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Elaine Redding
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Dear Ms Redding,

Focused visit to Bournemouth, Christchurch and Poole Children's Services

This letter summarises the findings of a focused visit to Bournemouth, Christchurch and Poole Children's Services on 13 October 2020. The inspectors were Neil Penswick, HMI, Louise Hollick, HMI, Peter McEntee, HMI, Jan Edwards, HMI and Chris Smith, HMI.

Her Majesty's Chief Inspector of Education, Children's Services and Skills is leading Ofsted's work into how England's social care system has delivered child-centred practice and care within the context of the restrictions placed on society during the COVID-19 (coronavirus) pandemic.

The methodology for this visit was in line with the inspection of local authority children's services (ILACS) framework. However, the delivery model was adapted to reflect the COVID-19 context. This visit was carried out fully by remote means. Inspectors used video calls for discussions with local authority social workers, managers and leaders. The lead inspector and the corporate director of children's services agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19 and meeting the needs of the local authority's workforce.

This visit looked at the quality and impact of key decision-making across help and protection, children in care and care leavers services, together with the impact of leadership.

Overview

There are serious and widespread weaknesses in the quality of children's services in Bournemouth, Christchurch and Poole (BCP). This leaves vulnerable children at risk of harm. Many children are repeatedly referred to children's services and do not have their needs responded to fully, or in a timely manner. Children in high risk situations are referred to early help services inappropriately by children's social care, without a thorough evaluation of whether they are being protected. The vast majority of assessments, to evaluate whether children and their families need a service, are unfit for purpose. They lack sufficient evidence, analysis and challenge. The failure of managers to provide appropriate oversight of the pre-proceedings stage of the public law outline (PLO) results in children remaining for too long in unsafe situations. Children in care, and care leavers, do not consistently have their needs met. Consideration of permanence for children in care is often absent, and significantly delayed when it does occur. There are no quality assurance systems in place, and therefore managers do not properly understand the quality of the services they provide, or the experiences of individual children and their families. Children in care and care leavers who met inspectors powerfully expressed serious concerns about the lack of support given to them by the council, including during the period of the COVID-19 lockdown.

Bournemouth, Christchurch and Poole council came into being in April 2019, following the merger of two previous unitary authorities and a town from a neighbouring county council. While there has not been a full inspection of this local authority, a focused visit was undertaken in November 2019, which focused on permanence arrangements. The areas for improvement identified at that time have not been effectively addressed.

A new interim corporate director of children's services (DCS) was appointed in September 2020. Prior to this focused visit, and due to the concerns already identified by the government, the Department for Education (DfE) appointed an improvement adviser to provide support and challenge to the authority and partner agencies. The Chief Executive of BCP council and politicians were made aware of the widespread deficits by the Interim DCS and DfE Adviser in September 2020. Plans are in place to address these concerns. The council has identified improving children's services as a priority, and additional finances have been secured in order to transform services.

Areas for priority action

The local authority needs to take swift and decisive action to address the following areas of weakness in:

- the arrangements for management oversight and quality assurance of social work practice
- the quality of practice, including the application of thresholds, the quality of assessments, the actions taken at the pre-proceedings stage of the Public Law Outline and the decision-making for permanence.

What needs to improve in this area of social work practice

- Social work supervision.
- The quality of children's plans.
- Attendance by partner agencies at strategy meetings.
- Placement sufficiency.
- Support given to children in care, and care leavers, during the COVID-19 pandemic.
- The quality and timeliness of social work recording.
- The profile of the virtual school so that its role is better understood by senior leaders in schools.
- The quality of personal education plans (PEPs).
- Plans to prevent exclusions from school for children in care.
- The response to electively home-educated children.

Findings

1. In the Multi-Agency Safeguarding Hub (MASH) managers prioritise the incoming work and identify tasks that need to be completed. However, the MASH focuses too narrowly on whether a contact meets the children's social care threshold for immediate involvement, rather than considering the longer-term needs of the family. As a result, there are high numbers of repeat requests from other agencies asking for assistance for those families whose home situations are deteriorating due to lack of support.
2. In the last 6 months, the local authority received 8,000 contacts. Less than 2,000 of these were accepted as referrals. When a referral was accepted, screening completed in the MASH was not sufficiently child-focused and did not take account of all of the issues. A high number of children's cases were passed to early help services. However, inspectors saw that many of these were children at risk of harm, and that a more robust response was needed from the MASH to ensure that they were protected.
3. When a child needs an urgent child protection response, strategy meetings are convened in a timely manner. But these are not always attended by all of the relevant agencies, in particular schools. This is a missed opportunity to ensure that all known information is shared to inform decision-making. The meetings do not always focus on the needs of all of the children in the family, which results in not all risks being considered well enough. Actions are often vague and without timescales.
4. In the last six months, over 700 assessments were completed which did not result in a social work service being offered. Inspectors found that the vast majority of the assessments undertaken were not fit for purpose. They failed

to consider all of the current and historical issues, accepted parental self-reporting, and did not check out information with other agencies. Most importantly, they failed to focus on the experience of the children and young people. Many sections of the actual reports were left blank. Despite their evident poor quality, these were signed off by managers as acceptable pieces of work. This means that many children do not receive a service when they would benefit from doing so.

