

Dorset

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

Inspection dates: 22 February 2016 to 17 March 2016

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Children's services in Dorset require improvement to be good		
1. Children who need help and protection		Requires improvement
2. Children looked after and achieving permanence		Requires improvement
	2.1 Adoption performance	Good
	2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance		Requires improvement

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

The director of children's services and her senior team provide strong leadership. They know which areas of the service need to be better and are taking steps to improve these. However, many of the improvement measures they have planned are not yet in place or have been too recently implemented to have made a sustained difference. Consequently, children and young people in Dorset do not receive a consistently good enough service. Referrals about children's welfare are not always dealt with quickly or well enough. Such drift and delay generally stem from poor management oversight and decision making at this important early point of involvement with children and their families.

On appointment two years ago, the director inherited a staffing structure in which social work team managers had just been replaced with practice managers. As individuals, many are capable managers but, as a whole, they lack the depth of experience of more established team managers. Plans are in place to strengthen first-line management later in the year. In the interim, the director has added extra management capacity to one of the busiest area offices. While inspectors found no children left at immediate risk of significant harm, this lack of consistency means that some wait longer than they should to see a social worker, to have their needs assessed and to receive services. However, most referrals are dealt with effectively and the work of the Multi-Agency Information Sharing Team (MAIST), which handles police and domestic abuse referrals, is strong.

Most social workers know the children they are working with well, but this is not always reflected in assessments. Some assessments are good, but many lack a strong enough sense of children's wishes and feelings or a clear analysis of the issues affecting children. This means that plans arising from these assessments do not always make the difference they could, because they are often vague about what needs to change, who is going to do what, by when and how progress will be measured. This is true for child in need and child protection plans, care plans, personal education plans and care leavers' pathway plans. Specialist assessments for children at risk of sexual exploitation or living in homes where there is domestic abuse are not completed often enough. For some children, this limits social workers' ability to understand risk and to plan to reduce it. Steps have been taken to improve work with children who are at risk of sexual exploitation or from going missing, but this work remains weak. In particular, children do not always receive 'return home interviews'. When these do take place, learning from them is not used well to support planning for individual children, nor is it analysed to identify themes that could inform prevention work and service development. Work to identify and assess the welfare of privately fostered children is poor and requires significant improvement.

The number of children looked after by Dorset council has risen significantly over the past 12 months. This rise stems from a sharper focus on identifying those children and young people whose welfare can only be secured by becoming looked after. Although some children looked after experienced delay at the point they entered care, the large majority of recent decisions to take children into care are timely, and care proceedings are completed quickly. Most children benefit from stable placements. The local authority does well at placing children with extended family members and at placing brothers and sisters together. The virtual school makes good use of the pupil premium, but attainment and progress of children looked after at key stages 1, 2 and 4 is low in comparison to national rates, and fixed-term exclusions are high. The number of children looked after who receive a conviction, final warning or reprimand is high.

Permanence planning is stronger for younger children, particularly those for whom adoption is the best option, but lacks rigour and pace for older children. Early consideration is given as to whether adoption is in a child's best interests. When it is, swift action is taken to secure the necessary legal status and a good match. However, the quality of life story work could be improved. Social workers and personal advisers provide strong, responsive support to care leavers, but longer term planning is weaker. A high number of care leavers are not in education, employment or training. They do not always receive information about their health histories or their rights and entitlements.

Children's and young people's engagement in the Children in Care Council, Dorset Kidz, is limited and is not sufficiently representative of all children looked after. Although some young people have been very effectively involved in the local authority's commissioning of services, opportunities to contribute to service development through the corporate parenting board are limited. Advocacy is not used enough to help involve children in their looked after reviews or, particularly, in their child protection conferences. Scrutiny arrangements provide insufficient challenge. Additional funding has been provided to strengthen scrutiny by independent reviewing officers and chairs of child protection case conferences and there are plans to improve member scrutiny, but these measures are yet to have an impact. The analysis of complaints, and thus the processes for using learning that arises from these to improve practice, is also weak.

While there are examples of good multi-agency coordination in the commissioning of services, such as Dorset Families Matter or the newly commissioned child and adolescent mental health services (CAMHS) transformation programme, strategic planning and commissioning across agencies are not strong. They are not driven by a shared, multi-agency set of priorities and plan against which services can be commissioned and progress measured. This has a particular impact on early help, which is underdeveloped. Some services, such the local authority early intervention

teams, are strong but, overall, services are poorly coordinated and most are not of this standard. The local authority's Forward Together for Children vision has a focus on early help and prevention, but the lack of a mature, multi-agency plan limits agencies' abilities to provide a cohesive early help offer and to maximise the difference they make for children.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates three children's homes. One was judged to be good and one was outstanding at their most recent Ofsted inspections.
- The previous inspection of the local authority's arrangements for the protection of children was in September 2011. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in September 2011. The local authority was judged to be good.

Local leadership

- The director of children's services has been in post since January 2014.
- The chair of the LSCB has been in post since December 2015.
- The LSCB is not shared, but there are shared sub-groups and other working arrangements with Bournemouth and Poole LSCB.

Children living in this area

- Approximately 77,000 children and young people under the age of 18 years live in Dorset. This is 18.5% of the total population in the area.
- Approximately 11.7% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
 - in primary schools is 12.5% (the national level is 15.6%)
 - in secondary schools is 9.9% (the national level is 13.9%).
- Children and young people from minority ethnic groups account for 3.8% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are mixed White and Asian and mixed White and Black Caribbean.
- The proportion of children and young people with English as an additional language:
 - in primary schools is 3% (the national average is 19.4%).
 - in secondary schools is 2.4% (the national average is 15%).

² The local authority was given the opportunity to review this section of the report and has updated it with local, unvalidated data where this was available.

Child protection in this area

- At 31 January 2016, 2,439 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 2,687 at 31 March 2015.
- At 31 January 2016, 406 children and young people were the subject of a child protection plan. This is an increase from 372 at 31 March 2015.
- At 31 March 2015, 12 children lived in a privately arranged fostering placement. This is an increase from seven at 31 March 2014.
- Since the last inspection, seven serious incident notifications have been submitted to Ofsted and six serious case reviews have been completed or were ongoing at the time of the inspection.

Children looked after in this area

- At 31 January 2016, 466 children were being looked after by the local authority (a rate of 60.5 per 10,000 children). This is an increase from 385 (50 per 10,000 children) at 31 March 2015. Of this number:
 - 121 lived outside the local authority area
 - 22 lived in residential children's homes, of whom nine lived outside the authority area
 - 5 lived in residential special schools³, none of whom lived outside the authority area
 - 336 lived with foster families, of whom 57 lived outside the authority area
 - 16 lived with parents, of whom one lived outside the authority area
 - no children were unaccompanied asylum-seeking children.
- In the last 12 months:
 - there have been 16 adoptions
 - 21 children became the subject of special guardianship orders
 - 181 children ceased to be looked after, of whom 11 subsequently returned to be looked after

³ These are residential special schools that look after children for 295 days or less per year.

- 326 children and young people ceased to be looked after and moved on to independent living
- 6 children and young people ceased to be looked after and are now living in houses of in multiple occupation.

Recommendations

1. Prioritise the implementation of measures to strengthen management oversight and decision making, to ensure that when children are referred to children's services they are seen, their circumstances are assessed and services that match their needs are provided in a consistently prompt and effective manner.
2. Improve the quality of analysis and the focus on children's and young people's wishes in assessments, so that the plans they give rise to are more sharply focused on their needs.
3. Improve how plans are used to achieve better outcomes for children by making sure that they are clear about what needs to be achieved, who will complete what actions, in what timescale and how progress will be measured.
4. Complete the implementation of plans to improve the scrutiny and challenge of child protection and care plans by the independent conference and review service.
5. Ensure that specialist risk assessments are completed when this is relevant and will support better understanding of children's and young people's circumstances, particularly those for children at risk of child sexual exploitation or living in homes where there is domestic abuse.
6. Take action to ensure that all children living in private fostering arrangements are identified and receive a timely and thorough assessment of their needs.
7. Improve the use of 'return interviews' for children who have been missing from home or care, to protect them better individually and through the identification of any patterns or themes that can inform prevention work and service development, particularly when these relate to child sexual exploitation.
8. Help children and young people to be more actively involved in their child protection case conferences and looked after reviews through strengthening the use of advocacy.

9. Take action to reduce the high number of short-term exclusions of children looked after, particularly those in Years 9, 10 and 11.
10. Broaden the range of children and young people who are able to participate in the Children in Care Council, Dorset Kidz, and improve consultation and participation, so that their views are better reflected and used to influence service development.
11. Commission a review of the children looked after who are involved in the criminal justice system, to understand the issues resulting in the high percentage receiving formal interventions and develop a strategy to reduce this.
12. Make sure that care leavers are provided with clear and accessible information about their health history and their rights and entitlements.
13. Develop a full range of opportunities for work experience, traineeships and apprenticeships for care leavers, to increase the number who are in employment, education or training.
14. Strengthen the quality of permanence planning for children who do not have a plan of adoption and for older children and young people.
15. Improve the quality and timeliness of life story work, life story books and later life letters, ensuring that they are completed by suitably skilled practitioners.
16. Improve the coordination and impact of both early help and safeguarding services for children by working with partner agencies to ensure that there are shared priorities and plans against which services can be commissioned and progress measured.
17. Conduct an analysis of the increased number of complaints to identify the common themes and, additionally, strengthen the processes for disseminating learning from complaints to improve practice.
18. Help drive service improvement by strengthening oversight and challenge of children's services by the local authority's scrutiny function and corporate parenting panel.

