Poole Borough

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 Board[1]

Inspection date: 11 September 2017 to 5 October 2017

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

[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

Children's services in Poole require improvement to be good. Since the last inspection in 2011, the director of children services (DCS) and her senior leadership team have worked purposefully with partners to implement a number of systemic changes to sustain and improve outcomes for children. These include the introduction of a new electronic casework system, the appointment of an interim service head, the development of a stable and committed workforce, the creation of the multi-agency safeguarding hub (MASH), the transfer of adoption services to a regional adoption agency, the strengthening of early help services and restructuring of services to children in need.

As a result, some children receive helpful interventions. Yet, despite these developments, outcomes for children across the services are inconsistent. While the council's adoption performance and its support for care leavers are strong, the pace of overall improvement across the service has been variable, and weaknesses have emerged in services for children looked after and in need of help and protection. Senior managers know that there is still work to do to strengthen many aspects of social work practice to make it consistently good.

Leaders and politicians have a good understanding of strengths and weaknesses. Nevertheless, this has not translated into swift enough action to drive improvement and achieve consistent standards across the service. Clear governance arrangements are in place. The improvement board's role in overseeing performance and progress has been strengthened by independent validation. The council's improvement plan is focused on the right areas and has led to some improvements, such as regular visits from social workers, timely children looked after reviews and a reduction in social workers' caseloads. Nonetheless, there has not been sufficient impact to improve all key areas of practice. In particular, a minority of strategy meetings and child protection investigations are delayed, and partners are not consistently attending child protection conferences or core groups. Weak management oversight and some poor practice in the out-of-hours service have left some children vulnerable.

Senior leaders' introduction of a comprehensive quality assurance framework has strengthened service improvement in some areas. Still, quality assurance activity is not yet improving outcomes for all children across the whole service, due to inconsistent management oversight of frontline practice. Regular supervision takes place for the vast majority of social workers, but the quality is variable and not yet sufficiently reflective to challenge ineffective practice.

Vulnerable children benefit from comprehensive and coordinated early support to prevent problems from escalating. Staff act quickly to protect children at risk of serious harm. Strategy meetings, where appropriate, lead to child protection enquiries and timely conferences for those most at risk. A lack of capacity in the MASH has, however, affected the timeliness of responses to non-urgent referrals. Additionally, the authority has not put in place the performance data needed to

monitor the effectiveness of step-up and step-down processes. Staff are not consistently recording parental consent or the reasons for overriding it.

Assessments, including pre-birth assessments, are informative and include the child's views or perspectives, with a clear analysis of ongoing needs. Conversely, staff do not always adequately capture the child's identity and cultural heritage. Most plans facilitate positive change. However, there is neither sufficient attention to contingency planning or identification of potential alternative carers earlier, which creates potential delay. The authority makes effective use of the Public Law Outline (PLO), as confirmed by feedback from the family justice courts and the Child and Families Court Advisory Support Service (Cafcass).

The local authority looks after children when necessary. Occasionally, for older children, the admission to care has been delayed due to a lack of suitable local foster placements. When children are placed in an emergency, foster carers report that they are not always provided with sufficient information to meet their needs. A small but significant number of children have remained overnight in police custody or in unsuitable environments as a result of the lack of placements. However, overall, most children live in good-quality foster placements that meet their needs. Care plans support effective permanency planning, and contact arrangements are up to date. Plans for children who return home from care are thorough, and they reduce the likelihood of children returning into local authority care.

Work with children who have experienced or are at risk of sexual exploitation and/or going missing is effective. Risk assessments and return home interviews carefully consider all risks and are timely. The local authority and the police have significantly strengthened their response to this area of work. As a consequence, children are better supported and protected.

Services for children requiring adoption are good. The authority is achieving permanence through adoption for children from a range of different ages and backgrounds. Social workers prepare children well for their transition to their adoptive families.

Care leavers receive a good service. Staff support them well to progress in education, training and employment, and in preparation for independent living. Young people speak highly of their personal advisers and the availability of the pathway team. While pathway plans are up to date, they do not adequately record young people's aspirations.

The corporate parenting panel scrutinises performance and outcomes for children looked after. It works closely with the Children in Care Council and scrutiny panel. Leaders involve children effectively in a wide range of decisions about services. The council offers apprenticeships to care leavers. However, elected members have not exerted enough challenge in response to the insufficient provision of foster carers for older children.

Contents

The local authority

Information about this local authority area[2]

Previous Ofsted inspections

- The local authority does not operate any children's homes.
- The previous inspection of the local authority's safeguarding arrangements was in November 2011. The local authority was judged to be good.
- The previous inspection of the local authority's services for children looked after was in November 2011. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since October 2012.
- The DCS is also responsible for adult social care and housing, which together with children's social care comprise the 'People' theme.
- The chief executive has been in post since June 2014.
- The chair of the LSCB has been in post since July 2016.
- The LSCB is shared with Bournemouth. Some working groups are also shared with Dorset LSCB.
- Adoption services are delivered jointly with two neighbouring local authorities through a regional adoption agency, Aspire, launched in July 2017

Children living in this area

- Approximately 30,000 children and young people under the age of 18 years live in Poole. This is 20% of the total population in the area.
- Approximately 16% of the local authority's children aged under 16 years are living in low-income families.
- The proportion of children entitled to free school meals:
  - in primary schools is 12% (the national average is 15%)
  - in secondary schools is 7% (the national average is 13%).
- Children and young people from minority ethnic groups account for 7% of all children living in the area, compared with 21% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Other White, and White and Asian.

[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.

- The proportion of children and young people with English as an additional language:
  - in primary schools is 9% (the national average is 20%)
  - in secondary schools is 5% (the national average is 16%).

Child protection in this area

- At 12 September 2017, 929 children had been identified through assessment as being formally in need of a specialist children's service. This is a decrease from 974 at 31 March 2017.
- At 12 September 2017, 106 children and young people were the subject of a child protection plan (a rate of 35 per 10,000 children). This is an increase from 80 (27 per 10,000 children) at 31 March 2017.
- At 31 August 2017, five children lived in a private fostering arrangement. This is an increase from one at 31 March 2017.
- In the two years before inspection, one serious incident notification had been submitted to Ofsted and one serious case review had been completed.
- There are no serious case reviews ongoing at the time of the inspection.

Children looked after in this area

- At 12 September 2017, 200 children are being looked after by the local authority (a rate of 66 per 10,000 children). This is an increase from 190 (64 per 10,000 children) at 31 March 2017. Of this number,
  - 90 (45%) live outside the local authority area
  - 17 live in residential children's homes, all of whom live out of the authority area
  - 126 live with foster families, of whom 36% live out of the authority area
  - eight live with parents, of whom 38% live out of the authority area
  - 24 children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been 16 adoptions
  - nine children became the subject of special guardianship orders
  - 102 children ceased to be looked after, of whom 2% subsequently returned to be looked after
  - 12 children and young people ceased to be looked after and moved on to independent living
  - no children and young people ceased to be looked after and are now living in houses in multiple occupation.

