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Dear **local partnership**

Joint targeted area inspection of the multi-agency response to child sexual exploitation, children associated with gangs and at risk of exploitation and children missing from home, care or education in Dorset

Between 21 and 25 May 2018, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to these related areas in Dorset.[1] This inspection included a 'deep dive' focus on the response to children experiencing these vulnerabilities.

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

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door', which receives referrals when children may be in need or at risk of significant harm. In this JTAI, the evaluation of the multi-agency 'front door' particularly focused on children at risk of sexual or criminal exploitation, those associated with gangs and those missing from home, care or education. Also included was a 'deep dive' focus on this vulnerable group of children and young people. Inspectors also considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board (LSCB).

[1] This joint inspection was conducted under section 20 of the Children Act 2004. It considered the responsibility of Dorset County Council and did not include the separate local authority areas of Bournemouth or Poole.

Multi-agency working is not always effective in Dorset, and vulnerable children face negative experiences because of ineffective partnership working. There are some positive examples of joint working, such as the relatively new multi-agency safeguarding hub (MASH), and a commitment to developing and strengthening this further. The significant weaknesses identified within the deep dive relate to longer-term practice and the experiences of young people long after the involvement of the 'front door'.

Partners in Dorset are in different states of readiness to fully prioritise multi-agency working. This is particularly the case with the local authority, which recognises that the standard of its practice is not consistently safe or effective for all children within this most vulnerable group. This recognition of some of its own poor practice has meant that the local authority has prioritised internal improvement and an inward-looking focus over the last six months. This decisive action to address and raise baseline practice in the local authority means that, currently, there are different levels of capacity and investment in developing the partnership. This state was described by the director of children's services as them not being able to participate fully because they are not yet functioning properly. The local authority has had to take assertive action to 'get their own house in order', and thus has not been in a position to contribute to effective partnership working.

The partnership group has not comprehensively explored or understood the risks for children within the scope of this inspection. However, some positive work is undertaken, particularly in relation to a protective response to sexual exploitation and to children going missing. A shared risk assessment for child sexual abuse and appropriate awareness of every episode of going missing works well. Return home interviews are undertaken, but the many ways in which these are completed is confusing for professionals and they are not always timely or undertaken by the most appropriate person for each child. Of critical concern is the premature closure of work with children, particularly if this is because of the lack of engagement by the young person.

The extent of criminal exploitation and potential exploitation of children by organised drug dealers in Dorset through 'county lines' is not understood by partners other than the police. Other partners have not asked questions, interrogated known information or proactively considered the risks posed by 'county lines' to children. As a result, there is little knowledge about the nature and scale of criminal exploitation, and expertise to deal with this is considerably under-developed. An unhelpful distinction made by partners between Dorset children and children who spend some time in Dorset results in some children at risk who might be in the area very briefly not being prioritised operationally or strategically. Dorset police have seen a significant rise in the police cases involving 'county lines' offences, but the

partnership is not yet collectively using this intelligence to provide an effective multi-agency response for children.

Areas for priority action

- The local authority must ensure that actions and decision-making for the most vulnerable children are robust and ensure that the response matches the degree of risk.
- As part of this decision-making, the local authority must put in place a mechanism to ensure that children who are still at risk, or for whom the extent of the risk is unknown, do not have their involvement with children's social care prematurely closed.
- The partnership must put in place a mechanism to ensure intelligence in relation to criminal exploitation and risks associated with 'county lines' is collected, shared, analysed and acted on to provide an effective multi-agency response for children.

