust arrangements to screen all paediatric attendances at unscheduled care settings.

5.2.3 The reduction in multiple and fragmented record keeping systems and a move towards the shared use of SystmOne across the majority of the health partnership, has improved the timeliness of information sharing and enables practitioners to have access to children and young people's full health history. The ability to access other health records is effectively informing ongoing case management. However, whilst the introduction of a shared electronic patient record system is positive, some practitioners that we spoke with in CAMHS, adult mental health and the BDCFT health visiting service, told us that they find the system difficult to navigate and would benefit from additional training to enable them to use the system to best effect. The current SystmOne implementation plan does not provide a sufficiently strong focus on workforce development needs. **(Recommendation 1.17)**

5.2.4 Named safeguarding leadership in BDCFT is strong with good joint working with designated professionals to ensure the required standards of safeguarding practice are met. Results from audits that have been undertaken to ensure that appropriate referrals to children's services are being made and tracking outcomes in accordance with local safeguarding standards have been shared with the Trust's safeguarding team to enhance quality assurance at a strategic level and help to identify emerging trends in need.

5.2.5 There is also effective use of audit by two local acute trusts AFT and BTHFT. Continual cycles of audit which are providing the CCG with greater assurances regarding the effectiveness of frontline safeguarding practice. Audits are also effectively facilitating the identification of areas for development, gaps in service provision and areas of innovative and good practice.

5.2.6 All health partners across the health economy are involved in regular cross health audits. This is enabling partners to share learning and best practice and develop pan-Bradford policies such as the cross health best practice child not bought policy. Cross health audits and shared learning between health partners are helping to ensure that practitioners are responding consistently and equitably to children and young people who are in need of help and protection.

5.2.7 The ED at AGH are in the process of transitioning to a fully electronic record system. Paper CAS (casualty) cards are still being used until the transition is fully complete. Some of the CAS cards that we reviewed were not always completed in full, and clinicians were over-reliant on the information held on the electronic patient record systems. We were therefore not assured that important questions are being consistently asked to capture changes in family demographics and circumstances which may indicate increases in risk, for example where significant adults enter into new relationships. **(Recommendation 3.6)**

5.2.8 Whilst there are systems in place which enables the named safeguarding midwife for AFT to have oversight of all the referrals that have been made to social care and to track outcomes of referrals, there is insufficient focus on the quality of the referrals made. The quality of the referrals which we reviewed, were too variable. For example, in one tracked case, we saw a referral to social care which did not adequately articulate risk, and there was inadequate consideration of the potential impact that identified risks may have on the unborn. Social care made the decision to not carry out an assessment during the antenatal period on the basis of the information provided. The child was later referred to social care following concerns regarding neglect. This highlights that poor quality referrals may lead to missed opportunities to protect and safeguard families at the earliest opportunity. **(Recommendation 3.7)**

5.2.9 The quality of safeguarding referrals made by midwives at BRI are also too variable. Some records reviewed were incomplete as they did not contain a copy of the safeguarding referral that had been made to social care. In one record reviewed the quality of the referral indicated a lack of understanding of the impact of domestic abuse on children. Midwives did not routinely state what action they wanted from the referral, and there is no quality assurance process in place to enable the Named Midwife for BTH to review, and therefore improve, the quality of referrals. A lack of clarity when referring to children's social care increases the likelihood of the receiving social worker not fully comprehending the risk to the family.

(Recommendation 2.13)

5.2.10 Leaders of the BDCFT health visiting service have recognised the impact on quality caused by the increasing pressure on their service. In the last month leaders have developed an audit tool to dip sample records to check for quality. The tool will identify any areas of practice which require development and practitioners will be supported to improve their practice. Leaders state this tool will be used to identify and address issues and gaps in effective safeguarding practice. However, at the time of this review it is too early to assess the impact and findings of this audit.

5.2.11 Frontline adult mental health professionals make effective use of the BDCFT's safeguarding team in accessing advice and guidance about the management of safeguarding risks. The BDCFT safeguarding team are consistently informed when a referral is made to children's social care by adult mental health practitioners. This is enabling BDCFT safeguarding team to actively monitor emerging trends issues.