Recommendations

1. Ensure that there is sufficient capacity in the multi-agency safeguarding hub for timely sharing of information to meet the needs of children.

2. Ensure that parental consent is recorded at the point of referral and that, when overridden, the rationale to do so is clearly explained.

3. Improve contingency planning in child protection and child in need cases, so if the plan is not effective it is clear what actions will follow.

4. When children step down from children's social care to early help services, take steps to ensure that the child's plan is clearly understood and recorded prior to the point of transfer.

5. Ensure that there is sufficient capacity in the out-of-hours service to meet the needs of children and provide effective oversight and challenge of the management of this service.

6. Ensure that staff, including out-of-hours staff, receive regular good-quality supervision with appropriate critical challenge and opportunities for reflection.

7. Increase the effectiveness of management oversight across the service, ensuring that decisions and actions are clearly recorded, including from meetings, within children's case files.

8. Accelerate progress in increasing the numbers of foster carers who can meet the needs of older children with more complex needs, particularly in an emergency. Ensure that this is informed by a clear needs analysis.

9. Ensure that foster carers are provided with sufficient up-to-date information about children placed with them to enable them to provide the support that they need.

10. Ensure that identification of potential carers and viability assessments are routinely considered at the earliest opportunity as part of the Public Law Outline process.

11. Develop the skills of the workforce to ensure that children's identity, culture and ethnicity are actively considered in assessments, and inform planning.

12. Strengthen systems for oversight of the progression of children's permanence to ensure that they do not experience unnecessary drift and delay.

Summary for children and young people

- Not all services for children in Poole are good enough. There is still more work to do to make sure that all children have the help and support that they need at the right time, and to make sure that there are enough foster homes.
- There are plenty of different services in Poole that help children and families so that small problems do not become big ones. Sometimes, however, it takes too long for the help to start to make things better.
- When children are at risk of very serious harm, social workers act quickly to make sure that they are as safe as possible.
- Social workers spend time with children and listen to them to find out what is worrying them. However, they do not always talk to all of their family members to help them to work out the best way of helping children.
- When children go missing from home or school, social workers and police officers work hard together to find them and make sure that they are safe. Once children have been found, someone independent talks to them to try to understand the reasons why they went missing and to find ways to stop this happening again.
- For children who cannot live with their families, social workers find the right families for them where they can feel happy and safe. For a few children, though, this takes too long.
- When adoption is the best plan for children, social workers find the right family for them quickly. Children are well prepared for their move to their 'forever' family and they receive bright, colourful life-story books to help them to understand their life experiences.
- When young people leave care, they are well supported. They get on well with their personal advisers, who keep in touch with them well into their adult lives.
- There is an active Children in Care Council in Poole. Senior leaders listen to children's views and act on them.
- Senior leaders understand their responsibility to make sure that children in care are well looked after. They have high aspirations for them to succeed in later life.
- Senior leaders want to make sure that all children and families have good help and support. They have some really good ideas about how they are going to improve some services for children.

The experiences and progress of children who need help and protection	Requires improvement to be good

Summary

Children and families in Poole benefit from early help services that are well targeted and coordinated effectively. Staff undertaking early help assessments engage parents and children effectively, and families are signposted to appropriate activities and groups.

The multi-agency safeguarding hub (MASH) is ensuring the prompt initial screening of contacts and the prioritisation of the most urgent cases. For the majority of children, multi-agency coordination is effective. However, information sharing is not timely for all children and, as a result, delays can occur in progressing contacts and referrals. Parental consent is not always routinely recorded.

The majority of strategy discussions and child protection investigations are timely. However, a small number are delayed due to the lack of police availability. Child protection conferences are appropriately convened, but they are not always well attended by key professionals. Social workers see children regularly and alone. They build trusting relationships with children and undertake creative, child-centred direct work, including the child's voice in their assessments.

Children's views are well represented and inform subsequent child protection plans. Although plans are timely and child focused, they do not always include contingency plans in case children's circumstances do not improve. When risks to children have reduced and responsibility for helping them is stepped down to early help services, plans are not always clear about what support will be provided.

The majority of assessments include appropriate historic and multi-agency information, with clear analysis leading to appropriate decisions and actions. However, in a small number of cases, birth fathers and other extended family members are not spoken to. Consequently, their views and potential contribution to improving children's lives are not known or fully considered.

Decision-making and management oversight in the out-of-hours service are not consistently effective. This weakens the council's response to children's needs when issues arise outside of office hours.

Children who go missing receive timely and supportive return home interviews. Partners work together well, sharing intelligence to safeguard children who go missing and reduce risks of exploitation or drug- and group-related criminal activity. Staff ensure that regular risk management meetings take place. However, these are not always well recorded.

Inspection findings

13. The local authority has strengthened its early help provision to try to ensure that children and families receive the right interventions at the right time. As a result, children and families benefit from a wide range of early support. For example, the aligning of health visitors with children's centres has led to 88% of all children aged up to five years in Poole being registered with a children's centre, enabling early access for those who need speech and language support and ensuring that children are better prepared for starting school. However, a lack of performance information is limiting the ability of managers to understand the impact of some of its targeted services on individual children's outcomes over time.

14. Early help assessments are comprehensive and mostly of good quality. Early help plans are clear and regularly reviewed. Workers are tenacious in ensuring that actions are progressed, with signposting and support for other activities and groups. They are stepped up appropriately to social care if risks or concerns escalate. This is making a positive difference to children's lives, for example in improving school attendance and educational outcomes.

15. When children are in need of help and protection, the recently developed MASH is the central point of contact for members of the public and professionals. Thresholds are generally well understood and applied by partners. However, police notifications are not all of good quality, and not all meet the threshold for children's social care. As a result, social workers in the MASH are placed under pressure through gathering unnecessary information. The initial screening of contacts by the manager is prompt, and the most urgent cases are prioritised. In the majority of children's cases, the response to referrals is effective, ensuring that risks are well managed. However, parental consent is not routinely recorded, and the rationale for the overriding of consent is not clearly evidenced. Where it appears that there are low levels of need at the point of contact, there are delays in gathering information to inform decisions on the next steps needed to support children and families. (Recommendation)

16. Children who need help from the out-of-hours service do not consistently receive a good enough response. Inspectors found shortfalls in the service, including poor recording and management oversight. In a small number of cases, unacceptable responses left children in vulnerable situations for too long. While the pace of progress in response to concerns has been too slow, during the inspection senior managers took action to review and strengthen the service.