Summary for children and young people

- Children's services in Dorset provide help that makes things better for most children. A few wait longer than they should to see a social worker and to get the help they need. The council know that this is not good enough. They are working hard to make it better, but still have a lot to do for all services to be good as they should be.
- Almost all social workers know the children they are working with well. Social workers have a good idea of children's wishes and feelings and can explain what help they need. These are not always written down clearly in assessments or plans. This means that children and families, social workers and other people involved, like teachers, are sometimes muddled about what is expected of them.
- When children are found after they have been missing from their families or from care, they do not always get to sit down with someone to explain why they went missing or anything that is worrying them. Although the council is getting better at doing this, information from these interviews is not always used to make sure children get the help they need and make it less likely that they will go missing again.
- Social workers do not always complete specialist assessments to help them understand the risk to children and young people living in homes where there is domestic violence between parents, or when they might be at risk of sexual exploitation. Inspectors told the council that it needs to work harder at keeping these children and young people safe.
- Children and young people only come into care when they really need to. When this does need to happen, social workers make sure that it happens quickly, which helps to keep children safe. They support children in care by finding them foster homes where they can feel settled, sometimes with people like aunts, uncles or grandparents. Brothers and sisters are placed together whenever possible.
- When adoption is the best plan for children, social workers work very hard to find the best families for them. Adopters told inspectors that they felt the local authority did a good job of making sure they were properly prepared to look after a child and that they were the right family.
- Social workers need to do better at making plans for the future of older children and young children who are not going to be adopted. They also need to do better at helping children and young people do well at school and make sure care leavers have good opportunities to find a job, training or to stay in education.

- Managers and councillors have asked the young people involved in the Children in Care Council, Dorset Kidz, what their views are about how to improve services. However, they need to make it easier for a larger group of young people to be involved to share their views and they need to do better at listening to what young people say.

The experiences and progress of children who need help and protection	Requires improvement
<p>Summary</p> <p>The local authority does not deal consistently quickly or well enough with all the referrals it receives about children’s and young people’s welfare. While inspectors found no children or young people were left at immediate risk of significant harm, this lack of consistency means that they wait longer than they should to see a social worker, to have their needs assessed and to receive services. Drift and delay in such cases generally stemmed from poor management oversight and decision making. Measures to strengthen management oversight are either not yet in place or too recent to have had a significant impact. Despite this, most referrals are dealt with effectively, and the work of the Multi-Agency Information Sharing Team, which deals with referrals from the police and those relating to domestic abuse, is strong.</p> <p>While some early help services, such as Dorset Families Matter, are strong, overall, the local authority and partner agencies are not working well enough together to provide a cohesive early help offer. The common assessment framework (CAF) is not used well. Most CAFs are not clear about what needs to change, by when or how this will be achieved. A lack of clarity around private fostering arrangements results in a poor service to this small but vulnerable group.</p> <p>Social work assessments are of variable quality. Many lack a robust analysis or a strong enough focus on children’s experiences. A screening tool to help assess risk to children living with domestic abuse is not used as often as it should be. Advocacy is not being used well to strengthen the voice of children in child protection conferences. Social workers do well at involving a range of agencies in work with children but services do not always make sufficient difference. This is because plans are often vague about what needs to be achieved and, as a result, help is sometimes poorly coordinated and progress is difficult to measure.</p> <p>Services for children and young people who go missing, and those at risk of sexual exploitation, are not robust. ‘Return interviews’ are not always carried out when children return from being missing. This limits both understanding of the reasons why they went missing and future safety planning. Child sexual exploitation risk assessments are not always completed, are not used well to inform planning and are rarely reviewed. A new service to provide ‘return interviews’ and therapeutic work has been commissioned from a national charity and 15 child sexual abuse champions roles have been created within the local authority. This has led to improvements, but services remain poorly coordinated and improvement lacks pace.</p>	

Inspection findings

19. Although inspectors found no children or young people left at immediate risk of significant harm, the local authority's response to referrals about children is neither consistently prompt, nor of sufficient quality. In three of five locality offices that receive referrals, a large majority of decisions are appropriate, made within 24 hours, with assessments promptly allocated and children seen in a timely manner. For a few children in these offices and for a significant minority in the other two area offices, decisions are not always made within 24 hours or are consistent with referral information, assessments are not allocated in a timely manner and there are delays in children being seen. These delays mean that some children are left in situations of unassessed risk and wait longer than they need to receive services. The local authority recognises these weaknesses and measures are planned to strengthen management oversight across these offices. However, with the exception of one of the area offices, where additional management capacity has been added but is still too new to have had a significant impact, these measures will not be in place until later in the year. Parental consent to information sharing is not consistently recorded at the point of referral (Recommendation).
20. Referrals from the police, including those relating to incidents of domestic abuse, are dealt with promptly and effectively by the pan-Dorset Multi-Agency Information Sharing Team. The MAIST is staffed with social workers from Dorset, Poole and Bournemouth, as well as police and health staff. When referrals are received, information is quickly shared between agencies. This means that decisions are supported by a clear rationale, and children's cases are quickly passed on to the relevant area office for any further assessment needed and to receive services. Plans are in place to expand the MAIST into a pan-Dorset Multi-Agency Safeguarding Hub from September 2016. This extended service will deal with all referrals about children and young people.
21. The out of hours service (OOHS), jointly commissioned with Poole and Bournemouth, is appropriately staffed with sufficient experienced qualified workers. The OOHS provides a direct-access 24-hour social worker telephone service, which is a real strength. It enjoys good working relationships with the police and has extra flexibility and depth of resources due to its three-council coverage. Decision making is timely, appropriate and clear. This leads to effective interventions that protect children out of office hours.
22. Inspectors saw some examples of good quality early help services that are making a positive difference for children. However, the quality of early help services for children and their families is not consistent. The common

assessment framework is not used well and most CAFs seen by inspectors are not clear about what needs to change, by when or how agencies and families will work together to achieve change. An online CAF (e-CAF) system is being introduced across the county to increase the use of the CAF by agencies. E-CAF identifies the lead professional but do not clearly detail how activity is to be coordinated. The impact of this is that, while an increasing number of e-CAFs are undertaken by partner agencies, these are not consistently making a positive difference to the well-being of children.

23. The local authority has a number of early intervention teams for children and young people whose needs are complex or multiple, yet just below the threshold for statutory social work services. Workers in these teams are completing comprehensive early help assessments of children's needs, leading to plans of intervention that are worked through with families until either their circumstances have improved or they are referred for a statutory social work service.
24. Dorset has 22 children's centres, all of which provide services targeted at children and families with additional support needs. Parents who met with inspectors spoke highly about the services that they are receiving. Dorset Families Matter, the name given in Dorset to the government's Troubled Families programme, has successfully improved outcomes for all of the 590 families worked with up to the end of March 2015 in phase one of the programme. As a result of this effective work, the local authority was chosen to be an early implementer of phase two of the programme.
25. When children are at risk of significant harm, strategy meetings are generally held very quickly. However, decisions made at these meetings do not always take sufficient account of historical factors or make it clear how quickly children need to be seen. In a few cases, child protection investigations do not take place by the time of the initial child protection case conferences agreed at strategy meetings. This results in some initial conferences taking place without a substantive assessment to inform decision making. Decisions about whether children may be at risk of significant harm, and how agencies should proceed, are primarily made during telephone strategy discussions, rather than at face-to-face strategy meetings. While many discussions have to take place by telephone due to the urgency with which decisions need to be taken, inspectors did see a few situations in which the time available would have allowed face-to-face strategy meetings to be held. In these cases, meetings would have enabled more comprehensive information sharing to have taken place and would have supported better planning.

26. The quality of child protection investigations and reports to initial child protection conferences is variable. Although many are good, most are not of this standard and a small number are very poor. In common with initial decision making about referrals, this variability has a strong correlation with the quality of the management oversight and direction given to social workers. Some investigations lack rigour and focus. Social workers do not always consider historical factors sufficiently, see children alone or consider their views and experiences carefully enough. Better investigations are characterised by a comprehensive analysis of children's circumstances, based on relevant multi-agency information and a stronger child focus. Work with children and young people with disabilities balances attention to the needs arising from their disability with a clear focus on any needs for help and protection they may have. Between 1 April 2014 and 31 March 2015, 91% of conferences took place within 15 days of the strategy discussion. This means that children and young people have a stronger chance of receiving coordinated help sooner and is significantly better than the 75% average for similar local authorities. However, the involvement of children in conferences is weak, whether through attendance, meeting with independent chairs beforehand, or by submitting letters or recordings. Between July and October 2015, advocates only attended six conferences out of the 223 held. Although the local authority has plans to move from an 'opt in' to an 'opt out' approach to providing advocates for children, current use of advocacy to support their engagement in conferences is minimal (Recommendation).
27. Many reports to conferences (42% of reports between July and October 2015) are either not shared with parents prior to conferences or are only shared at the last minute. This hinders parents' ability to understand concerns relating to their children by giving them too little time to consider reports, or to query points that they either do not understand or disagree with. While the attendance of agencies at conferences is generally good, and this ensures that conferences have up-to-date information on which to base decisions, police and GP involvement is noticeably weaker. Local authority monitoring data between July and October 2015 showed that only half of conferences received a contribution from a GP and that only 65% of conferences were attended by the police.
28. Over the last year, the number of children subject to child protection plans has risen significantly. At the time of the inspection, 426 were the subject of a child protection plan. This is a rise from 372 at 31 March 2015 and, representing a rate of 55 per 10,000 of the population under 18 years of age, is much higher than the most recently recorded average rate of 39 per 10,000 for similar local authorities at 31 March 2015. Although high, inspectors saw no examples of

children subject to plans for whom this was not an appropriate and proportionate response to their needs and levels of risk. However, inspectors did see examples of children for whom there had previously been delay in identifying and responding to long-standing chronic concerns and who had only more recently become the subject of a child protection plan. This rise in the number of children subject to child protection plans is consistent with a parallel rise in the rate of care proceedings, and in the number and age of children coming into care.