5.2.12 Locala sexual health service make good use of data and audit to drive improvements within the service. A number of audits have been undertaken over the last year in conjunction with a rolling programme of development and re-audit to confirm improvements have taken place. Specific focus on under 18's and SARC referrals has led to changes which have improved service engagement with children and young people under 18.

5.2.13 Practitioners in the Locala sexual health service told us that the ability to access information on GP records has been adversely affected since the introduction of GDPR. Efforts have been made by Locala to contact GPs to reinstate access to primary care records which has had some success, however there are still practices which do not share information and this impacts on the services ability to consider all relevant information and health history which is required to ensure that responses to risk are sufficiently effective and robust. **(Recommendation 1.18 and 5.1)**

5.2.14 The designated safeguarding lead of the New Directions adult substance misuse service, provided by CGL, has effective oversight of safeguarding activity. The designated safeguarded lead carries out regular quality assurance of referrals made to the MASH and reports submitted to child protection conferences. All referrals are signed off by the safeguarding lead or member of the leadership team prior to their submission. This ensures that the quality and standard of safeguarding referrals are consistent, and that practitioners are provided with feedback which provides opportunities for them to continuously improve their safeguarding practice.

5.3 Training and supervision

5.3.1 Both of the local acute trusts recognise the importance of training and continual professional development to ensure that clinicians and staff have the knowledge, confidence and skills to effectively identify, and support those children and young people in need of help and protection. Despite increasing demand on capacity, leaders of both the acute trusts ensure that there is protected time for staff to attend and input into training events, such as the recent 'Safeguarding Week', a multi-agency safeguarding awareness raising event which was organised by BCSB.

5.3.2 The named nurse for safeguarding children has recently been supported by AFT to complete a Master's degree in advanced safeguarding children. Practitioners from BTHFT have also been supported to complete Master's degrees. We saw evidence of how learning has informed improvements in front line practice and local policy. The fact that both AFT and BTHFT are investing in clinician's continual professional development demonstrates a real investment and commitment to the safeguarding children's agenda.

5.3.3 The health practitioner from BDCFT who sits in the CSE hub has provided training to staff across the health partnership to support them with understanding what appropriate language and terminology they should use when discussing or documenting the experiences of children and young people who may be at risk of CSE. This is helping professionals to avoid using victim blaming language which may minimise and normalise the child's lived experience and may result in agencies not responding in a way that is appropriate to children's risks and needs.

5.3.4 Clinicians in the ED at AGH and BRI benefit from regular peer group safeguarding supervisions. Clinicians are asked to bring examples to the meeting where they have identified safeguarding concerns. This reflective practice, which is provided in addition to clinical supervision, is helping to improve clinicians' ability to recognise and appropriately respond to safeguarding concerns in their day-to-day interactions with children and young people. Leaders maintain a database to enable them to identify staff who have not attended supervision sessions which ensures that all clinicians and staff on the unit are in receipt of supervision and support.

5.3.5 Leaders at BTH have a good understanding of the demography and complexity of the service user and patient population, and level three safeguarding children training at BTH is tailored to include local issues that might impact on Bradford's children and young people. This means that staff are well placed and qualified to provide proportionate, effective care and support to children and young people that they care for. However, at the time of this review, ED level three training figures were at 63%, which is significantly less than the Trust target of 85%. WE heard that plans are in place to address this and we were assured that BTH will ensure that 85% of ED staff will be trained to level three safeguarding children by May 2019.

5.3.6 The named midwife, named nurse and specialist practitioners for BTHFT has accessed peer supervision and additional learning via a regional network of named and safeguarding professionals. This ensures that the practitioners receive professional challenge and the opportunity to continually improve safeguarding practice. Attendance at the regional network is also enhancing knowledge of cross border issues which may impact on the local population.