Areas for improvement

- Multi-agency working is not always effective in Dorset. The different stages of development and performance of each agency has impacted negatively on the effectiveness of the partnership working. There are many concerns regarding practice in the local authority. However, the director of children's services has a good awareness of what needs to change and has a considerable improvement plan in place. The local authority needs to now ensure that it effectively balances an outward focus on partnership working alongside the comprehensive internal improvement work underway.
- The most vulnerable children are not being sufficiently safeguarded in the local authority and while some work is of a reasonable quality, the poorest work is very poor. This is seen particularly through the experiences of the children in the 'deep dive', who have not been served well by the partnership. Of critical concern is the premature closure of work with children, particularly if this closure is based on a lack of engagement by the young person. There needs to be greater urgency and persistence in working with and for these young people.
- The director of children's services quickly formed a view on the quality of practice on arrival in post in October 2017. He has a clear understanding of the extent of areas for improvement and has provided a focus that is starting to yield some early results. A significant financial commitment by Dorset County Council in December 2017 to increase the number of social workers has resulted in a

successful social work recruitment campaign and a reduction of caseloads. Team managers are in the middle of a targeted training programme. This progress is being guided and informed by an improvement board and an extensive independent audit programme, which has looked at the service response to nearly 300 children. Further early indicators of progress are seen in the consistency and timeliness of assessments for children and plans underway to reconfigure the out of hours service. The local authority is midway through a whole-staff transformation programme called 'Reinvigorating Social Work', which has brought considerable energy and enthusiasm to the local authority.

- Local partnership work to help children at risk of sexual exploitation and going missing does include some positive and improving practice. However, there is a significant gap in some agencies' understanding of the risks posed by gangs, 'county lines' and criminal exploitation. The draft 'Pan Dorset Multi-Agency Strategy to address child exploitation, 2018–2020' does not fully address the prevalence of child exploitation or offer a comprehensive multi-agency perspective to inform the next steps. It provides only a partial picture of the victim and perpetrator profile.

- The police have been highly proactive in their work around criminal exploitation but have not been met with a similar level of interest or engagement from their partners. Therefore, police have needed to develop their own single-agency response to protect children. For example, they shared information on one child who was being criminally exploited but partners did not work adequately together to safeguard him. In this case, the police used innovative tactics, including obtaining a criminal behaviour order, to work with the child themselves. However, this did not address the underlying wider multi-agency safeguarding issues.

- Despite the proactive and informed response of the police, their own well-established quarterly meeting with partners (Project Spotlight), set up to tackle serious and organised crime, does not currently consider 'county lines' and the criminal exploitation of children. This is a missed opportunity as Project Spotlight provides an existing framework that has the potential to enhance the quality and impact of this work.

- Children with complex and often chronic needs who are at the cusp of the early help/statutory social work threshold for intervention do not consistently receive a good enough service. This specifically relates to those children and young people whose cases have been 'stepped down' from statutory services prematurely to early help and without the local authority ensuring that ongoing early help services will continue or be properly coordinated. Despite escalating need, some children have had their cases closed by early help services due to non-engagement and have then been the subject of repeat contacts and referrals to statutory services before receiving a service at a level that matches their needs.

The practice of failing to get the right service in place has contributed to the consistently high re-referral and re-contact rate.

- In the local authority, parental consent is not routinely recorded at the point of contact or referral, even when managers have directed that it should be sought. It is therefore unclear whether the appropriate consent has been sought or gained. Chronologies and regular case summaries are not routinely completed, and there were many examples seen where these would have significantly improved social workers' understanding of the complex needs and histories of this group of young people.
- When children return from being missing, the majority of them are offered and receive a return home interview. However, most children have to wait too long to undertake an interview. Arrangements about who conducts these are complicated and poorly understood by many professionals. As a result, not all children have the benefit of an interview from an independent professional in a timely way. While most interviews carried out are of a reasonable quality and some are strong, they are not consistently used to inform planning for children. A plan is currently being actioned to offer a new, more streamlined service for independent return home interviews by July. However, some aspects of the existing, wider contracted service, such as the need for therapeutic provision, are not yet fully scoped or agreed.
- Social workers who work with children who have been sexually exploited do not consistently have the right skills and knowledge. While training is available, social workers could not recall any recent training to refresh their knowledge.
- The 'top 10' meeting for children who go missing and child sexual exploitation considers the children most at risk and does provide some challenge and direction for individual children. It is helpfully chaired by a local authority service manager in the MASH. It takes place every eight weeks, but there is no mechanism to track and progress work for individual children and young people between these meetings. Specific meetings to plan and drive work with individual children and young people from this vulnerable group and to add specialist knowledge, skills and information, were not routinely being held in Dorset until the re-introduction of multi-agency child exploitation (MACE) meetings in May 2018
- Although there are a range of meetings and mechanisms to consider the risks for children at risk of child sexual exploitation, going missing and criminal exploitation, both at an operational and strategic level, these are not yet sufficiently coherent or robust in order to direct joint working. The bi-monthly Pan-Dorset child sexual exploitation intelligence meeting is not sufficiently effective. There has been one meeting since October 2017. Key partners and personnel are not always present, including those who specialise in substance misuse and sexual health. The latter have not been invited to attend.