29. The quality of assessments of children's needs ranges from good to poor, with most requiring some improvement to be good. Delay in seeing children is a frequent weakness and, in most assessments, they are seen only once during the course of the assessment process. In poorer assessments, the wishes and feelings of children and family members are not clear, analysis is weak and what needs to happen to improve things for children is not made clear. In most assessments, insufficient attention is paid to understanding the views of fathers, particularly when they were not living with their children. Research evidence is rarely used to inform assessments and there is little evidence that direct work tools are used to engage with children and elicit their views. Better assessments are completed in a timely manner, clearly reflect the wishes and feelings of children, contain fuller analysis and make clear recommendations for further work. Some good assessments were seen that were completed by a specialist assessment and intervention service. The greater clarity and focus of these assessments support more effective interventions. This is reflected in the very positive feedback received from 116 parents and carers in a survey in November 2015 (Recommendation).
30. The local authority's own analysis of the 187 child protection conferences which took place between August 2015 and February 2016 shows that domestic abuse was a significant concern in almost all cases, parental mental ill health in half of cases and parental alcohol misuse and drug misuse in a third of cases each. The 'toxic trio' of domestic abuse, parental mental ill health and parental drug, alcohol or substance abuse was present in combination in 44% of cases. Despite this high prevalence, screening tools designed to help assess the level of risk to children living in homes where domestic violence is present are not routinely completed by social workers. This means that the level of risk which some children may face may not have been correctly identified, reducing the likelihood that they will receive the help they need. Arrangements are in place to share information between professionals and to coordinate support to victims of domestic violence at multi-agency risk assessment conferences (MARAC). However, the number of referrals from children's services is low. This may be linked to the underuse of domestic abuse screening tools, but does mean that

MARACs are not generally being used to enhance and complement support to children from existing child in need and child protection plans (Recommendation).

31. The local authority has completed a strategic needs assessment into the needs of children and young people living with domestic abuse, parental mental ill health and parental drug, alcohol or substance misuse. This document recognises that there is more work to be done on information sharing and data recording to understand better the issues relating to the 'toxic trio'. While there is information about activity levels of adult service provision aimed at improving parenting capacity, there is very limited information about the outcome of these interventions. This means that the local authority is not able to plan service delivery effectively to address such issues. Social workers spoken to by inspectors particularly highlighted a lack of service provision to tackle the impact of parental mental ill health on children and a lack of programmes for perpetrators of domestic violence.
32. Most child in need and child protection plans set out the desired outcomes to be achieved, but lack clarity about what needs to be done, who will do it, by when and how progress will be measured. This is also true for child protection core groups and children in need planning meetings. This means that, although these meetings are generally well attended and clearly recorded, there is delay in achieving change for some children and, for others, professionals are sometimes slow to recognise the need to 'step up' to a child protection plan or legal proceedings. This is particularly the case for children experiencing chronic neglect or when there has been a series of incidents, each of which on its own may not be significantly concerning but which, taken together, should give rise to significant concern for a child. For a very few children, an over-optimism about the extent or permanence of progress achieved leads to premature decisions to 'step down' from child protection to child in need, or from child in need to early help services (Recommendation).
33. Work with children and young people at risk of child sexual exploitation is not consistently good enough. Although the local authority is developing this work and has improved identification of children at risk of sexual exploitation, this work lacks rigour and depth of analysis, and is not well coordinated. Child sexual exploitation risk assessments are completed for a very large majority of children who may be at risk. However, when risk assessments are completed, they are often completed in a 'tick-box' manner, rather than as an aid to professional social work judgement. As a result, for a few children and young people, the full extent of the risks are not being recognised. The number of children who are assessed to be at a significant risk is low, with numbers

considerably below those in neighbouring local authorities. Only three young people from Dorset, assessed to be at high risk of child sexual exploitation, were discussed at the pan-Dorset child sexual exploitation meeting in January 2016. Risk assessments are not used well to inform planning for children and are not regularly reviewed to help understand if risks have increased or decreased. This means that the local authority does not have a clear picture of the difference it is making for children. This makes it more difficult to improve the effectiveness of both planning for individual children and of planning services for all children (Recommendation).

34. The local authority recognises that it needs to do more to help and protect children and young people at risk of sexual exploitation. It has identified 15 child sexual exploitation champions across children's services. These 'champions' provide advice and support to social workers working with children or young people who are at risk of sexual exploitation. A new service, providing 'return home' interviews to children and young people who have been missing and therapeutic work with those at risk of child sexual exploitation, was commissioned in 2015 from a national charity experienced in this work. This new service has been phased in from June 2015 to February 2016. While the additional capacity and expertise offered by this new service is clearly positive, it is too soon for it to have had a significant impact. Although no cases have been referred to the local authority, clear safeguarding policies, good communication with partner agencies and substantial training for staff show that the local authority has taken a thorough approach to the risks of female genital mutilation and radicalisation (Recommendation).
35. Work to reduce the risk to children from going missing is weak. A significant number of children and young people who have been missing are neither offered nor receive a 'return interview', or do not receive one within 72 hours of their return from being missing. Between October 2015 and February 2016, 31 children went missing on a total of 72 occasions, but 'return interviews' were only completed for 60% of these missing episodes. While this is an improvement on the 52% achieved between April and July 2015, it still leaves a large number of children without 'return interviews' and with the circumstances surrounding their missing episode unassessed. The failure to carry out 'return interviews' for this minority of children and young people limits the local authority's ability to assess risk fully and put in place plans that are likely to reduce the risk of their going missing again. It also limits their ability to make any connections that may exist between going missing and a risk of sexual exploitation for individual children and young people. Intelligence from 'return interviews' is not aggregated to help identify particular themes, such as what children are running from or to, that could helpfully inform service development

and prevention and disruption work in relation to child sexual exploitation (Recommendation).

36. Two hundred and forty-three children are known to be electively home educated in Dorset; this is broadly in line with national averages. The local authority has a team of four designated visiting officers to monitor the education and welfare of these children and young people by making at least one annual monitoring visit to those families who agree to meet with them. However, the local authority's ability to monitor their education and welfare is limited because, in the year 2014–15, only 57% were visited. Safeguarding concerns identified by visiting officers are dealt with promptly. In the last year, this has resulted in four children returning to mainstream education.
37. The lack of provision in the county for children with social, emotional and mental health problems has resulted in some being placed in one of Dorset's five learning centres instead of mainstream provision. The learning centres cater for a wider cohort than would be present in a pupil referral unit and include some long-term specialist placements. Recent data for all learners in learning centres shows often very low attendance by a significant minority, and low attainment compared with their peers by the small number of children looked after in centres. A low proportion of pupils in learning centres was reintegrated back into mainstream education or specialist provision between September 2015 and January 2016, varying between 10% and 23%.
38. The arrangements to re-engage children missing education mainstream school or specialist setting are not strong. The vast majority of the cohort are long-term non-attenders at school, but there is no clarity as to when persistently low or non-attendance translates into a child being defined as missing education and referred to the children missing education team. In too many cases, visits did not take place when planned or follow-up actions were delayed. This not only slows children's reintegration into full-time education, but limits the local authority's knowledge about their welfare when they are not in school. Of the 90 children missing education cases recorded in the 12 months to February 2016, 63 were identified as having been found suitable places in education, but 27 had not been placed successfully and remained on the concerns list for at least three months.
39. The quality of case recording is not consistently good enough. In a minority of cases, recording does not identify whether children were seen alone and it is difficult to gain a clear sense of their wishes, feelings, fears and hopes. Recording does not always show when or if direct work has been undertaken with children to understand their world. Even when it was apparent from other

case recording, or it was clear from inspectors' conversations with social workers that it took place, management decision making, oversight and direction is not consistently recorded on children's case files. When management decisions and oversight are recorded, they often lack sufficient frequency or clarity to ensure that work with children is progressed with enough pace or focus.

40. Sixteen- and 17-year-old homeless young people are safeguarded by good quality work. A comprehensive procedure identifies the legal and procedural framework and helps to ensure that the needs of this group are addressed. Assessments are timely, and both the provision identified and decisions about whether young people need to become looked after are appropriate and are made on the basis of need. Effective mediation work is undertaken with some young people, enabling them to return home with packages of support.
41. The local authority's arrangements to safeguard privately fostered children are poor. Little has been done to raise the awareness of either the public or other agencies, particularly schools and GPs. The authority does not have an accurate picture of the numbers of young people in private fostering arrangements in Dorset. Work with the small number of children who are known to be privately fostered is mostly weak, lacking focus or timeliness. This means that the local authority cannot be sure about the welfare of these children and young people (Recommendation).
42. Management of allegations about professionals by the designated officer are thorough and the arrangements that support his work are sound. The creation of a dedicated post has enabled a clear focus to be sustained on the management of allegations against staff to ensure that children are safeguarded. The work of the designated officer is clearly recorded and enquiries are responded to appropriately and, almost always, promptly.