5.3.7 The systems in place that record level 3 safeguarding training received by midwives at both BRI and AGH are not sophisticated enough to assure us that staff have received training that is compliant with intercollegiate guidelines. Leaders were able to tell us the percentage of midwives that have completed level three training, but were unable to ascertain if the training received was single or multi-agency. Furthermore, leaders could not provide assurances that staff have followed local areas recommendations to complete training on specific substances such as domestic abuse. **(Recommendation 2.14 and 3.8)**

5.3.8 Whilst six midwives at AGH have recently completed training to become safeguarding supervisors, safeguarding supervision is yet to be fully embedded. It is heard that only a small percentage of maternity staff from the hospital and the community have received group supervision. This means that there are missed opportunities for reflective practice and scrutiny of safeguarding work. **(Recommendation 3.9)**

5.3.9 There is a culture of wanting to improve safeguarding practice amongst health visitors in BDCFT, and the trust has been actively addressing its performance in relation to the coverage of safeguarding training in response to previous CQC inspections. Staff attend a daily safety huddle where safeguarding issues are discussed. Staff spoke positively about the safeguarding newsletter where recent learning is shared. It is mandatory for staff to attend 4 monthly group supervision sessions, which are documented in the client's record. Staff report they have instant access to one to one supervision on specific cases whenever it is required.

5.3.10 Leaders of the BDCFT health visiting service told us that health visitors are 85.7% compliant with the number of hours of level 3 safeguarding training they have attended, however were unable to assure us that staff are compliant with the full intercollegiate safeguarding training guidelines as the data recorded does not capture if the training was multi or single agency. This means that leaders do not have effective oversight of gaps in health visitor's knowledge around pertinent safeguarding issues. *This has been brought to the attention of public health.* **(Recommendation 4.13)**

5.3.11 CAMHs practitioners have good access to relevant training, safeguarding and clinical supervision. Managers are proactive in enabling them to continuously build their specialist knowledge and expertise to benefit individual children and strengthen their contributions to multi-agency working.

5.3.12 GPs across Bradford are receiving regular safeguarding training and awareness sessions which are delivered by the CCG's safeguarding team and named GPs. All of the 79 GP practices across the city have a safeguarding children's lead, and all of these leads are frequently attending training sessions and disseminating their learning and safeguarding updates to other GPs in their practices. This is ensuring that primary care practitioners are aware of changes across the wider health partnership.

5.3.13 Children and young people benefit from an appropriately trained workforce at Locala sexual health service. Practitioner's staff records have been audited to evidence continuous professional development in a range of bespoke topics with action plans and re-audits in place to ensure that all competencies are met. The service has also contributed their expert knowledge to the local safeguarding week delivering training to other professionals to upskill the professionals network across Bradford.

5.3.14 Professionals in Locala sexual health service benefit from good safeguarding support via ad-hoc advice, peer review, safeguarding supervision, in addition to monthly well attended MDT meetings. Cases of concern are reviewed with a clear, documented discussion of the presenting risk factors and any additional actions which may need to be undertaken. This additional layer of oversight ensures that practitioners feel well supported in their safeguarding practice and that all appropriate actions are taken to keep children and young people safe.

Recommendations

1. **Bradford City CCG, Bradford Districts CCG and Airedale Wharfedale and Craven CCG should:**
 - 1.1 Work closely with public health to address capacity issues within the health visiting service to ensure that all families across Bradford are in receipt of support in line with Healthy Child Partnership targets for ante-natal care, and ensure women are consistently screened for maternal mood and provided with appropriate support when perinatal mental health issues have been identified.
 - 1.2 Work collaboratively with public health and local authority partners to identify appropriate arrangements to ensure that school age children from all communities are in receipt of important health promotion messages and support from the school nursing team to address health inequalities and needs.
 - 1.3 Support both AFT and BTHFT to review and strengthen current arrangements in midwifery to ensure that home visits are routinely carried out by community midwives to inform early identification of the hazards and risks that may be present in the home environment.
 - 1.4 Ensure that robust processes are in place to help embed partnership working and improve timely information sharing between midwifery teams at BRI and GPs to deliver co-ordinated care for complex and vulnerable families.
 - 1.5 Work with health providers to improve the quality and consistency of referrals made to the MASH and consider the use of a standardised CSE screening tool to help reduce variability in the assessment of risk.
 - 1.6 Continue work to implement a clear peri-natal mental health pathway to ensure that women with peri-natal mental health needs have timely access to the specialist help they need.
 - 1.7 Work with health partners and public health to strengthen relationships and improve integrated working with substance misuse teams, and ensure that information held by substance misuse teams is shared in a timely way to underpin decision making.
 - 1.8 Work in collaboration with Local Authority partners to review current arrangements for discharge planning and provide assurances that current processes effectively safeguard babies and vulnerable families.