- Overall, adult and young person's substance misuse services are not appropriately invited to and therefore not represented within strategic and operational safeguarding groups. Joint protocols and care pathways need further development to embed the role of the new substance misuse service in early help and MASH decision-making. The sharing of intelligence about the needs, risks and trends relating to young people and adult substance misuse in the area also needs to improve.
- Key patient information is not consistently available to the MASH health professionals. For example, systems for sharing information about children and families supported by adult substance misuse services are not in place to enable full identification of need and risk. Dorset County Hospital is reliant on the use of paper-based referrals, which can result in delays in information being shared.
- A move to a new IT system in the local authority in November 2017 impacted negatively on the production of management reports and the accuracy of data. While this has mainly been resolved, the local authority still needs to address some key reports, including the frequency of visits to children and data on return home interviews. The different IT systems in use within health agencies create delays in promoting effective and efficient sharing of information within and between health teams and wider partner agencies. This results in delayed communication to understand children's needs.
- While strategy discussions to make decisions about child protection enquiries mostly work well, the National Probation Service (NPS) or Community Rehabilitation Company (CRC) are seldom consulted unless it is already known that they have been involved. Intelligence is reliant on police checks to identify potential offenders and then undertake checks directly to identify whether adult offenders are known to probation services. This leaves room for error.
- Health practitioners do not receive the minutes of strategy discussions in a timely manner. A recent audit undertaken indicates that only 25% of records had been received. This means that professionals are having to rely on their own records of agreed actions and therefore a margin of error is introduced.
- Although there is clear evidence of a shift by the police towards a more explicit focus on the reduction of risk and vulnerability, this has not yet been translated into consistent improvements in operational delivery or decision-making. The focus of performance measures in the police is currently on the quantity (or timeliness) of child protection and exploitation incidents and cases. Assessment of the nature and quality of decision-making is under-developed and, as a consequence, senior leaders cannot be assured that front line staff are consistently making the best decisions for vulnerable children in all cases.
- While the police force clearly recognises the vulnerability of those who are or may be the victim of criminal exploitation, the current approach is often crime- rather than victim-focused. This means that children who commit criminal offences while

being exploited may be prosecuted for those offences. While this might be appropriate in some cases, the force recognises that further work is required to ensure that all those who have been coerced and trafficked into the area receive the appropriate support and that best use is made of the legislation available to legitimately discontinue prosecutions where those who have committed them are victims of exploitation.