17. When children are at possible risk of harm, the vast majority receive a timely response, and risks and protective factors are identified effectively. However, inspectors saw delays in a small number of strategy discussions and child protection enquiries due to the lack of police availability. All child protection investigations are discussed with the manager of the child protection

conference chair's team to consider whether the threshold for an initial conference is met. Timely initial child protection conferences are held, and the vast majority appropriately lead to child protection plans as the most effective means to ensure that children are safeguarded and their needs responded to.

18. Social workers see children regularly, and they see them alone when appropriate. They build trusting relationships with children and undertake creative, child-centred direct work to include their views and experiences in assessments. Inspectors saw some good examples of sensitive engagement with disabled children that is ensuring that their voice, opinions and feelings are heard. Workers engage with families to ensure that appropriate support and intervention are in place to reduce risk and improve outcomes for children.

19. Most assessments, including pre-birth assessments, consider appropriate historic and multi-agency information. They have clear analyses and lead to appropriate decisions and actions. However, in a small number of cases, birth fathers and other extended family members are not spoken to. As a result, their views and potential contribution to improving children's outcomes are not known or considered.

20. Children's identity and culture are not sufficiently considered in assessments. For example, in large groups of brothers and sisters, individual children's needs are not always clearly differentiated. Children are often only seen once, and do not routinely receive feedback on the outcome of their assessments.

21. Young people aged 16 to 17 who present as homeless are jointly assessed by social work and housing support colleagues. Appropriate efforts are made to support children to remain in their extended families. A wide range of supported accommodation is available. However, assessments of a small number of children are not sufficiently rigorous, and they remain without suitable accommodation for too long.

22. The majority of child protection plans are timely and child focused, supporting change for children. Conferences and core groups are largely effective in progressing plans, though attendance by relevant health colleagues is not consistently good. This means that information regarding some children's health needs and progress is not always available. This issue has been escalated to the Local Safeguarding Children Board, yet it has not been resolved at the time of the inspection. An advocacy service supports children effectively to present their views at child protection conferences, which informs child protection plans.

23. Contingency plans in child protection and child in need cases are not always specific about what will happen if a plan is not successful. For example, in the event of circumstances changing, the only contingency recorded is to seek legal advice. (Recommendation)

24. When concerns reduce and children transfer from social care to early help, their records do not show clearly enough how their needs will be met and what services they will receive. This makes it difficult to assess whether children are receiving the right step-down service. (Recommendation)

25. Disabled children benefit from comprehensive plans. Transition planning for disabled children is appropriately and thoroughly considered at an early stage. They are well protected when safeguarding concerns are identified. Effective management oversight and good use of letters of expectations with parents ensure that risks are clearly understood and addressed.

26. However, the quality of management oversight and supervision is not yet consistently good across children's social care as a whole. For some children, this means that actions to progress plans and improve children's circumstances are not taken quickly enough. In a small number of children's cases, there is drift and delay in responding to increasing risks or limited progress.

27. Children living in families where domestic abuse is a feature are appropriately referred to effective and well-attended multi-agency risk assessment conferences (MARAC). These arrangements are well coordinated and partner agencies appropriately share information to consider risk. A wide range of commissioned services are available to help children, victims and perpetrators, and reduce risk. Co-locating a specialist domestic abuse worker in children's social care, alongside adult mental health and substance addiction practitioners, ensures that the right knowledge and skills are available to manage risks to children and address identified needs.

28. When children return, having gone missing, a dedicated worker coordinates return home interviews. Most children are seen promptly, with appropriate information gathered about the reasons why they have gone missing. A rationale is recorded for each child not receiving an interview within 72 hours of their return. Effective systems are in place to ensure that all missing notifications of children are tracked to completion, including children looked after. Intelligence is appropriately shared with the police child sexual exploitation and 'missing' team.

29. Effective partnership working reduces risks to children from sexual exploitation. Six-weekly meetings share intelligence about the most vulnerable children. They focus on hotspots and the planning of disruption activities, leading to a number of prosecutions in the last year. Thorough, good-quality risk assessments are routinely undertaken by social workers, resulting in safety plans to reduce risk. Regular meetings take place to discuss high-risk cases. However, recording of these meetings is poor, therefore it is hard to evidence the difference that multi-agency arrangements are making to reduce risk for children in a timely way.

30. The local authority is meeting its responsibilities with respect to private fostering. A dedicated private fostering social worker takes responsibility for the assessment of all carers. However, despite the majority of private fostering arrangements in Poole relating to overseas students attending language schools, issues of diversity and identity are not well recorded in assessments. Assessments and plans are not routinely shared with children and birth families.

31. Responses to allegations against professionals are well managed by the designated officer. Allegations are taken seriously, resulting in proportionate and robust plans. Briefings and training sessions are provided to ensure that a wide range of employers are kept up to date. A dedicated designated officer supports all education establishments, making relevant staff and school governors aware of their roles and responsibilities.

32. Good arrangements are in place to monitor children who are electively home educated and those who go missing from education. Home visits are carried out to assess arrangements to protect and safeguard children and ensure that they are receiving a good education. There is swift follow-up where there is non-compliance.

33. Arrangements are in place to identify and respond to children at risk of radicalisation. The 'Prevent' lead provides effective oversight and coordination. There is clear guidance in place for local professionals, and regular training is provided across the partnership, both face to face and via e-learning. However, there have been no training events planned or delivered to supportive lodgings providers. This is a missed opportunity.

34. The council and its partners have delivered multi-agency training to ensure that professionals are aware of risks and reporting requirements in relation to female genital mutilation and forced marriage. There has been only one female genital mutilation referral in the last six months. Agreed procedures provide clear guidance, including a flowchart to help staff to understand what needs to happen, including the need for strategy discussions and who should be involved.

The experiences and progress of children looked after and achieving permanence	Requires improvement to be good

Summary

Outcomes for children looked after in Poole are not yet good, because services are not consistently meeting the needs of all children. When children are unable to live with their families and need to be looked after, the majority benefit from timely decision-making and entry to care. However, the local authority is not providing suitable accommodation for all children quickly enough. As a result, a small but significant number of older children have remained in police custody overnight when they should have been in the care of the local authority.

A small minority of children have been looked after for too long because of delays in progressing permanence plans, and this has impacted on their emotional health and behaviour. The majority of children looked after live close to home and benefit from good-quality, stable and safe placements. However, there are not enough local placements for children needing to be placed in an emergency or children who have complex needs. Foster carers are not always provided with detailed information about the children whom they are caring for in an emergency.

Most assessments of children's needs are of sufficient quality to inform placement choice and support care planning well. However, many do not consider children's ethnic, cultural and identity needs carefully enough. Children benefit from regular reviews, and independent reviewing officers increasingly challenge and escalate concerns. However, they do not consistently identify drift early enough.
When children go missing from care or are at risk of sexual exploitation, timely appropriate action is taken to monitor, review and reduce risks. Up-to-date health assessments are in place for most children. However, the provision of mental health support is insufficient to meet the needs of the looked-after population.