- 1.9 Continue with the current review of the LAC health service and urgently address capacity shortfalls of the LAC health provision to reduce lengthy waits for IHA's and RHA's.
- 1.10 Ensure that paediatricians promptly share the outcomes of IHA's with the LAC health nursing team to underpin future review health assessments and to strengthen effective and holistic care planning.
- 1.11 Work with local authority partners to enable the BDCFT LAC Health service to offer training to foster carers and residential staff to help build their knowledge and expertise in meeting the specific health needs of children they care for.
- 1.12 Continue work to understand the recent prevalence of teenage pregnancy locally, including care leavers, and provide further assurances that young pregnant women and their partners are accessing support that meets their needs.
- 1.13 Review the current capacity of the health practitioner in the CSE hub and consider ways that continuity of health input can be achieved when the CSE practitioner is absent.
- 1.14 Review the capacity of the current designated and named professional network and address any gaps in strategic capacity to ensure the sustainability of local arrangements and to drive forward and implement improvements and transformations.
- 1.15 Continue working with key partners to develop arrangements to ensure that under 13's who require STI testing are able to access provision without delay.
- 1.16 Consider developing a cross health response to help reduce child deaths and the incidence of young people with complex health conditions.
- 1.17 Review and respond to the workforce development needs of the health partnership to ensure that practitioners are making best use of shared electronic health system (SystemOne).
- 1.18 Work to mitigate issues with information sharing between some GP practices and the Locala sexual health service which have arisen since GDPR and ensure timely and appropriate sharing of information.
- 1.19 Ensure that clear pathways and systems are in place to meet the emotional and mental health needs of looked after children and that this particularly vulnerable and disadvantaged cohort are able to access services with minimal delay.

2. Bradford Teaching Hospitals NHS Foundation Trusts should:

- 2.1 Appoint clinicians and staff with adequate paediatric skills and competencies which would enable paediatric areas to be utilised 24/7 at Bradford Royal Infirmary.
- 2.2 Provide adult ED clinicians with an effective screening tool to facilitate the identification of vulnerabilities, needs and safeguarding risks of children and adolescents.
- 2.3 Provide midwives with screening tools or prompts to encourage routine enquiry into parental mental health and substance misusing behaviours and to ensure that midwives are providing consistent and equitable support to women and families where substance misuse issues have been identified.
- 2.4 Ensure that hospital and community midwives are routinely sharing information and safeguarding concerns with the BDCFT health visiting team to enable them to support families with needs, vulnerabilities and risk.
- 2.5 Strengthen arrangements in the ED at BRI to identify and respond to the vulnerabilities of children and young people with learning disabilities and special educational needs and disabilities.
- 2.6 Review current arrangements in midwifery to ensure that community midwives are routinely carrying home visits to improve the identification of hazards and risks in the home environment.
- 2.7 Ensure that midwives are consistently sharing information with GPs and provide information to vulnerable families' meetings as appropriate to ensure vulnerable and complex families benefit from co-ordinated care.
- 2.8 Ensure that there is governance assurance within their organisation that screening for CSE is embedded in practice.
- 2.9 Improve arrangements to ensure that leaders have effective and improved oversight of women who are accessing support from the perinatal mental health team.
- 2.10 Ensure that systems are in place to notify community health teams of all children and young people's attendance at unscheduled care settings without delay.
- 2.11 Consider the implementation of clear policies and processes to ensure that staff are supported and skilled to safely restrain children and young people in ED who may be injurious to themselves or others when in distress.
- 2.12 Ensure that midwives are regularly contributing to the safeguarding process by consistently attending child protection conference and submitted good quality reports to facilitate decision making and robust safety planning.
- 2.13 Improve the quality assurance of referrals made to social care to ensure that midwives' analysis and explanation of risk is sufficient.

- 2.14 Improve the way that training for midwives is recorded on systems to provide greater assurances that training provided is compliant with intercollegiate guidance.