5. There is a great deal of variability in the quality of children in need, and child protection, plans. Some plans are appropriately targeted, focused and clearly identify the areas of need. However, the majority of plans do not include all the essential actions that need to occur to protect the children, and they do not include timescales or identify the person with the responsibility for carrying them out.
6. A range of positive interventions, such as the CAMHS counselling and crisis team, emotional support in school, and attachment courses for parents, are included in some children's plans.
7. Inspectors had serious concerns about the PLO panel. In the majority of cases looked at, the panel did not respond in a timely manner, did not take action when repeated safeguarding incidents were occurring and left children in unsafe situations for too long. When children enter the family court system, inspectors saw better quality work, including up-to-date recording and supervision.
8. Too many children in care are placed some distance from their homes, families and communities. A sufficiency strategy is currently being developed and is due to be published in December 2020.
9. Inspectors saw some stronger practice, with social workers engaging with children and challenging parents. Social work visits are often purposeful, but they are not always well recorded. During the COVID-19 lockdown period, inspectors saw examples of where face-to-face visits to children in care, and care leavers, had been risk assessed and prioritised. There has also been good use of technology, such as video calls, to enable social workers to keep in touch with children and their carers. Some children have also been able to keep in touch with their families by using technology, and, more recently, they have been able to have face-to-face family time.
10. However, the children in care and care leavers who met with inspectors reported that they felt let down by BCP. They spoke about having minimal contact from their social workers or personal assistants (PAs), and, as a result, they felt alone, isolated and unsupported. Young people who are parents, or those who had left school and were going to university, spoke of having to cope pretty much alone.
11. Virtual school leaders have made some sensible decisions across the COVID-19 period. They have prioritised children's welfare and safety. They have communicated their expectations more effectively with school leaders. The 3 to 19 school improvement team has also provided effective leadership over

the last 6 months. It has fostered a closer working relationship between schools in the BCP area, which headteachers appreciate. All schools decided early on to stay open, although access to education has varied considerably. Link workers ensured that there were effective lines of communication, with a clear focus on helping and protecting vulnerable pupils. An increasing number of pupils were brought back into schools over the summer. Schools were supported to put in place COVID-19 risk assessments, and they reopened for all pupils in September.

12. However, there are some fundamental weaknesses that have not been addressed. The virtual school's profile is not high enough to champion the education of children in care effectively. Its role is not understood well enough corporately. It is not connected closely enough to the work of the 3 to 19 school improvement team.

13. Personal education plans for children in care are too variable. Schools fail to take ownership of the PEPs. The plans include little of any substance from the child's social worker. The voices of the carer and the child are not strong enough. The actions contained in the plans are often inappropriate or too generic to be meaningful. Management oversight of PEPs has not led to improvement.

14. Children in care told inspectors that they felt let down by the education system during the COVID-19 lockdown period. They describe how GCSE courses ended abruptly and little or no teaching was provided for them. In their own words, school was no more than 'baby-sitting'. On average 36% of children in care of school age attended school across the summer term, despite the government guidance being that children in care should attend school. Local authority records indicate that 82% of children in care were accessing home learning.

15. There are too many children in care being excluded from school, and some are excluded permanently. The inclusion team is establishing a 'preventing exclusion panel', but there is not an established culture in which schools hold one another to account for the use of exclusion. Academic outcomes for children in care have been low in recent years.

16. In September 2019, there were 478 children being educated at home. At the time of this visit, it had risen to 580. The local authority does not have the necessary capacity to make the statutory welfare, safeguarding and education checks it is required to make. There is no evidence that the local authority is challenging schools with higher numbers of pupils moving into elective home education that could, potentially, be off-rolling pupils.

17. Drift and delay in achieving permanence were evident in the experience of almost all children in care. Matching and permanence decisions are not timely, often taking several years. This is unacceptable. Ofsted carried out a focused visit on permanency in November 2019, and there has been a failure to ensure that there has been effective management oversight in this area since then.

18. Independent reviewing officers are not carrying out their duties sufficiently well or drawing up robust plans and ensuring they are progressed.
19. Inspectors had serious concerns about the quality of management oversight across children's services. This oversight is not sufficient to ensure that children are protected, or that their plans are progressed. During the course of this focused visit, inspectors asked the local authority to review the cases of 50 children, due to serious concerns about their safety and well-being.
20. Up until recently, there was no quality assurance framework, or dedicated staff, in place to fully ensure that senior managers understand the quality of the work, and the experiences of children and young people. The lack of this, or appropriate other arrangements, has been a major contributory factor in the corporate failure of the council to address the long-term serious weaknesses identified during this focused visit. A new quality assurance framework has been developed, a quality assurance manager has been appointed, and additional staff have been recruited, but it is too early to demonstrate any impact of this.
21. Social workers described that one-to-one supervision is perfunctory, lacking in challenge and does not assist them to progress children's cases or their own professional development. There is a lack of reflective discussion and poor management direction. Some workers described their caseloads as manageable, while others stated that they remain too high.
22. Overall, there is an over-reliance on short-term workers and managers at all levels. At the time of this focused visit, 55 agency staff were engaged by BCP, including some providing additional workforce capacity. Some social workers expressed dissatisfaction about working for BCP. They told inspectors that they felt there was too much churn in the workforce, with permanent staff leaving, too many agency staff, and too much reliance on recently qualified social workers who need to be better supported to be able to provide high-quality work and to build up resilience to carry out their challenging job.

We have notified the DfE of the areas for priority action and we understand you will receive separate correspondence from them. In terms of our next steps, we will be considering whether our next activity in Bournemouth, Christchurch and Poole will be a focused visit or a standard inspection in due course.

Yours sincerely

Neil Penswick
Her Majesty's Inspector