<p>The experiences and progress of children looked after and achieving permanence</p>	<p>Requires improvement</p>
<p>Summary</p> <p>The number of children looked after by Dorset has risen significantly over the last 12 months. This rise stems from a sharper focus on identifying those children and young people whose welfare can only be secured by becoming looked after. Although some children looked after experienced delay at the point they entered care, the large majority of recent decisions to take children into care are timely. Most benefit from positive placements. Plans to further improve placement choice through improved commissioning and increasing foster carer numbers are in place. Permanence planning is strong for younger children, particularly those for whom adoption is the best option, but is less rigorous or timely for older children.</p> <p>Social workers know most children and young people well, but do not always complete up-to-date assessments and plans that reflect children’s current needs. The local authority has taken action to improve the independent conference and review service, but challenge and scrutiny of children’s plans remains limited. The virtual school makes good use of the pupil premium and provides strong support to children in primary schools, but the attainment and progress of children at key stages 1, 2 and 4 is low in comparison to national rates. Risks to children and young people associated with either being missing from care or sexual exploitation are reported and tracked. However, the quality of ‘return interviews’ is variable and information gathered is not used well to inform children’s care plans to reduce the likelihood of future missing episodes.</p> <p>The local authority has engaged a limited number of children looked after in Dorset’s Children in Care Council, Dorset Kidz. The number and age range of children and young people involved are not sufficiently representative of all children looked after. Opportunities to participate and contribute to service developments through the corporate parenting board are limited and the pace of change is slow.</p> <p>The local authority’s use and provision of adoption are good. It considers at an early stage whether adoption is in a child’s best interests and, when it is, acts swiftly to secure the necessary legal status and a good match. Responses to prospective adopters are welcoming and assessments are thorough and sensitively conducted.</p> <p>Care leavers receive strong support when they need immediate help, but planning needs to be much better and to start earlier to provide effective longer-term support. Their health needs are poorly considered and the number of 19- to 21-year-old care leavers who are not in education, employment or training is high.</p>	

Inspection findings

43. At the time of the inspection, Dorset was looking after 485 children. The rate of children looked after, at 60 per 10,000 of the population under 18 years of age (January 2016) has increased from the rate of 50 per 10,000 at 31 March 2015 and is higher than the average for similar local authorities of 53 per 10,000 (31 March 2015). This rise in numbers is appropriate, and stems from a sharper focus by the local authority on identifying those children and young people whose welfare can only be secured by becoming looked after and on ensuring that this is achieved in a timely manner. Although some children currently looked after experienced delays in decision making and action at the point they entered care, the large majority of recent decisions to take children into care are timely and based on clear reasons. This means that children are protected more quickly and are less likely to be at risk of further harm.
44. The council is not consistently achieving positive outcomes for children and young people. Most children are receiving appropriate care, are well matched in a timely way with carers, and their life chances are enhanced. However, for a minority, outcomes are not so positive because children's and young people's care is not effectively assessed and planned. This means that they do not always receive the support and services that they need to help them make sense of their past life experiences, to get the best out of being in care and to settle in permanent homes.
45. When the plan is for children or young people to return home, the majority have appropriate plans to support them and risks are clearly understood and minimised. However, for a small minority of children and young people, support is not as strong. Since November 2015, action has been taken to improve systems, and a pilot project in Weymouth has been providing more intensive, flexible help and support to ensure that children on the edge of care are safe to return or remain at home. While impact is necessarily limited, due to the pilot project only operating in Weymouth, plans are in place to expand this service across the whole county from September 2016.
46. The use of legal proceedings is effective and timely. Since 2014, the number of care proceedings has risen appropriately. In the 10 months from April 2015 to January 2016, 168 care orders had already been made, compared with 127 for the whole 12 months up to April 2015. This increase is in line with the local authority's sharper focus on identifying those children and young people whose welfare can only be secured by becoming looked after, and where it has sought to reduce the inappropriately high percentage of children looked after in voluntary arrangements under section 20 of the Children Act 1989. Where

children have been placed under such voluntary arrangements and parents have not worked in partnership with the local authority, it has lacked the legal capacity to drive planning for these children and discharge its obligations fully as a 'corporate parent'. While significant progress has been made over the last year, the local authority still has a higher percentage of children placed under such arrangements than the average for similar councils.

47. Effective tracking mechanisms are in place to ensure timely decision making and progression of care proceedings. With an average duration of 27 weeks between April and December 2015, the timeliness of care proceedings is better than the national average of 30 weeks for the same period. Feedback from the Children and Family Court Advisory and Support Service and the Local Family Justice Board describes ongoing improvement in the quality of assessments and in the timeliness of applications to court, particularly for babies and young children and in situations where children have experienced chronic neglect.
48. A small number of family group conferences have taken place since November 2015, when the local authority commissioned a service to provide them. Parallel planning for children within care proceedings is appropriately applied, and thorough assessments to approve connected persons carers are in place, although the timeliness of Disclosure and Barring Service (DBS) checks requires improvement. However, this means that children can be placed safely and permanently with family members, where it is in their best interests to do so.
49. Permanence planning for children remains underdeveloped, particularly for older children. Most children looked after do not have clear permanence plans in place or, if they do, those plans are not being systematically implemented or tracked. This means that arrangements about important parts of their lives, such as their education and health, are not secured as quickly or effectively as they could be. Practice is more positive for younger children, particularly those in adoptive placements, for whom robust tracking systems are in place.
50. Action by the local authority to address this deficit is comprehensive and systematic. Measures to improve staff understanding and to embed effective permanence planning include: a permanence panel to oversee and drive planning for children and young people; clear new procedures, which include a requirement to hold permanence planning meetings; staff training; and additional resourcing of the independent reviewing service to provide stronger oversight and scrutiny. However, many of these measures are either relatively new or not yet fully in place and so have not had sufficient impact to embed consistent good practice and improve outcomes (Recommendation).

51. The majority of children and young people are being appropriately involved, consulted and listened to, and have good relationships with their social workers. Case recording, in electronic case files of children looked after, accurately reflects the work done with them in almost all cases. Assessments of children's needs are not always in place and are not regularly updated. This means that changes in their circumstances do not always inform care planning. The quality of care plans is variable. Most are not clear and lack sufficient focus, detail or clarity about desired outcomes. This means that neither involved professionals, nor children and their families can always check that actions are completed or progress is being made. Inspectors saw many examples of positive multi-agency working involving services such as the specialist CAMHS for children looked after, the virtual school, youth support workers, alcohol and drugs workers and the police. However, the lack of consistently strong and up-to-date assessments or clear and effectively monitored plans means that this positive work is often lacking in focus or is reactive and so does not achieve the best outcomes possible for children (Recommendation).
52. Arrangements for children looked after to have contact with their families and friends are good. They are well considered and facilitated. Regular sessional staff are used to provide continuity of transport arrangements and familiarity and consistent supervision of contact sessions. When children's identity needs are well considered in care planning, diversity issues, such as race, religion and language, are usually well considered too. However, for a significant minority of children and young people, diversity issues are not sufficiently taken into account. This is particularly the case when broader issues of identity, such as the emotional impact of past life events, have lacked attention or consideration.
53. A suitable pledge for children looked after is in place. It was reviewed in 2015, in consultation with young people, and is overseen by the corporate parenting board. Advocacy services for children are available and, although not limited by capacity, are under-used in supporting young people's engagement in statutory reviews. An independent visitor service is available for children, with 11 currently linked to the service. Complaints for children looked after are well managed. However, there is more work to do to ensure that the learning arising is used to inform practice development.
54. Children and young people are carefully matched with available placements, and the large majority benefit from positive, stable placements. In the 12 months preceding the inspection, 11% of children looked after experienced more than two changes of placement. This compares well with the most up-to-date average figure available for similar local authorities of 12% for the year

2013–14. Children are placed with their brothers and sisters whenever possible, and supported to remain with carers unless this is no longer suitable.

55. Children and young people looked after have good access to a range of leisure activities. In some cases, activities arranged through schools have been supported by the pupil premium. Foster carers exercise delegated authority on an individual child-led basis. However, foster carers told inspectors that they were unclear about where delegated authority was set out, and what they can and cannot do (Recommendation).
56. Procedures ensure that the reporting of children and young people missing from care is clear, and that they are reported missing promptly. However, the quality of 'return interviews' is variable. They are not always offered, held, or held within 72 hours. Information gathered is not used well to inform children's and young people's care plans to reduce the likelihood of further 'missing' episodes (Recommendation).
57. Dorset youth offending service has a focus on children looked after and undertakes individual work to prevent custodial sentences and to limit offences committed in residential children's homes. However, the number of children looked after who receive a conviction, final warning or reprimand is high, at 20 over the age of 10 between April 2014 and March 2015. At 10% of all children looked after, this is double the 5% national average for the same period. Drug and alcohol services are currently provided via a commissioned service, and trained outreach workers are also available to work with young people (Recommendation).
58. There has been historic poor performance and slow progress in improving the provision of initial and review health assessments for children looked after. This means that children's health needs have not always been properly identified or progressed. An increase in resources since November 2015, combined with significant improvements to systems, has led to rapid yet very recent progress. For example, January 2016 figures for initial health assessments increased from 20% to 70% in quarter three of 2015 and, for review health assessments, from 50% in December 2015 to 78% in January 2016. This means that children looked after are receiving more timely health assessments to address their health needs.
59. Where children are placed out of county, the health team provides good continuity of care. Where this is not possible, arrangements are put in place and tracked by the care and support panel to ensure that young people's health needs will be met. A small but dedicated CAMHS team for children looked after offers helpful expertise and consultation to social workers, carers and

residential staff, in and out of county, which assists and promotes placement stability.