Children have meaningful relationships with social workers, who know them well. Effective direct work undertaken with children is helping them to understand their histories. Children looked after are making appropriate progress in their level of development, as well as improving their personal and social skills. Attendance at school is improving steadily. While most receive prompt health assessments, this is not happening consistently for those living at distance from Poole.

Adoption services are good, and permanence through adoption is achieved for children from a range of different backgrounds and ages.

Staff support care leavers well, helping to sustain them in education, training and employment. This includes creating individualised apprenticeships for them within the council's services.

Inspection findings

35. The majority of children in Poole become looked after when it is in their best interests to become so. However, for a small number of children, earlier planning and identification of risk would have prevented the need for emergency admission into care. There are not enough emergency placements available. Due to an insufficient number of local placements, seven of 15 children arrested in the last six months have been held in police custody overnight when they should have been transferred to the care of the local authority. This can be a confusing and traumatic experience for children. A minority of children who become looked after, particularly on an emergency basis, do not always benefit from robust multi-agency assessments and experience a number of early placement moves, compounding the emotional distress that they are experiencing.

36. Decisions about children's long-term futures are taken early enough in most cases. The local authority works to reunite children with their parents where possible, and actively considers special guardianship orders with relatives where this cannot be achieved safely. However, for a small number of children, permanence decisions have not been considered or progressed with sufficient urgency. At the time of this inspection, a number of children who were settled and thriving in their foster homes had not been matched to their current long-term carers, whether as foster carers or adopters. Managers are aware that this affects children's emotional health and behaviour.

37. Most children are placed with foster carers within 20 miles of their home, and long-term placement stability is good. Robust commissioning arrangements mean that children, including unaccompanied asylum-seeking children, are in supportive, stable and safe placements. However, the local authority does not provide or commission enough suitable local foster homes or emergency placements for older children who have more complex needs. As a result, children are sometimes placed at some distance from their homes. This adversely affects their family contact, relationships and travel time. While senior managers identified this shortfall in 2016, their action plan to increase capacity in this area has not yet had the impact needed. (Recommendation)

38. The local authority does not provide a specific 'edge of care' service to reduce the need for children to become looked after. However, there is early planning to return children home. This is strengthened by clear support plans and good direct work undertaken by social workers and family support workers. Effective intervention services ensure that reunification is successful in the majority of cases. When it is appropriate for children to remain at home while they are looked after, the local authority provides a good range of interventions to ensure that they are safe, and cared for.

39. Thresholds for care proceedings are appropriate and they progress in a timely manner, with the majority of children's cases being completed within 27 weeks, on average. Court reports and assessments of family members are of

good quality and undertaken by well-supported and experienced social workers. The local authority has developed the skills of social workers to undertake specialist parental assessments, limiting the need for independent experts. However, it does not have a systematic approach to pre-proceedings, and this hampers effective oversight of cases and increases the potential for drift and delay. In a small number of children's cases, late identification of potential carers has impacted on the timely progression of care proceedings. (Recommendation)

40. Children have meaningful and consistent relationships with social workers, who know them well. Visiting is regular and purposeful. Most children understand the reasons that they are in care and the future plans for them. A stable workforce is ensuring that children do not experience unnecessary changes of social worker. Inspectors saw good examples of life-story and direct work helping children to understand their histories and make sense of their experiences.

41. Assessment of foster carers, including connected carers, is a strength. Appropriate training and support equip carers with the skills that they need to care for the vast majority of children. Children have access to a range of appropriate leisure and social activities. Carers are able to make decisions about children's day-to-day care arrangements. However, they report that they are not consistently provided with full information about children who are placed with them in an emergency, or those with complex needs. As a result, a minority of children are not always well matched. For some, this has led to a number of early placement changes and delays in their needs being met. (Recommendation)

42. The majority of children have an up-to-date assessment of need. They benefit from detailed and timely care planning. Contact with family and friends is routinely considered within assessments, reflecting children's needs and permanency plans. However, the use of chronologies is limited, therefore significant events in the child's experience and journey are not always recorded. Consideration of children's cultural, ethnic and identity needs is not consistently given or used to inform planning. (Recommendation)

43. The independent reviewing service is an experienced and stable staff group. Although caseloads are at the upper end of the range recommended in national guidance, reviews are undertaken in a timely manner. Independent reviewing officers (IROs) are increasingly raising challenges or escalating cases, aided by a formal alert system. However, capacity issues have limited the opportunities for IROs to check the progress of children's plans between their reviews. As a result, drift and delay in progressing permanence plans or service provision are not always identified at an early stage. (Recommendation)

44. Children actively participate in their reviews, and their wishes and experiences are listened to, reflected in records and inform planning. Advocacy is actively

promoted and children and young people are increasingly benefiting from access to independent visitors.

45. The school attendance of children looked after up to the age of 16 has improved over the last year, but is not yet meeting the local authority target. There were no permanent exclusions in 2016/17. Effective arrangements are in place for the small number of children looked after who are missing education to receive suitable education and improve their attendance and achievement.

46. There is appropriate monitoring and oversight of the pupil premium. The virtual school headteacher ensures that schools use pupil premium funding carefully to improve the educational, personal and social development of children looked after.

47. Children's personal education plans (PEPs) are monitored and reviewed regularly by the virtual school headteacher. There is good liaison with all schools to ensure that PEPs reflect and anticipate children's needs to improve their achievement and attainment. While schools receive clear feedback, the virtual school headteacher does not produce a summary of good practice from the findings from the individual reviews.

48. Children looked after are making appropriate progress in their level of development at the different key stages. The difference in achievement between children looked after in Poole and those nationally is reducing.

49. Following a significant dip in performance in 2016–17, children placed in Poole and in neighbouring authorities benefit from increasingly timely health assessments that identify their needs. These are informed by strengths and difficulties questionnaires. Regular reviews of plans are undertaken by the health team to ensure timely progression of actions. However, a small number of children who are placed at a distance from Poole experience considerable delays before their initial health assessments and when specific health services are required to address their needs.

50. Health professionals co-located with the children in care social work team are available to provide direct interventions with children, as well as consultation for carers to support children in their placement. However, not all children looked after and care leavers who need specialist mental health support have timely access to relevant services. For a minority of children, this has affected the stability of their placements, their emotional well-being or their educational achievement. The small number of young people with substance misuse issues or who are involved in the criminal justice system are known, and receive timely and effective multi-agency interventions to address needs and concerns. Effective services are in place across agencies to ensure that professionals are aware of and able to support children who are experiencing bullying or discrimination.

51. The Children in Care Council is a well-established, strong and visible group, and members are actively promoting the voice and experiences of children looked after. They are involved in staff recruitment, have contributed to the development of the 'Pledge' for children looked after and meet with the DCS on a regular basis, as well as attending the corporate parenting board.