- Not all children identified as being at either moderate or significant risk of child sexual exploitation are 'flagged' on police systems. This means that other officers are not aware of those children considered to be at risk of child sexual exploitation when assessing risk or dealing with incidents involving these children.
- In health services, the identification of levels of activity and performance management of safeguarding alerts about children at risk of exploitation are currently not well developed. NHS trusts are at different stages in terms of their ability to 'flag' children or track usage of the shortened sexual exploitation risk assessment tool (SERAF). The assessment tool is used, but the lack of flagging means that operational managers and safeguarding leaders cannot easily track the impact of actions taken or emerging trends regarding young people who may re-present in different health settings.
- Managers in health services are not yet making best use of quality assurance to support challenge and learning from practice. Too little attention has been paid to establishing a culture which includes: the routine use of chronologies; a better recognition of culture and diversity; and improved prompt escalation of concern and follow-up of issues that require multi-agency action. Case recording on individual young people in some services, specifically substance misuse and midwifery services, does not include all service and practitioner activity and multi-agency liaison in the running record. As a result, changes in evaluated risk and the rationale underpinning decisions are not sufficiently set out and do not support effective oversight and management of cases.
- Dorset County Hospital has recently been designated as the place of safety for young people detained under section 136 of the Mental Health Act 2007. However, the hospital does not have the necessary facilities, and staff have concerns about the hospital's ability to support this cohort of young people. The Dorset County Hospital Trust has appropriately put this on its risk register and raised the issue with partners and commissioners.
- Coordination of risk assessment and care planning across the partnership by frontline child and adolescent mental health services (CAMHS) practitioners is not well developed. CAMHS practitioners are not consistently well engaged in the support of children in need and those in need of protection. As a result, there are risks that key information about a young person's emotional and mental well-being and resilience are missed.

- School nurses are not always aware of children who may be in need because they do not receive this information in the way that they do for children subject to child protection plans. This omission places children in need at risk of not having their needs met.
- There are some protracted delays in the production of education, health and care plans and in joint commissioning to secure appropriate specialist provision for young people. These were key areas for improvement identified in Dorset's Statement of Action following the special educational needs and disability inspection in January 2017. Some of the children in the 'deep dive' have experienced poor practice in this area.
- In the CRC, there are significant differences between the understanding of qualified probation officers and non-qualified officers of the MASH referral criteria and processes. Information exchange is better in the cases that are supervised directly by qualified probation officers. As a result, child safeguarding is not consistently managed.
- As a result of the absence of comprehensive training, cases of adult offenders linked to children where there are safeguarding concerns are currently being managed by CRC staff who do not clearly understand their responsibilities to safeguard those children. Appropriate safeguarding training has not been delivered across the CRC.

Case study: area for priority action

The poorest practice across the partnership led to one highly vulnerable child receiving a very poor service.

The child's family has an extensive history of involvement with social care services. The child had previously been looked after by the local authority before returning home. A very recent assessment by social care services took too long, lacked depth and resulted in the child's case being closed due to lack of the child's engagement. This was despite concerns relating to possible sexual exploitation, likely criminal exploitation, non-school attendance, anti-social behaviour and drug use.

The partnership collectively failed to offer an appropriate protective response for this child, who has highly complex needs and is reluctant to engage with professionals. The agency offering home tuition did not escalate this case appropriately when they were unable to see the child. As a result, the child has now been out of education for over a year. The police failed to share the majority of criminal incidents with the local authority. Relevant contextual health information was not fully sought. The local authority stopped working with the child. Only the Youth Offending Service (YOS) succeeded in engaging with the child and his family. They identified, raised and escalated concerns about the lack of education provision, and this eventually led to a new placement being identified.

Although partners acknowledged the poor practice in their multi-agency audit for this child, this child would not have had this fresh consideration of their needs without their inclusion in this inspection. This child's experience exemplifies the area for priority action about concern for the most vulnerable children and young people in Dorset.

Key Strengths

- All partners have responded positively and engaged in difficult discussions to consider their individual and collective responsibility to the most vulnerable children in Dorset. As a partnership, there is an increased openness to take forward the learning with optimism and equity across all agencies. There is a commitment to tackle some challenging issues and build further on the positive work already present.
- There are some positive and strengthening multi-agency operational services in Dorset. Investment and co-operation from all agencies is evident in aspects

of the day-to-day core business of safeguarding children. This is particularly evident at the shared 'front door' and in elements of initial child protection work, such as regularity of attendance by key agencies at strategy discussions.