60. The virtual school staff team is well trained, experienced and determined to provide a good level of support to all children looked after. The team is well managed and stable. Working relationships between the virtual school team, schools and specialist agencies are generally productive. The virtual school team provides some good direct interventions and support for children looked after, particularly in English and mathematics. The virtual school also provides well-received training for teachers, foster carers and school governors on attachment issues and how they affect pupils' learning and behaviours. However, individual caseloads for virtual school advisers are now high due to the increase in the number of children and young people who have entered care. In response to this, the virtual school service is developing new ways to maintain the quality of delivery.
61. The pupil premium and high-needs funding are both used well to provide targeted and effective support to children looked after, including one-to-one support and specialist teaching. Achievements of children looked after are celebrated in a high-profile annual awards event. Attendance at schools, learning centres and special schools is high, and has improved to a current average of 95% across all year groups. No child looked after has been permanently excluded in the past year, but short-term exclusions are high, at 108, and are mostly in Years 9, 10 and 11 (Recommendation).
62. Educational progress of all children looked after is monitored closely, with prompt interventions. However, no data is generated identifying their attainment or progress by cohorts such as ethnicity, gender, geographical location or adviser. The vast majority of children looked after are placed in schools in Dorset and out of county which are judged good or outstanding. Those who are not remain at their school when it is in their best interests.
63. Half of the personal education plans (PEPs) reviewed by inspectors were of a good quality, and are helping children and the professionals working with them to focus on improvement, particularly at primary level. The other half of PEPs were mostly poor and some have little content or value. The quality and impact of post-16 PEPs is similarly variable (Recommendation).
64. A high proportion of children looked after have entered care during key stage 4 in the past three years and present particular challenges, notably poor behaviours and acceptance of low attainment, which the virtual school has not resolved. In 2015, the attainment of young people looked after with GCSEs at A* to C with or without English and mathematics was low. Although in line with

national rates for this cohort, this level of attainment has not improved over the past three years.

65. More generally, attainment at key stages 1 and 2 in 2015 showed a slightly better picture than previous academic years. However, the proportion making expected levels of progress between key stages 1 and 2 in reading, writing and mathematics was well below national rates for children in care. The number of Year 11 pupils progressing to Year 12 also improved, yet a fifth of Year 11s still ended up not in education, employment of training (NEET), or entered employment without training. Opportunities for work experience, traineeships and apprenticeships for children looked after are underdeveloped. A new initiative to increase the provision in these areas is positive, but has only just been approved by the council.
66. The fostering service operates to full capacity and has met the increase in demand for children needing foster carers by expanding the use of connected persons and independent fostering agencies (IFAs). Plans include a new placements team to rationalise the commissioning of all placements, to engage more fully with existing IFAs and residential frameworks, and to recruit and retain more local foster carers for older and more challenging young people.
67. Foster carer and connected persons' assessments are thorough, with good analysis of relevant information which enables sound decision making about approval. Delays in processing DBS checks by the police has caused difficulties in some connected persons carers being approved. Foster carers, including connected persons, benefit from good initial training and a range of good quality further training, on themes including child sexual exploitation and attachment. However, not all carers receive information about training opportunities. They say they are dependent on their supervising social worker for information and that not all supervising social workers are efficient in alerting them to what is available (Recommendation).
68. The independent conference and reviewing managers (ICRM) service is receiving significant financial investment to improve effectiveness. This is aimed at providing greater challenge and scrutiny of children's care plans, particularly around plans for permanence and to create more capacity and focus for children looked after. Although recently recruited, independent conference and reviewing managers met by inspectors had manageable caseloads. The average for the service is 77 (January 2016). This figure is slightly higher than the maximum of 70 recommended in the independent reviewing officer's handbook.
69. Data about how well the ICRM service is performing is not reliable. For example, December 2015 data shows a range from 73% to 95% regarding the

number of children's care plans that have been regularly reviewed. This means that the local authority does not have a clear picture of how well this service is performing on which to base performance management and service improvement activity. Mid-way monitoring of plans is not fully embedded and, at the time of the inspection, was only in place for 17% of children and young people. At 3%, the number of children and young people chairing their own reviews is low. This means that all children and young people do not have the opportunity to get to know their ICRM well or to engage and participate fully in their review process (Recommendation).

70. The Children in Care Council, Dorset Kidz, is an active group, but it is not representative of all children and young people looked after. For example, there is currently no juniors group. Participation processes for children and young people to be consulted and contribute their views to the corporate parenting board are underdeveloped and progress is slow. Some actions have been completed, for example the use of the MOMO 'app' to improve children's and young people's participation, but others have stalled, such as the proposal to have elected 'member champions'. The slow pace of change regarding corporate parenting priorities is acknowledged by corporate parenting members, and proposed changes to the functioning of the board are being progressed (Recommendation).

The graded judgement for adoption performance is that it is good

71. The local authority has made significant progress in considering adoption at the right time for those children for whom adoption is the best permanence option. The last twelve months have seen a substantial increase, from 24 to 47, in the number of decisions to place children for adoption. Inspectors judged that these decisions were well founded. As well as children who have entered care more recently, this improvement also benefits a group of children whose entry to care was delayed because of historic shortcomings in effective assessment and decision making. These children experienced drift in their early care planning but, where appropriate, now have plans for adoption that their social workers are actively progressing.
72. Once children enter care, the local authority pursues legal proceedings and care planning with appropriate urgency and makes early decisions to seek permanent homes for children through adoption. Care and placement orders

are made within reasonable time frames. The local authority has consistently met the adoption scorecard thresholds.

73. Family finding begins at the earliest opportunity and is broadened to include regional or national resources whenever necessary. For a minority of children, progress towards adoption is impaired by delays in the completion of key tasks, such as good quality child permanence reports. This is due to expertise being spread too thinly and some workers and managers lacking skills, experience and confidence in this area of work. The local authority is aware of this deficit and has clear plans to address it. Despite this weakness, overall timeliness is good and improving, with over 75% of children placed for adoption within 18 months of entering care. While there have been delays in securing adoption orders in a minority of cases because of a lack of capacity, in the large majority of cases adoption orders are made in good time.
74. A thorough and robust tracking process supports strong adoption performance. This enables managers to identify and address potential problems quickly and to combat drift. At the time of inspection, 19 children had an adoption decision, 27 had a placement order and were awaiting a match, four were matched but not placed and 20 were in adoption placements but had not yet had final orders. This represents a substantial increase in adoption activity from previous years and none of these children had been waiting for an unreasonable period.
75. Good tracking has also enabled the local authority to review and, where necessary, change plans away from adoption for a small number of children. In a few of these cases, there were delays in rescinding the placement orders after the decision to use another form of permanent placement. However, the impact of this on children was minimal, because the local authority was clear about the decision and they all lived in other stable, long-term placements.
76. At the time of the inspection, the local authority had approved 19 sets of adopters who were awaiting placements. Ten of these were already linked to specific children. Only in exceptional circumstances do adopters wait long periods without being matched.
77. The local authority makes effective use of internal and external resources to ensure timely and good quality matching. Workers undertaking adopter assessments are well informed about children waiting for adoption. They use this knowledge effectively to identify potential matches, which can be swiftly pursued once adopters have been approved. Adopters told inspectors that this had been both reassuring and of great help in making the right matches. The local authority has also become better at securing good matches for harder to place children through its use of regional and national family-finding processes.

78. Matching is supported by good information sharing, including highly effective 'life appreciation days'. The transition from foster care to adoption placements is well planned and managed. In recent years, a few children have experienced adoption disruptions, but the local authority has good processes in place to learn from these disruptions and has used these to improve practice. For example, it has reinforced the critical role of foster carers in the transition process and ensured that carers are now better trained and supported to help children and adopters with this transition. Adopters reported that the improved involvement of foster carers in managing successful transitions had been invaluable.
79. Increasingly effective use of 'fostering to adopt' is further improving timeliness and enabling the local authority to place young children with their potential adopters early in their lives and, in some cases, immediately after birth. This means that children are given the best possible chance to form good attachments with their future parents. The local authority promotes 'fostering to adopt' well with potential adopters and provides good preparation, including specific training for this role. At the time of the inspection, the local authority had seven 'fostering to adopt' placements approved and ready for matching.
80. In most cases, services support brothers and sisters being placed together when this is in their best interests, and decisions to separate are based on robust assessments. However, in a small number of cases, brothers and sisters were separated primarily because the authority was unable to identify a suitable placement. Similarly, where brothers and/or sisters had been separated, plans to ensure continued contact were not always clear enough.
81. Once placed for adoption, children and their families can access post-adoption support informed by post-adoption support plans. The authority's post-adoption support team is highly skilled and passionate about its work. However, support plans are limited in scope and tend to put the onus on adopters to ask for help. Some new adopters told inspectors that they were not aware of whether they had a support plan. A particularly good and innovative feature of the post-adoption service is the work to support the education of adopted children. This includes improving the understanding and skills of teachers and other educational staff in meeting the needs of adopted children, promoting more effective use of the pupil premium and providing individually tailored programmes of support. Continuing contact arrangements are supported by an effective 'letterbox' scheme.
82. All children placed for adoption receive life story work and inspectors saw some examples of good quality work. However, books are not always completed in

good time and some adopters who spoke to inspectors said that their children had not yet received them. 'Later life letters' have some good features, but some also demonstrate a lack of understanding about the age of the reader at whom they are aimed (Recommendation).