The graded judgement for adoption performance is that it is good

52. The local authority considers adoption for all children who require permanence at the earliest opportunity. In the last year, the local authority has been successful in achieving adoption for an increasing number of children. This includes older children, brothers and sisters together, children from minority ethnic backgrounds and placements for children with complex needs. It takes longer to find the right families for these children, and this has had some impact on the local authority's overall performance in relation to the timeliness of adoption. Nevertheless, children in Poole still move to live with their adoptive families more quickly than children in many other parts of the country.

53. Positively, a number of older children have achieved legal and emotional permanence through adoption by their long-term foster carers. However, for a very small minority of these children, there has been some delay in having this arrangement ratified by the court. While the impact of this is minimised by children not having to experience a change of carer, they have found the need to remain in care frustrating.

54. Family finding is thorough and sensitive to the needs of each child. Social workers and managers rigorously track all children with a potential adoption plan from a very early stage. Having a family-finding social worker allocated to children early in care proceedings means that, by the time that the court has confirmed an adoption plan, social workers know children well and understand what they need. Social workers share information about children and prospective adopters promptly across the regional adoption agency and the south west consortium. This, as well as the good use of national links and the use of adoption exchange and activity days, helps to ensure that permanence is achieved quickly. All but a small minority of the 12 children currently waiting have potential links to adopters.

55. The local authority actively promotes fostering to adopt arrangements. At the time of the inspection, seven children were benefiting from these arrangements. A foster to adopt carer spoken to during the inspection commented: 'It's the best thing we have ever done. We weighed up the risk and it is the right thing for the child.'

56. Assessments of potential adopters are timely and thorough. They explore the prospective adopters' motivation and capacity to adopt, as well as their practical and emotional circumstances. This enables the adoption panel and agency decision maker (ADM) to make informed recommendations and decisions about approval. Adopters from a range of backgrounds are approved, reflecting the composition of the local area.

57. The majority of child permanence reports are of a good quality. They provide a clear understanding of the child's lived experiences. Matching reports demonstrate the efforts of social workers to find the right match for children. However, matching reports could be further strengthened by carefully considering children's identity needs when they become adopted.

58. Overall, matching is effective. Prior to placement, every adopter has the opportunity to meet with the medical adviser and a clinical psychologist to discuss the child's physical, emotional and psychological needs. This, as well as the life appreciation days held before placement, provides adopters with in-depth information about their children. There have been no adoption disruptions in the past two years, demonstrating the effectiveness of the local authority's matching processes and support services.

59. A diverse panel, supported by an experienced independent chair, makes effective decisions regarding adoption decisions. Panel and ADM minutes demonstrate robust scrutiny and appropriate challenge when considering approvals and matches. Quality assurance systems are well established. The panel provides feedback to social workers in every case considered and seeks feedback from prospective adopters about their experiences during their adoption journey. The senior manager of the agency knows the service well and is committed to continually improving the quality of the service.

60. Social workers and family support workers use effective tools to help children to prepare for their transition into their adoptive family. Colourful, individualised 'moving calendars', similar to advent calendars, help children to understand their transition. Beautifully presented life-story books, written in child-friendly language with plenty of photographs, bring children's histories to life. These books, combined with informative later-life letters, help children throughout their childhoods and into adulthood to understand their life experiences in a meaningful way.

61. Adopted children benefit from sensitively assessed, meaningful contact with birth family members. Staff in the adoption and special guardianship support team facilitate letterbox contact and, where appropriate, direct contact between children and members of their birth family. As a result, children benefit from maintaining relationships and receiving letters that will add value to their lives in terms of their identity.

62. Adopters and their children have access to a range of post-adoption support. This includes support groups, activities, celebrations, parenting programmes,

training opportunities and access to clinical psychologists. Well-trained social workers undertake direct work with children and their adoptive parents. The agency is in the process of increasing capacity and skill within the adoption support team to meet an increasing need for support. Good use is made of the adoption support fund when more specialist support is required. This has helped children and their parents to deal with specific difficulties and to maintain stability in their families. Birth parents also have access to appropriate counselling and support, and are routinely signposted to them.

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

63. The pathways team provides effective support to 125 care leavers. Of these, 73 are aged 18 and above and 52 under 18. The numbers include 20 unaccompanied asylum-seeking children.

64. Children looked after receive a smooth and effective transition to the pathways team. Their involvement starts at 15 years and three months, when personal advisers come to know them while they are still supported by their social workers. These children benefit from this arrangement until they are 18. They speak highly of the support that they receive and the frequency of contact. At the time of inspection, personal advisers were in touch with all care leavers, improving on the previous year when they were in touch with all but four care leavers.

65. Care leavers feel safe and are aware of risks, such as misuse of alcohol and drugs. They know where they can obtain help when they need it. For example, the close support of personal advisers enables care leavers to overcome substance misuse and the challenges of family contact. Personal advisers make sure that care leavers have suitable plans in place when they are being released from custody. They are vigilant about risks to vulnerable young people from exploitation, particularly for young unaccompanied asylum seekers.

66. Constructive involvement of care leavers through the pathway planning process helps them to review their progress and plans. Plans are regularly updated, comprehensive and cover areas of importance such as health, finance and accommodation. Through the process, care leavers express their views clearly. Although only a few do so with enthusiasm and they consider pathway plans to be too long, they value and act on the suggestions, helping them to make choices about work or training and education or to cope with changes in their personal circumstances.

67. In recording the views of care leavers, pathway plans do not bring out sufficiently their feelings about themselves and their aspirations. Timescales and contingency arrangements in the plans are not precise enough.

68. Pathway plans include comprehensive information on the health of care leavers. They receive health passports that record the essential information in one place, which they find helpful. They have support from the children in care nursing team, and some emotional well-being services are available for them. However, inspectors found that some young people who need clinical mental health services face long waits before accessing the specialist help needed. Their personal advisers make sure that their dental and other medical health needs are met in a timely way.

69. Care leavers receive good support from their personal advisers on their journey towards being independent, including helping them to look after their finances sensibly. The pathways team makes sure that care leavers use the grants for which they are eligible prudently, and that they learn how to budget. Care leavers learn about living independently through short-term use of a training flat. The service is now acquiring another such training flat for older care leavers.

70. Accommodation for care leavers is well planned and they live in safe, stable and suitable accommodation. At the time of inspection, 14 young people had 'stayed put' with their foster carers. Personal advisers or social workers always visit and assess accommodation risk and, in most cases, prepare care leavers well in pre-placement meetings. They are firm in rejecting unsuitable accommodation in areas of high anti-social behaviour, where the young people would be vulnerable. The pathways team works closely with the housing manager in the housing bidding system so that care leavers gain preferential status.