- The MASH is a positive example of multi-agency collaborative working. It operates in an environment of high staff morale, a sense of pride in joint working and a culture of respectful communication. The establishment of the MASH is an important step forward in Dorset and provides a foundation for further improvement. Decisions taken in the MASH about referrals and next steps are timely and proportionate to need and risk for most children. The common 'child sexual exploitation risk assessment' is used effectively by partner agencies and forwarded to the MASH for a professional discussion to take place to agree on a shared risk score and on the next steps.
- Decisions to hold child protection strategy meetings are appropriate. Meetings are timely and are always attended by police, health services and the local authority. When the decision is made to begin child protection investigations, this is proportionate to the presenting risks to children. Children's cases are swiftly transferred to area teams and allocated to social workers. This means that delay is minimised between concerns being raised and children being seen by social workers.
- When children go missing, notifications are passed swiftly to the MASH by the police and immediately entered on the local authority electronic system in the MASH so that their wider needs can be considered. All missing children are given an appropriate priority status by agencies at the point of referral.
- The early help offer, delivered through seven family partnership zones (FPZs), is well supported by a range of partner agencies. The FPZs act as a key vehicle in driving forward shared work to improve early identification of need and to support a local outreach approach to families and communities. This is particularly effective as an early preventative and 'lower level' intervention for children.
- The local authority has an appropriate system to provide information on children missing from education (CME) across the county. There is helpful guidance for schools on procedures for informing the local authority about children missing from education. Triggers in the system alert local authority staff if the missing child is identified as being vulnerable. A local authority CME prioritisation group has been established, chaired by the senior manager for safeguarding, to prioritise safeguarding issues. The local authority team works appropriately to locate children whose whereabouts are unknown.
- Within the MASH, children's social care management oversight, guidance and decision-making by team managers are consistently prompt and clearly

recorded in children's records. Management oversight is largely appropriate to presenting need and risk and helps focus and progress work for children.

- Overall, children receive regular visits from their social workers. In most cases, recording of these visits is purposeful and has a focus on recording children's wishes and feelings. The timeliness of assessments has very recently improved. Social workers understand the need to complete 'child sexual exploitation risk assessments' for children, and the completion of these assessments is becoming well embedded. The best of these are thorough and are used to inform decision-making and planning for children.
- The 'top 10' meetings for child sexual exploitation and children who go missing, when convened, are consistently attended by police, the local authority and health services, and these meetings add value to interventions for some of the most vulnerable young people. The agreed actions stem from effective information-sharing between the agencies present and are broadly appropriate. They add to and sharpen the focus of existing interventions for children at the highest risk.
- The co-location of all looked after children health practitioners with children's social care supports a strong, shared approach to safeguarding looked after children who are at risk of exploitation. The enhanced looked after children health service offers quarterly reviews, with prompt action taken to address new or escalating health or well-being concerns. The service receives a high level of positive feedback from young people and their carers (90%). This innovative model of care appropriately recognises the impact of neglect and trauma on children, with good recognition of the need for enhanced support as children move through their care journey and prepare for adulthood.
- Governance and managerial oversight of risk assessment and safeguarding practice in the acute health services, the emergency department and minor injury units is in place, and is, for the most part, effective in reducing the likelihood of risks and vulnerabilities being overlooked.
- Named GPs for child sexual exploitation are leading a significant and effective programme of continuous improvement to equip local primary care practitioners with the knowledge and tools required to protect children and young people at risk of exploitation. Positively, the approach also includes actions to safeguard adults at risk of harm, including those exposed to domestic abuse, as part of the local area's strategy to strengthen whole-family safeguarding. An audit of primary care child sexual exploitation-related work is appropriately planned for later this year to assess progress and to share learning.
- Specialist health support for vulnerable young people has been strengthened, for example there is additional support from specialist teenage pregnancy midwives for young people who are pregnant. Recently introduced services

such as the targeted sexual health team and school nurses' Chat Health (a texting health service for 11–19 year olds to contact their school nursing team) have increased young people's access to specialist advice in creative ways. This is particularly positive in an area where it can be difficult for young people to access services due to their locations. These services are effective in identifying risks of sexual exploitation, taking prompt referral action that facilitates the multi-agency protection of children and young people.