83. The agency decision maker is knowledgeable, suitably senior and brings a strong commitment to the role. This ensures that key decisions are subject to proper scrutiny and challenge. The adoption panel is appropriately constituted and chaired by an experienced practitioner. It provides a valuable quality assurance process and promotes good practice. Workers generally value the challenge and scrutiny it provides. The panel reports regularly to the corporate parenting panel on its work and on wider adoption performance and practice.
84. Applicants who met inspectors said that their initial contact with the local authority was welcoming and informative. Assessments are thorough and contribute to preparing potential adopters. They are completed promptly, though in some cases time was lost due to delays in the police processing DBS checks. Adopters are supported to expand the range of children they might consider caring for, but are not pushed to make unrealistic commitments. Support and guidance for adults, such as birth relatives, is good and ensures that the local authority meets its statutory duties in this area.
85. A strong overall feature of the adoption service is the quality and range of training offered to workers. This is often provided by national experts and enables workers to stay up to date regarding good practice and to develop specialist skills in, for example, understanding and managing attachment problems.

The graded judgement about the experience and progress of care leavers is that it requires improvement

86. Care leavers say that when things go wrong or become difficult, the responses from social workers and personal advisers are prompt and characterised by a dogged approach to solving problems, with generally positive outcomes. The provision of such reactive help and support by social workers and personal advisers is a strength. Social workers and personal advisers generally have a good knowledge of the concerns and circumstances of the individual care leavers with whom they are working. They intervene promptly to maintain or improve care leavers' health and safety. Those care leavers interviewed felt

safe in their lives generally and in their current accommodation particularly. Feeling unsafe had never been a key concern for any of them.

87. The local authority recognises that transition arrangements for care leavers of 16 years or older, which involve changing to a new social worker at age 16 and then to a personal adviser at 18, do not work well. Care leavers find this disruptive and it makes it difficult for them to build effective long-term working relationships. Managers recognise how this lack of continuity has also hindered individual medium- and long-term progressive planning. A new structure designed to build sustained relationships between care leavers, from the age of 13 upwards, and the social workers and personal advisers working with them is planned, but will not be implemented until September 2016.
88. The lack of continuity within the present structure has meant that important life decisions have often been made without recourse to professional support. All care leavers interviewed stated that family and friends had been the key catalysts in selecting a career path, not their social worker or personal adviser. No care leaver said that they felt they had received sufficient support or guidance to help them to develop basic life and coping skills, for example the need for a television licence, how to operate a washing machine or cooking. However, they all said that they very much appreciated timely practical interventions, such as organising new white goods, or assistance with getting repairs and maintenance completed in their accommodation.
89. Care leavers' pathway plans are completed and updated regularly, but are used more to record formal contact and updates than to identify and plan for the achievement of specific individualised goals. The majority of pathway plans do not record care leavers' special interests or talents, which might in turn provide a realistic starting point from which to shape their vocational or academic pathways. Caseloads in the care leavers' team are mostly in the mid-twenties. Although not particularly high, this is added to by the rapid changes in staffing and the logistical challenge posed by the size of the county, which reduces the amount of time available to spend with care leavers (Recommendation).
90. Care leavers do not consistently receive enough information about their entitlements before leaving care. There is no brochure currently available and the web-based information available is incomplete and under review. Nevertheless, most are receiving the benefits and financial support to which they are entitled. The care leavers' team provides prompt financial assistance on a needs basis, for example for carpeting or new white goods in independent accommodation, which care leavers appreciate (Recommendation).

91. Almost half (47%) of care leavers aged 19 to 21 were not in education, employment or training in 2015. This compares unfavourably to the national rate of 39%. Formal arrangements for care leavers to benefit from work experience, access to traineeships or apprenticeships are underdeveloped. The local authority has only very recently approved a proposal to improve opportunities for care leavers in these respects. A notably high percentage of 19 to 21 year old NEET care leavers (17%) is identified as having an illness or a disability. The local authority's own NEET data covering the 16 to 25 age range shows that up to 60% of NEETs in this broader cohort have mental health or broadly related problems that are identified as hindering them from entering employment, education or training. The local authority is implementing a strategy to improve the early identification and effectiveness of its responses to social, emotional and mental health issues. This is at a very early stage, although a pilot programme has had some early success (Recommendation).
92. The vast majority of care leavers aged 16 to 21 (93%) are in suitable accommodation. At the time of the inspection, 101 care leavers were in formal tenancies. A very small number of 16- to 17-year-olds in unsuitable accommodation chose to leave care and returned to live with their own families in circumstances that the local authority judged unsuitable. These young people receive continuing support. Dorset was an early adopter of 'staying put' and 16 young people over the age of 18 are currently benefiting from the stability of living with their former foster carers. The local authority has a well-developed supported lodgings scheme, with 22 households providing accommodation for 34 young people.
93. Care leavers requiring high and medium levels of support are well served but, overall, the local authority does not have access to sufficient one-bedroom housing for 16- to 18-year-olds. The local authority is currently guarantor to a large number of short- and long-term lets, particularly for 16- to 18-year-olds. This is a real strength because it is helping these younger care leavers to live more settled and secure lives. The very few care leavers living in houses of multiple occupation (HMO) had found this accommodation on their own account and are receiving good practical and financial support, including with deposits and advance rental costs. The team directly assessed the quality of each HMO and determined that it was in good condition, reasonably well maintained and suitable for occupation.
94. Three care leavers aged between 18 and 20 and two between 16 and 17 have been housed in bed and breakfast accommodation for between two and six weeks within the last 12 months. The local authority recognises that such accommodation should not be used for care leavers and has provided enhanced

levels of support, including daily visits in some cases. Risk assessments have been completed in some, but not all, cases. The lack of a formal risk assessment means that the potential negative impact of living in bed and breakfast accommodation has not been fully understood or mitigated for all young people.

95. The health needs of care leavers are not considered or addressed with sufficient rigour or urgency. Only five of 18 health passports planned for completion between November 2015 and March 2016 were completed. The designated nurse team for children looked after is not formally commissioned to provide health advice and guidance to care leavers post-18 years. Although staff do provide such support if requested, this support is individual and reactive rather than part of proactive planning to identify and meet young people's needs (Recommendation).

Leadership, management and governance	Requires improvement
<p>Summary</p> <p>The director of children’s services and her senior team provide strong leadership. They understand the strengths and weaknesses of their service and take action to address deficits. However, the local authority is not providing a good service, because many of these measures are not consistently in place, are too new to have had a significant impact or are yet to be implemented.</p> <p>The local authority recognise that more needs to be done to ensure that social work responses are consistently timely and that all children receive a response that matches their needs. Although improving, inconsistent and sometimes poor management oversight, causing drift and delay, remain central to this weakness. While inspectors found no children left at immediate risk of significant harm, this remains an important weakness. On appointment two years ago, the director inherited a staffing structure in which social work team managers had just been replaced with 42 practice managers. While many are capable managers as individuals, as a whole they lack the depth of experience of more established team managers. Plans are in place to strengthen first-line management later in the year and, in the interim, the director has added extra management capacity to one of the busiest area offices.</p> <p>Early help is underdeveloped. Although some services are effective, such as the local authority early intervention teams, services are poorly coordinated and most are not of this standard. The local authority’s Forward Together for Children vision focusses on early help and prevention, but the lack of a mature multi-agency plan limits agencies’ abilities to provide a cohesive early help offer and to maximise the difference made for children. While there are examples of strong multi-agency coordination in commissioning services, such as Dorset Families Matter or the new CAMHS transformation programme, strategic planning and commissioning across agencies is underdeveloped. It is not driven by a shared, multi-agency set of priorities and plan against which services can be commissioned and progress measured.</p> <p>The corporate parenting panel is not sufficiently proactive or challenging. It lacks the clarity of purpose and pace necessary for the local authority and its partners to be fully effective corporate parents. Scrutiny arrangements lack focus or sufficient challenge. Local authority performance data has a number of important omissions. For example, data is not gathered on when children are seen following a referral. Information from ‘return interviews’ with children who have been missing is not analysed to identify themes that could inform prevention and disruption work in relation to child sexual exploitation. This work lacks both rigour and pace.</p>	

Inspection findings

96. The director of children's services and her senior leadership team know the strengths and weaknesses of their service well. They quickly identify areas for improvement and put in place measures to address them. They have made important progress in developing an open and positively challenging culture. This has begun to have an impact on improving practice and outcomes for children and young people. Their plan for improvement, Forward Together for Children, is a whole-council approach that sets out their vision and planned improvement journey. This is an outcome-based approach with a strong emphasis on early help and partnership working.
97. The leader of the council, the lead member for children and the chief executive are now providing effective support to the director to implement this programme of change. This support includes additional funding in key areas, such as strengthening the independent review officer and independent child protection chairing services, increasing the children looked after budget and taking a whole-council approach to improvement. However, current arrangements to discharge the local authority's children's scrutiny function do not provide sufficient focus or challenge on aspects of the service that require improvement. New arrangement to bring together the overview and scrutiny function, to deliver the corporate plan outcomes along with changes to the partnership governance through the Children's Trust Board, are aimed at strengthening the prioritisation of children's services and helping to ensure that appropriate political and partnership action results in improved outcomes for children. However, these new arrangements are not yet in place (Recommendation).
98. The director, who represents the local authority on the LSCB, engaged an interim independent chair for the board in December 2015 to work with partners and to develop an improvement plan. This followed the identification of weaknesses in the effectiveness of the board. In January 2016, the director took further decisive action by commissioning a peer review that confirmed this view and provided a diagnostic of areas for development.
99. The local authority has started to model an outcome-based approach to planning services and has engaged well with partner agencies in some specific areas, such as Dorset Families Matter, Dorset's approach to the government's Troubled Families programme. However, strategic planning across agencies is underdeveloped in relation to the safeguarding and non-health social care needs of children and young people. A children's joint strategic needs assessment produced in December 2015 has a sharper focus on these needs

than its predecessor, but is still in draft. The Health and Well-being Strategy 2013–2016 and Children’s and Young People’s Plan 2014–2016 are both high-level documents which are light on children’s social care and safeguarding issues. A new plan is under consideration, but is not yet in place. This means that there is no shared multi-agency vision, set of priorities or plan against which services can be planned or commissioned, progress measured and partner agencies held to account for their delivery (Recommendation).