71. Care leavers receive good support to enable them to remain in education, employment or training. The partnership with the local college is very effective and a high proportion of care leavers undertake appropriate courses. They receive appropriate advice and guidance before making their decisions. A well-resourced drop-in centre in the town is also a good source of information and support for them.

72. A dedicated employment and education adviser works closely with care leavers and schools to make sure that the young people have the right information to help them to make their choices. Several young people have benefited from a good placement scheme through which they gained work experience or employment at different settings, such as at a leisure centre, in charity shops and Poole culture and community services. Currently, the pathways team is supporting six care leavers in higher education.

73. The local authority has made good progress in reducing the numbers of care leavers who are not in education, employment or training. At the time of inspection, four care leavers were not in education, employment or training, although their whereabouts were known to the pathways team.

74. The pathways team and virtual school staff provide prompt feedback to schools for immediate follow-up action, and they regularly track the progress of care leavers. They identify by wards the places where young people are not in education, employment or training, and involve councillors to take action. Several care leavers have entered apprenticeships that the local authority has specifically created for their group. Care leavers with special educational needs have the opportunity to undertake supported internships.

75. Care leavers enjoy annual events that celebrate their achievements. They take a very active role in planning the occasion and other events, which include performances and music provided by a band of their peers who are in care. They also undertake activities such as singing lessons, music tuition, horse riding, language lessons and swimming. However, they are not aware of the leisure card that is available to them.

76. Care leavers, as part of the Children in Care Council, attend the corporate parenting panel. They take part in interviewing social workers and have their say on changes in policies, including contributing to making the language in the care leavers 'Pledge' leaflet simpler for them.

Leadership, management and governance	Requires improvement to be good

Summary

A cohesive group of senior and political leaders share a vision to continually improve services for children in Poole. They have sustained good services for children who require adoption and for care leavers since the last inspection in 2011, when the local authority was judged good overall. However, management oversight and supervision are not consistently effective across children's social care as a whole. The overall quality of help, protection and care for children has not been sustained, and these now require improvement to be good.

A children's service improvement board has ensured oversight, but it has not been fully effective in addressing key weaknesses in some notable areas. These include children left in the custody of police overnight, delays in progressing children's cases in the multi-agency safeguarding hub, and poor management oversight and decision-making by the out-of-hours service. Managers are not rigorous enough in responding to weaknesses. The authority is not yet providing a good enough service for all children in Poole.

Governance arrangements are effective, with clear lines of reporting and accountability. Outward-looking leaders ensure shared ownership of the strengths and weaknesses of the service. Corporate commitment to children's services is evident, including financial support to deliver and strengthen services. Partnership working is mainly effective, but there is more to do to ensure that key professionals attend and contribute to child protection conferences and core groups.

A well-developed strategic needs assessment informs commissioning plans. Rigorous monitoring of arrangements ensures a sound understanding of service effectiveness, informed by the views of parents and children. Despite work to increase placement availability, there remains a lack of foster carers, particularly for older children with complex emotional and behavioural needs.

Quality assurance and performance management arrangements are improving and beginning to strengthen practice, with follow-on action plans addressing areas of weakness. A renewed focus on performance information has resulted in an increased understanding of service effectiveness. However, there is further work to do to develop performance information for early help and ensure that this is analysed effectively to inform service provision.

The workforce is stable, and caseloads are manageable in most teams. Social workers enjoy working in children's services in Poole. They appreciate the training they receive, as well as the availability and support of senior managers, whom they describe as visible and approachable.

Inspection findings

77. Senior managers and leaders are both challenging and ambitious in their aspirations for vulnerable children in Poole. They have been successful in strengthening some areas, including the development of the multi-agency safeguarding hub (MASH) and the transfer to a regional adoption agency. They have sustained good adoption and care-leaving services since the last inspection. However, they have not done enough to tackle the inconsistent quality in the broader scope of services for children in need of help and protection and those looked after. These services now require improvement to be good.

78. Reflective, outward-looking leaders proactively seek to learn from other organisations. Good use has been made of findings from a local government association safeguarding diagnostic in 2016 which identified that the threshold for services was too low. This has resulted in the implementation of a relaunched thresholds document, strengthened early help provision and the development of the MASH. There is some evidence of the impact of services and the difference that early help services are making to children's outcomes, but there is further work to do to systematically evaluate the effectiveness of services provided.

79. The local authority's self-assessment is sufficiently self-critical and provides a sound evaluation of the service. Although shortfalls are identified, managers are not consistently effective in responding to these, therefore some notable weaknesses remain. These include the lack of foster carers for older children with complex needs, which has resulted in children being left in the care of police overnight, delays in progressing children's cases in the MASH, and poor management oversight and decision-making by the out-of-hours service. (Recommendation)

80. Management oversight, including by independent reviewing officers and child protection chairs, while improving, is not yet consistently good. While examples of effective management oversight were seen, too many lacked a clear focus on children's progress against plans. (Recommendation)

81. The director of children's services (DCS) and her senior management team provide stable and visible leadership. They have established strong working relationships and share ownership of the strengths and weaknesses of the service. Together with the chief executive, they have a collective vision to continually improve and deliver good services for children in Poole. They have responded effectively to the vast majority of the recommendations from the last inspection (2011). However, contingency planning and the effective use of chronologies remain work in progress.

82. The children's services improvement board, chaired by the lead member, has overseen progress against the local authority's improvement plan since its

introduction in 2016. However, the board has not responded rigorously enough to poor practice and weak management oversight in the out-of-hours service or to the lack of foster carers for older children with complex needs.

83. Governance arrangements are effective, with clear lines of reporting and accountability. The chief executive and elected members provide scrutiny, challenge and oversight of activity. For example, the council's cabinet commissioned a working group to carry out a review of child sexual exploitation in Poole, leading to an effective action plan to respond to areas for development. Links between senior leaders and the Local Safeguarding Children Board (LSCB) are strong. The lead member is well informed, chairs the Children's Trust, attends LSCB meetings, and provides regular briefings to elected members.

84. Children's services are one of the four corporate priorities set out in the council's corporate plan. The children's plan (2017–20) sets out the key priorities for children. It is aligned with the joint strategic needs assessment and the Health and Wellbeing strategy, and is overseen by the Children's Trust. Children's services performance indicators are regularly received by senior managers, elected members, the Children's Trust and the LSCB. The lead member regularly attends meetings with senior managers to review performance and to improve the understanding of the service.

85. Members of the corporate parenting group demonstrate a sound understanding of issues facing children looked after. The group has a diverse membership, including elected members, key partners, children and foster carers. Children are involved in decisions about services through active engagement. For example, meetings are held at venues of their choice, which enables them to feel comfortable to raise issues that are important to them. Issues considered include pocket money and contact venues, both of which have resulted in changes to practice and policy. However, members need to exert more challenge to officers around the lack of foster carers for older children.