3. Airedale NHS Foundation Trust should:

- 3.1 Ensure that hospital and community midwives maintain effective records. Detail of interactions and observations of families should be clearly and consistently documented to facilitate the identification of need, vulnerability and risk.
- 3.2 Strengthen arrangements in the ED at AGH to identify and respond to the vulnerabilities of children and young people with learning disabilities and special educational needs and disabilities.
- 3.3 Review current arrangements in midwifery to ensure that community midwives are routinely carrying home visits to improve the identification of hazards and risks in the home environment.
- 3.4 Ensure that there is governance assurance within their organisation that screening for CSE is embedded in practice.
- 3.5 Ensure that systems are in place to notify community health teams of all children and young people's attendance at unscheduled care settings without delay.
- 3.6 Ensure that demographic information and changes in circumstances which may indicate escalation in risk is captured consistently.
- 3.7 Improve the quality assurance of referrals made to social care to ensure that midwives' analysis and explanation of risk is sufficient.
- 3.8 Improve the way that training for midwives is recorded on systems to provide greater assurances that training provided is compliant with intercollegiate guidance.
- 3.9 Increase the percentage of midwives who access safeguarding supervision from trained safeguarding supervisors to provide further scrutiny of complex safeguarding cases.

4. Bradford District Care NHS Foundation Trust should:

- 4.1 Ensure that effective processes are in place to effectively and consistently screen women for maternal mood and that appropriate action is taken when perinatal mental health concerns have been identified.

- 4.2 Work with public health and the CCG to identify appropriate arrangements to ensure that all school age children are in receipt of important health promotion messages and support from the school nursing team to address health inequalities and needs.
- 4.3 Ensure that effective processes are in place to ensure that ED notifications are uploaded onto the electronic patient record system without delay to enable practitioners to identify emerging vulnerabilities and needs.
- 4.4 Further embed the Think Family agenda and consider the risks potentially posed by paternal figures and adults that form part of the wider family network.
- 4.5 Consider the use of chronologies and genograms to support practitioners working with particularly complex and dynamic family structures.
- 4.6 Improve processes to ensure that all relevant documents are uploaded to the electronic patient record system without delay to improve oversight of emerging risks and vulnerabilities.
- 4.7 Strengthen current partnership arrangements to ensure that school nursing teams are able to contribute to health partnership meetings to improve the identification of vulnerabilities and needs of children aged 5 and above.
- 4.8 Improve oversight of the receipt of IHA's that have been completed by paediatricians and a process of following up IHA's to reduce drift and delay.
- 4.9 Ensure that information from SDQ's are consistently and effectively utilised to ensure that practitioners have a comprehensive picture all looked after children and effective oversight of their emotional and mental wellbeing.
- 4.10 Maintain robust quality assurance of practitioner's case work to monitor dips in performance which may result due to enduring capacity shortfalls within the LAC health nursing team.
- 4.11 Re-evaluate the importance of providing training and support to foster carers and residential staff to increase the sustainability and permanence of placements.
- 4.12 Work closely with the CCG's to ensure that clear pathways and systems are in place to meet the emotional and mental health needs of looked after children and that this particularly vulnerable and disadvantaged cohort are able to access services with minimal delay.
- 4.13 Improve the way that training attended by health visitors is recorded on systems to provide greater assurances that training provided is compliant with intercollegiate guidance.

5. Locala should:

- 5.1 Ensure that systems are in place to communicate effectively with GPs where information sharing via shared electronic systems is currently prohibited as a result of GDPR and ensure timely and appropriate sharing of information.

6. Change Grow Live should:

- 6.1 Work proactively and collaboratively with health partners to ensure that pertinent information is shared in a timely way to underpin effective decision making and safety planning.
- 6.2 Develop and agree a transitional pathway with the young person's substance misuse team to improve care continuity for young people who require support for substance misuse post 18.
- 6.3 Improve arrangements to ensure that children of adults who are accessing treatment for substances are identified and that risks to children are regularly considered and reviewed.

Next steps

An action plan addressing the recommendations above is required from the CCGs within **20 working days** of receipt of this report.

Please submit your action plan to CQC through childrens-services-inspection@cqc.org.uk The plan will be considered by the inspection team and progress will be followed up through CQC's regional compliance team.