100. A handbook on involving service users in commissioning and service planning supports good practice in involving children and young people in commissioning. The recent involvement of 'young inspectors' in recommissioning the children’s and young people’s drug, alcohol and substance abuse service is an example of good practice. There is a clear, systematic 'how to' guide to good practice in involving children and young people. Although there are individual examples of effective multi-agency working in commissioning services, because commissioning at a strategic level is not driven by an agreed multi-agency set of priorities and plans against which services can be organised, commissioned and progress measured, the overall coordination and effectiveness of services is limited (Recommendation).
101. Early help services are underdeveloped. While there are some strong individual services, such as Dorset Families Matter and the local authority’s own early intervention teams, most are not of this standard, with services being poorly coordinated. The local authority has a focus on early help in its Forward Together for Children vision, but the lack of a mature multi-agency strategy limits agencies’ ability to provide a cohesive early help offer and to maximise the difference they are making for children. Although an e-CAF system is being rolled out across the county to support use of the CAF and an increasing number of professionals from other agencies are taking on the role of lead professional, the CAF is not used well to improve children’s well-being. Assessments do not routinely or clearly identify desired outcomes and services are poorly coordinated. Without a system in place to track the timeliness of CAFs, of meetings with families and whether planned outcomes are being achieved, the local authority and partners cannot fully understand or effectively improve performance (Recommendation).
102. Members of the corporate parenting panel are motivated and committed. They know the issues facing young people, but the panel is not sufficiently proactive and challenging. The panel lacks the clarity of purpose and pace it requires to understand how and if it is making a positive difference for children and young people, and to ensure that agreed actions are implemented, such as the delayed establishment of 'member champions'. The Children in Care Council,

Dorset Kidz, is not representative enough of the wider group of young people looked after and there is currently no forum for younger children looked after to share their views and experiences (Recommendation).

103. A group of young people from Dorset Kidz has undertaken helpful work on various subjects important to children and young people who are looked after. This work includes information for young people coming into care, champions for children looked after and developing exit interviews for young people when leaving a foster placement. Young people spoken to expressed frustration about not receiving feedback from the corporate parenting panel about how issues they raise are addressed or their suggestions used. The impact of this is that they do not feel sufficiently listened to or clear about how they are able to influence or make changes to practice that may benefit young people in care. Progress is slow and the local authority is late in embracing its corporate parenting responsibilities. For example, while a new apprenticeship scheme is a very positive development, along with the care leavers' charter it was only agreed by the local authority during the course of the inspection and has not yet made a positive difference for young people (Recommendation).
104. Governors of the virtual school have a good range of expertise and experience, and hold the headteacher closely to account for the running of the school. Although governors have a good range of expertise and experience, they currently include too few senior teaching professionals. Formal virtual school reports to governors and the corporate parenting board are thorough and detailed, but are not focused sufficiently on identifying specific priority areas for improvement, such as improving attainment, or identifying clear action plans to address them. The virtual school development plan for 2015–16 includes input from a range of partners and identifies a number of key areas for improvement. However, the plan contains no clear and specific impact measures or success criteria, making it difficult for virtual school managers and governors to gauge progress or achievement.
105. Managers are beginning to understand, interrogate and improve the accuracy of data and to identify performance and practice concerns at a team level. This progress is supported by a reporting and analysis manager. The local authority knows that this work is at an early stage and so is not consistently supporting the application of good practice across all areas, but it is helping to identify areas for priority action. Monthly outcome-focused performance reports identify the 'story behind the data' and include actions to address practice concerns and improve performance. This is beginning to help senior managers to understand the quality of social work practice and its impact on improving outcomes for children and young people (Recommendation).

106. Performance data gathered by the local authority has a number of important omissions. For example, no data is gathered on when children are seen following a referral or whether they have been seen alone. The local authority is not routinely tracking and aggregating other key performance data effectively to identify priority areas for action, for example children who are at risk of sexual exploitation. Work in relation to child sexual exploitation and children and young people who are at risk as a result of going missing, is underdeveloped and lacks both rigour and urgency. In cases where children go missing, 'return interviews' are not completed in all cases and there are no clear aggregated reports to identify themes and particular areas of concern to inform and plan future service delivery and interventions. This means that the local authority is not in a position to identify its own performance accurately or to implement remedial action (Recommendation).
107. Management oversight of practice by first-line managers is inconsistent and often absent. When it is recorded in children's case notes, the quality of decision making and guidance is also mixed, with a significant minority being poor. This lack of robust oversight by practice managers has led to drift and delay in progressing work with children and their families. Where it falls short, social work practice is weakest and assessments and plans lack rigour and purpose. Where inspectors saw management oversight of a higher standard, this helped support clear assessments, plans and interventions that are making a positive difference for children and young people. The level of scrutiny and challenge by the independent chairs of child protection case conferences is limited and lacks purposeful oversight and decision making, failing to identify or remedy weaknesses in cases. This adds to delays for children in receiving the right support for their help and protection needs (Recommendation).
108. Most social workers receive regular supervision, although the quality, timing, and recording of these are varied. Better examples seen provided clear analysis and direction with specific actions and some were linked to personal development reviews and contained case reflection. However, this is not a consistent picture and the majority of supervision is not of this standard. This means that social workers are less likely to receive the best support to develop their knowledge and skills to improve outcomes for children. Case notes do not always accurately reflect the level of management oversight that may have been given verbally. The result of this is that important detail or decisions about children may not be available in the absence of a manager, in the event of a change of social worker, or if it should be needed out of hours. Social workers report good access to training, but say that they are frustrated by uncertainty about the proposed new structure.

109. Practice is beginning to show some use of research and practice models to inform assessment and planning, but this is quite recent and limited in scope. There is little evidence in work with children and their families of any impact of the outcome-focused approach that the local authority has adopted. Despite some examples of good practice, such as young people's involvement in commissioning, feedback, including that from children looked after, is not generally used well to inform practice. The annual report for complaints in 2014–15 shows a rise from 29 in 2013–14 to 52 in 2014–15, with 2015–16 now at 69. However, the report lacks information about the reasons behind the increase. Learning from complaints is identified and recorded, but it is not clear how and if it informs practice development (Recommendation).
110. The local authority has developed a new structure to deliver its vision for improvement in children's services and taken some important and necessary steps to ensure that social workers have the right skills, knowledge and attitudes to deliver this and to improve outcomes for children and young people. A skills audit of the workforce has informed the integrated workforce strategy 2015–17, which appropriately focuses on culture change, collaboration, early help and protection, leadership and management, safeguarding knowledge and skills. A set of core skills and behaviours, informed by young people, is included in revised job descriptions. The structural proposals, currently in the consultation stage, are supported by a clear narrative and rationale about how the changes should improve practice. These planned changes have been risk assessed to make sure that service delivery is not negatively affected. Staff do not fully understand the detail and rationale for the plans. Most staff spoken to by inspectors were unable to explain the wider vision, despite a series of consultation and engagement events.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is inadequate

Executive summary

The Dorset Safeguarding Children Board (DSCB) is inadequate because it does not fully discharge its statutory responsibilities. The board is failing to adequately monitor the effectiveness of help being provided to children, young people and their families, including early help. It is not providing sufficient challenge and leadership at a strategic level, working with the Health and Well-being Board, as statutory guidance directs, or with partner agencies through the Dorset Children's Trust. This limits the board's ability to understand the key issues affecting children and young people, to assess whether DSCB partners are fulfilling their statutory obligations and to influence their practice.

The appointment of an experienced interim chair, who has provided leadership and helped focus the board, is an important step forward. This appointment is too recent to have made a demonstrable difference to the board's ability to fulfil its statutory functions. However, there is now a shared commitment from partners to make necessary improvements in the rigour with which the DSCB discharges its role as a 'critical friend' to agencies and provides leadership in key areas of practice, such as with children who go missing or are at risk of sexual exploitation. The active engagement of three capable lay members is a strength.

A lack of involvement from some agencies in the three multi-agency audits in 2015 limits the board's ability to understand the quality of frontline practice. The board's performance management framework lacks rigour and depth of analysis. It does not support shared partnership understanding and there is insufficient alignment to the business plan and annual report. This means that it cannot be confident that it knows about the seriousness or scale of any poor practice, areas of good practice, or understands the impact that these are having on children. As a result, and despite this being identified as a weakness in the 2014–15 annual report, the board remains unable to provide sufficient informed or effective challenge to agencies.

The DSCB's sub-groups are largely joint arrangements with the Poole and Bournemouth Local Safeguarding Children Board and these demonstrate some effective activity. However, a lack of consistent and appropriate Dorset membership of some sub-groups limits effectiveness. Up-to-date policies and procedures, an appropriate range of training and a process for the dissemination of learning from serious case reviews (SCRs) are all in place. A lack of evaluation means that the board does not consistently understand their effectiveness.