86. The local authority has strengthened its commissioning function over the past year, and a clear needs analysis drives commissioning plans. Commissioners make good use of joint budgets and commission a broad range of services which respond to identified needs effectively. These include a range of domestic abuse services and independent visitor and advocacy services. Robust monitoring of arrangements includes visits to providers and regular performance oversight. Parents and children are fully involved in commissioning processes, which adds an extra layer of oversight.

87. The sufficiency strategy (2014–17) is clear and coherent, with appropriate priorities linked to present and future need. Senior managers recognise that they have had insufficient foster carers for older children. They have revisited their recruitment strategy and strengthened provision for unaccompanied asylum-seeking children who occasionally arrive through the international ferry

port. External independent resource has been utilised to support recruitment activity, which has led to an increase in the number of in-house foster carers. However, shortfalls in the number of carers for older children with more complex needs have persisted so that services are not always responsive to their needs. This is most notable for a small but significant number of children who have remained in police custody overnight because there are insufficient placements available. (Recommendation)

88. A comprehensive quality assurance framework is beginning to give the local authority a rich picture of the standard of social work practice. Managers at all levels are involved in auditing, including the DCS. The strategic safeguarding and quality manager recognises that some audits are not always sufficiently self-critical and that quarterly reports on audit activity lack analysis. Both these factors have the potential to dilute the effectiveness of quality assurance activity. Nevertheless, quality assurance activity is not yet embedded across the service, and there are some key gaps. For example, there is no clear systematic quality assurance approach to inform the development of early help services. Moreover, quality assurance had not picked up the weaknesses in the out-of-hours service or the number of children remaining in the care of police due to the shortage of emergency foster placements.

89. Recently improved performance information enables senior managers and leaders to identify emerging issues and leads to remedial action at the earliest opportunity. For example, a recent increase in children subject to repeat child protection plans led to a thematic audit to understand the reasons. Managers use weekly performance information effectively in their service areas. This has led to some areas of improvement in the timeliness of statutory visiting and children looked after reviews. Nevertheless, performance information relating to early help, step up/step down and initial health assessments is underdeveloped. This means that senior managers and elected members cannot be confident about the effectiveness of the services provided.

90. The majority of staff access regular supervision, but are not consistently afforded the opportunity to reflect on their practice. Case supervision records seen by inspectors were, in the majority of cases, appropriately regular and of an adequate standard. Inspectors saw some good examples of analytical supervision. However, supervision is not yet of a consistently good quality, as demonstrated in a minority of children's cases brought to the attention of the DCS during the inspection, as managers had not progressed plans effectively or fully recognised risk. (Recommendation)

91. The arrangements for children missing and children at risk of sexual exploitation are effective, with strong partner engagement. Partners, including schools, early years, health, police and licensed providers, are appropriately engaged. Training and awareness raising have taken place and continue to have a strong focus across the partnership. In Poole, safeguarding training is mandatory for taxi drivers as part of their licence. The local authority has rigorously reviewed all children aged 12 and over who are receiving statutory

services in order to ensure identification of children at risk of sexual exploitation. Well-attended six-weekly risk management meetings provide an effective arena to share information and respond to children who go missing from home/care or those vulnerable to sexual exploitation. However, records from these meetings are poorly recorded and not routinely available in children's case records. Consequently, social workers and managers do not have a formal record of what actions have been agreed to inform planning and intervention. (Recommendation)

92. The appointment of a 'missing' coordinator in the MASH has ensured a more focused service for missing children and led to recent improvements in the quality and timeliness of return home interviews. The use of 'missing' passports containing up-to-date information is proving helpful to the police in locating children.

93. The stable and committed workforce in Poole is a real strength and provides firm foundations to sustain and build on service improvement. The use of agency workers is low. Caseloads for social workers are manageable and closely monitored by senior managers. The local authority has invested in its workforce, has an established career structure and provides regular reflective practice learning sessions to promote social work and improve practice. The training programme is well regarded by staff and covers training needs arising from, for example, themes in case audits and serious case reviews. Social workers are consistently able to articulate lessons learned from a recent serious case review. For example, one social worker said, 'I have better awareness of "disguised compliance" and the need to take a whole-family approach in assessments.'

94. Appropriate arrangements are in place to respond to complaints, with the DCS taking a direct interest in ensuring that learning from children's complaints informs practice development. A designated complaints manager is proactive in seeking to resolve complaints at an early stage. Learning from complaints is incorporated into training. The number of complaints has reduced substantially in the past year. The local authority's commitment to ensuring that the voice and views of children and families influence service development effectively is strong. A participation worker ensures that children are consulted through a number of forums. There are many examples of effective consultation to inform specific projects.

95. The local authority is an active, responsive participant in the work of the local family justice board, and its relationship with Cafcass is positive, helping to reduce and minimise the risk of delay for children in care proceedings.

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The Local Safeguarding Children Board in Poole is good. It is a dual board, covering both Bournemouth and Poole. Partners are committed to the efficient and effective operation of the board. Members of the board hold strategic roles within their organisation and on other key local boards, influencing the safeguarding function across a range of organisations.

The independent chair provides strong leadership for the work of the board, and has secured commitment to the board's priorities from all partners. She is supported by an effective business manager, who helps to provide direction. Partners are held to account by the chair through their attendance at board meetings and through individual accountability reviews. She has created a culture of challenge, enabling partners to constructively explore and expand their organisational responsibilities and improve the delivery of safeguarding services.

A comprehensive multi-agency dataset informs the business plan. The business delivery plan accurately reflects the board's priorities and progress. Strategic training, learning and development, and quality assurance arrangements are shared. Effective pan-Dorset neglect and child sexual exploitation/'missing' sub-groups are helping to drive improvement in services offered to children, and have increased prosecution and disruption activity.

The board has successfully implemented a multi-agency programme of audits, including section 11 audits. This has strengthened the line of sight on frontline practice.

Frontline professionals have access to a range of training which enhances their skills, knowledge and confidence. Training takes account of the findings of audits and both local and national serious case reviews. Recognising that the evaluation of training is underdeveloped, an action plan is in place and due to be implemented to better assess the effectiveness of training courses.

There is effective challenge by the board, which it tracks. However, challenges are not reinforced by clear identification of risks and detailed in a risk register.

The board's latest annual report does not fully capture the work being undertaken on female genital mutilation and 'Prevent'. There is insufficient analysis of the effectiveness of services in this area or their impact on outcomes for children.

The board listens to children and makes improvements to services as a result of their suggestions.

Recommendations

96. Ensure that the board's proposed training needs analysis informs the development of the multi-agency programme of training and strengthens the evaluation of training to demonstrate its impact on practice and outcomes.