Recommendations

111. Ensure that the performance management framework, including a shared multi-agency dataset, is used to monitor and understand the effectiveness of services to children, to hold agencies to account for their effectiveness and to inform the DSCB's annual report and business plan.
112. Engage with agencies at a strategic level through partnership bodies, such as the Health and Well-being Board, to provide leadership and challenge, particularly in areas where services are weak or inconsistent, including those for children who may be at risk of sexual exploitation or from going missing and early help services.
113. Strengthen the multi-agency auditing of practice. Ensure that a full range of appropriate agencies are involved, that audits are linked to key areas of performance and that recommendations arising are tracked for completion and the impact they have on outcomes for children.
114. Ensure that learning from SCRs is effectively disseminated to staff across agencies, included in multi-agency training and that that the DSCB has a mechanism for evidencing that learning has positively effected changes in practice.
115. Make sure that the work of the SCR sub-group is effective by ensuring regular attendance by the full range of relevant agencies.
116. Ensure that the effectiveness of multi-agency training is monitored and evaluated to inform its development, and that it links to priorities identified within the board's business plan and by SCRs.

Inspection findings – The Local Safeguarding Children Board

117. The Dorset Safeguarding Children Board is not effectively discharging its statutory functions. These include failing to adequately monitor the effectiveness of help being provided to children, young people and their families, including early help. This is a serious failure because it restricts the board's ability to understand the key issues affecting local operational practice, whether DSCB partners are fulfilling their statutory obligations and the difference agencies are making for children and young people.

118. The board is not engaging with agencies at a strategic level to provide challenge and leadership. It is not working with the Health and Well-being Board, as statutory guidance directs, or with partner agencies in the Dorset Children's Trust. Agencies also report that they have struggled to fulfil board responsibilities due to a lack of capacity across the partnership. However, partners now express a shared commitment to drive forward improvements in the board's efficacy. Additional capacity has recently been added to the board's business support to help this focus on improvement and the future work of the DSCB (Recommendation).
119. The 2014–15 annual report highlights many areas for improvement, including strengthening the voice and influence of children, ensuring consistent membership of the board, developing a system to measure the effectiveness of training and improving the understanding of the profile of children at risk of sexual exploitation and those who go missing. The business plan for 2015–16 aligns with the outcome areas detailed in the 2014–15 annual report, but does not focus sufficiently on the activity required by partners to address these issues or how progress will be measured.
120. In January 2016, the director of children's services commissioned a peer review of the effectiveness of the board. This diagnostic report echoes the challenges highlighted by the 2014–15 annual report and identifies further significant deficits in the functioning and effectiveness of the board. These deficits include a lack of evidence of constructive challenge leading to change and improvement, and a failure to ensure that the safeguarding needs of children looked after and children with disabilities are clearly visible as a priority.
121. The experienced new interim chair of the DSCB is a strong appointment. Since his arrival in December 2015, he has demonstrated a clear understanding of strengths and development areas required of the agencies and individual members of the board. His approach of focusing on a small number of key areas has brought greater clarity and sense of purpose to the board, but is at too early a stage to have made a demonstrable difference to the efficacy with which the board discharges its statutory functions.
122. Three capable lay members are actively engaged in the work of the board. The DSCB business manager supports them to participate fully in board discussions and to have the confidence to contribute and offer challenge in meetings.
123. The DSCB performance management framework lacks rigour and analysis. This weakness, which was identified in the board's 2014–15 annual report, means that the board does not have a clear understanding of the strengths and weaknesses of frontline practice, to inform both the challenge and leadership it

provides to agencies. The framework has not been used by the DSCB to inform challenge to agencies or to drive service improvement. A lack of alignment between the performance management framework, the DSCB business plan and annual report limits the board's ability to monitor if agencies are making progress against identified priorities. The performance management framework is not actively used, alongside the annual report and business plan, to identify and shine a light on practice concerns, to challenge agencies to improve and then to monitor progress (Recommendation).

124. Scrutiny of work with children at risk as a result of going missing is particularly underdeveloped. A report to the DSCB on children who go missing contains a warning that the data may not be entirely accurate as work is ongoing, 'encouraging the accurate reporting of missing episodes'. This means that the board cannot be confident that it knows about the seriousness or scale of the problem, or the effect on children and young people. Despite this, and a lack of alignment between this work and that with children at risk of child sexual exploitation, the board has provided limited challenge or leadership to agencies (Recommendation).
125. The board's sub-groups are largely joint arrangements with Poole and Bournemouth Local Safeguarding Children Board. Both boards benefit from the well-established nature of these pan-Dorset sub-groups which demonstrate some effective activity. Such activity includes a refresh and revision of policies and procedures, the appointment of a training coordinator, and the development of a tracking system to monitor numbers of children at risk of sexual exploitation. Representatives from different agencies across the three local authority areas chair the sub-groups. This arrangement supports improved communication and cooperation between agencies and across local authority boundaries within the greater Dorset area. However, a lack of consistent and appropriate attendance at some sub-groups limits effectiveness in these areas. For example, the absence of a police representative at the last two meetings of the domestic abuse sub-group is unhelpful in this area of shared ground between the criminal justice and social care systems (Recommendation).
126. The DSCB quality assurance sub-group, which is not a pan-Dorset group, discusses key safeguarding issues. However the difference this group makes to the quality of agencies' practice is limited by the fact that audits and reports do not always give rise to clear actions and that when they do, these are not always accompanied by measures and processes for ensuring the implementation and for testing the impact of actions. The lack of involvement from some agencies in the three multi-agency audits in 2015 compounds the weaknesses in the performance management framework by adding a deficit in

the gathering and analysis of qualitative information to that in quantitative data. An audit of children at risk of child sexual exploitation did not have appropriate health involvement and did not sufficiently involve practitioners. Despite this, the report does make clear recommendations linked to accountable organisations or individuals with timescales for achievement. However, it lacks clear processes for measuring completion and impact. An audit of domestic abuse had limited police and out of area schools' engagement, meaning that the understanding and monitoring of multi-agency practice in these areas is limited. Despite the board's annual report noting the need for a stronger strategic approach and an improved early help offer from agencies, the board has exercised little scrutiny of practice or strategic challenge in this important area (Recommendation).

127. The child death overview panel (CDOP) is effective. It has a consistent membership of sufficient seniority to ensure that actions agreed can be followed up in individual agencies. An effective rapid response process provides a coordinated approach to unexpected deaths. There is clear evidence of how learning from the analysis of incidents drives improved practice. For example, an analysis of the deaths of children with life-limiting conditions led to a review of palliative care, which in turn shaped the recommissioning of services, improving the experience of families in these very difficult circumstances.
128. The SCR panel has a broad approach to learning and considers 'any case that is brought to their attention'. This open approach has the positive impact of maximising opportunities to identify learning that could be used to improve future practice. However, the volume of work arising from the high number of referrals to the panel also results in some partner agencies having limited capacity to participate in audits and sub-group activity. Meetings of the panel in October and December 2015 lacked sufficient multi-agency representation to be quorate. This means that, although meetings clearly highlight important issues and attribute remedial actions to agencies, the quality of discussion and analysis is necessarily limited by the reduced attendance. 'The SCR Overarching, Outstanding Action Plan from SCRs, Serious Case Audits and Domestic Homicide Reviews' is used to collate and monitor the completion of agreed actions arising from SCRs, serious case audits and domestic homicide reviews. However, actions are not prioritised according to importance or risk and the tool is poorly used to track implementation in agencies and to understand the impact on practice (Recommendation).
129. Learning from SCRs is disseminated to all frontline practitioners in the partnership through a 'synopsis of learning'. A recent review carried out by the local authority to measure the effectiveness of this approach found limited

evidence that social workers' practice was altered or improved as a result. Social workers spoken to by inspectors were not consistently aware of either the 'synopsis of learning' or key messages from local SCRs (Recommendation).

130. DSCB sub-group chairs meet regularly to gain an oversight of current issues for children in Dorset. This provides a positive opportunity for shared learning. The multi-agency training strategy, housing agreement for care leavers and threshold document all stem from the helpful coordination and overview role of this group.
131. The board provides a range of relevant training. A record of agency attendance at multi-agency training is kept, but the lack of analysis and evaluation means that the board is not able to assess the effectiveness of the training on improving practice. A recently appointed coordinator now provides the capacity for better coordination and monitoring, but this is new and not sufficiently established to have had a significant impact (Recommendation).
132. Records of board meeting minutes show that there is insufficient evidence of effective challenge. The board's challenge log records 21 challenges between January and October 2015, but little evidence of follow-up action demonstrating how challenge has improved practice, or children's outcomes. For example, challenge to partner agencies to provide data for the new performance management framework lacked specific actions, time-scales, or any monitoring process. A difficult issue, escalated to the board by CDOP about how to engage more closely with a bereaved family, did not receive any response from the board. The chair of CDOP reports that, since the recent appointment of the new independent chair of the DSCB, both the quality and promptness of communication between the board and CDOP have improved markedly.
133. Risks identified in the board's risk register predominantly relate to systems and resources. Although these risks do have a place in the register, there is a lack of focus on outcomes for children and a consequent failure to attach sufficient weight to areas of importance, such as the risks arising from child sexual exploitation, going missing and the inconsistent early help offer in Dorset.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of eight of Her Majesty's Inspectors (HMI) from Ofsted and two additional inspectors.

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