97. Ensure that the annual report captures action to protect children from female genital mutilation and from radicalisation, reporting on the effectiveness of practice and services.

98. Ensure that the challenge log is informed by clearly identified risks and is supported by a risk register.

Inspection findings – the Local Safeguarding Children Board

99. The joint Bournemouth and Poole board arrangements are appropriately constituted. The function of the board and its sub-groups is delivered well across the partnership. The board benefits from the involvement of two lay members, both of whom bring a strong focus on children. They are using their knowledge of local communities to increase the board's understanding of cultural issues impacting on children. The board has developed joint-working arrangements on a pan-Dorset basis. This approach benefits children and those working with them in key areas such as child sexual exploitation, quality assurance and the work of the child death overview panel (CDOP).

100. Governance arrangements between the board, elected members, the chief executives of the respective authorities and other key strategic partners are well developed and clearly set out within protocols, constitution and compact agreements. Pathways to the Health and Wellbeing Board, the Children's Trust Board and other children's partnerships are clear. They maximise the ability of the board to influence strategic planning and to ensure that its priorities are understood by all.

101. Local scrutiny functions ensure that there is a good interface and engagement between the board and elected members. Elected members are kept informed of issues relating to both safeguarding of children in the local area and the work of the board.

102. The independent chair took over responsibility for the board in July 2016. She has re-energised the board by providing greater clarity on partners' respective safeguarding responsibilities. The independent chair is also the chair of a neighbouring safeguarding board. She has taken the opportunity to realign priorities and sub-groups across both boards, sharing learning and practice.

103. The chair holds the partners to account well. The engagement and commitment of partners to the board are strong, reflected in good attendance and effective sub-groups. The operational work of the board is well supported.

A review of the board's sub-groups identified the additional support needed to ensure sustainability and the capacity to undertake key areas of work. For example, the child sexual assault sub-group has now secured a significant injection of funds to support its important work.

104. The chair challenges partners effectively. For example, she has appropriately challenged the lack of oversight and weak practice in the out-of-hours service for children, and the associated issue of children being held at police stations overnight. The pace of resolving the difficulties fully has been slow, although it is now progressing. Challenges are appropriately tracked through a challenge log, but this is not underpinned by a risk register. Risks are not clearly evidenced in the challenge log to inform the delivery of the work, for example the out-of-hours service.

105. Listening to children's experience is one of the board's key improvement objectives and is high on the board's agenda. The board has invited young people, including care leavers and parents, to share their experiences with them. As a result, therapeutic services have been commissioned to support children and young people who have experienced sexual assault. The board's sub-groups also benefit from children's support. Currently, the child sexual abuse sub-group is commissioning children to design a poster for a 'call to action' to schools. The project is being funded by a local college and demonstrates partners' contribution and commitment to the safety and protection of children.

106. The business plan, audits and performance monitoring all focus sharply on the board's three priorities of child sexual exploitation/going missing, child sexual abuse and early neglect. There is a clear thread supported by the sub-groups, linking the selection of areas to audit, the focus of the training, actions in the business plan and the agenda items tabled for the board.

107. The board's annual report 2016/17 delivers an accurate assessment of the board's performance. It identifies areas of good practice, areas for development, and learning from audits and serious case reviews (SCRs). However, it does not yet fully report on its work around female genital mutilation or 'Prevent', despite good work taking place in these areas. Additionally, the report does not sufficiently assess the effectiveness of the impact of these services on children's outcomes.

108. Working closely with the Children's Trust Board, the LSCB has oversight of early help arrangements and has refreshed the threshold guidance, providing clarity about levels of need to better support referral to services. This was underpinned by a local government review in 2016 which found that the threshold for services was too low.

109. The arrangements for going missing and child sexual exploitation are effective, with strong partner engagement, including with licensed providers. A multi-agency strategy includes actions to identify and disrupt child sexual

exploitation. Data collected built a picture of local hotspots. Police successfully disrupted perpetrators and secured convictions as a result.

110. An extensive action plan provides clear service pathways to other related vulnerabilities, such as children going missing, gang affiliation and neglect. Partners are appropriately engaged.

111. Training, briefings and awareness raising continue to be a strong focus across the partnership. Effective and comprehensive support is provided to children through a range of sources, including Barnardo's, outreach workers in schools, and the integrated missing person and child sexual exploitation team (IMPACT). The board monitors the progress and the effectiveness of responses to children, with oversight from the pan-Dorset child sexual exploitation sub-group.

112. The board monitors and evaluates practice effectively via a comprehensive performance dataset, which includes clear analysis. The board appropriately scrutinises and challenges data. It takes steps to understand the factors behind the data, for example in relation to an increase in repeat child protection plans. However, the data does not fully capture the performance of child and adolescent mental health services (CAMHS) for children and young people. The board is aware of this and is taking the necessary action to rectify this issue.

113. The CDOP operates effectively across three authorities, reviewing all child deaths and appropriately recommending changes to reduce risks and improve services. The CDOP annual report informs the board on the themes that it identifies, including concerns about co-sleeping and unsafe sleeping arrangements for babies, maternal smoking during pregnancy, and the mental health and well-being needs of young people.

114. SCRs are appropriately instigated. There have been four SCRs in 2016/17, one of which relates to Poole and which has been published. There is prompt action to disseminate lessons and improve practice through specific multi-agency events and training, including practice learning workshops. This happens following both SCRs and reviews into cases that do not meet the SCR threshold.

115. Section 11 work carried out by the board is strong. Effective systems are place for reviewing and checking partners' ongoing compliance. The board introduced peer moderation to the 2017–20 audit process. The completed audit identifies areas for development, including areas directed by the board.

116. There is good oversight of education safeguarding, with S175/157 returns completed. The education safeguarding sub-group prioritises strong links with schools/academies, supported by the education safeguarding adviser. The board's quality assurance sub-group monitors multi-agency safeguarding effectively across the areas.

117. A varied programme of multi-agency audits, systematically undertaken on behalf of the board, promotes learning and improves practice, for example child sexual exploitation and child sexual abuse audits. The audit topics are identified from reviewing quality assurance and performance data. Further evaluation needs to be undertaken to enable the board to know whether practice has changed or improved.

118. Training is responsive to emerging issues. The training programme is comprehensive and includes statutory safeguarding training. However, the board is not in a position to assure itself that the training offered fully meets all training needs. In recognition of this shortfall, improved evaluation systems are being implemented.

119. Good arrangements are in place to review and update safeguarding policies, procedures and guidance. There are good links with sub-groups, facilitated by the business manager, to ensure that updates from activities feed into the reviewing arrangements. For example, the child sexual exploitation and missing from home and care procedures are up to date and include reference to recently published guidance on definitions of child sexual exploitation and safeguarding children in education.

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 that 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 whom 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 seven of Her Majesty's Inspectors (HMI) from Ofsted.

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