- Young people with substance misuse issues, including those at risk of sexual exploitation, have good access to specialist support county-wide, through the EDAS REACH service (essential drug and alcohol services for young people under the age of 24). Once engaged, young people are well supported by a range of face-to-face, group and online app-based services.
- Police leaders have been particularly proactive in understanding and prioritising the protection of children who go missing or who are at risk of multiple forms of exploitation. There is a clear determination to reduce the risks to those identified as being vulnerable. This strong commitment to child protection is reflected in the police and crime plan and force priorities as well as in the investment of additional staff into specialist child protection functions.
- There is clear evidence of the shift in the culture of the police towards thinking about the wider context of abuse and exploitation. Senior leaders clearly recognise the challenges faced in the county by those children who are being criminally exploited or who are connected to adults who are being exploited. They have developed detailed local profiles that have informed a more sophisticated understanding of the prevalence, nature and scale of criminal exploitation and 'county line' criminality alongside similar profiles for sexual exploitation and missing. These are used to focus and prioritise police activity to ensure that those who are at most risk receive a timely response.
- Operation Voltage is the Pan-Dorset police response that focuses on intelligence gathering, safeguarding, disruption and investigation. Through a weekly meeting, activity is targeted, with incidents posing the greatest threat, harm and risk being prioritised. There are good examples of local efforts being undertaken by neighbourhood patrol teams and of the use of regional police resources to disrupt this type of criminal activity. The strong police response is working to promote diversion, prevention and the earlier identification of risk. This is particularly seen through the IMPACT team, Operation Voltage and Project Spotlight.
- The YOS has effective systems in place that allow comprehensive checks to be made at the point of initial referral to inform assessments. The YOS has a clear rationale for intervention with young people and a good understanding of child protection procedures. Staff in the youth offending service have had

training on both sexual exploitation and 'county lines', and the service has appropriate management oversight of their work. Young people known to the YOS experience good engagement and positive relationships with the YOS staff.

- The NPS staff have a good understanding of the processes and systems in place for making referrals to the MASH. There is a good knowledge of thresholds and escalation processes. The small number of NPS cases seen had assessments, plans and interventions of sufficient quality. The local team is well managed, with evidence of effective supervision and management oversight. NPS child safeguarding policy and procedure is well understood and complied with, and staff are up to date with relevant training.
- NPS staff are clear about their responsibilities to safeguard children. Information sharing between the NPS and MASH at pre-sentence stage is clear, consistent and supported by effective protocols. Assessments and plans consistently consider information obtained from the MASH. In most cases, NPS records clearly detail the safeguarding concerns, with good descriptions of family history. This information is used to inform analysis and to identify risk and protective factors for children.
- Dorset safeguarding children board (DSCB) has been strengthened since it was reviewed in 2016 and was found to be inadequate. It is benefiting from sharing the same chair with the Bournemouth and Poole LSCB and from a range of well-developed Pan Dorset resources, data sets and learning. Although there is room for further improvement, the DSCB offers a helpful source of development and challenge for the partnership.

Case study: highly effective practice

The police integrated missing person and child sexual and criminal exploitation team (IMPACT service) is comprised of a dedicated team of officers who work with other agencies to safeguard children at risk of exploitation and going missing. The IMPACT service works consistently with children who regularly go missing and tries to reduce the risks for them. It works with young people involved in exploitation and criminal activity, while ensuring that they are appropriately safeguarded. Recent activity has included a significant piece of work with a group of adolescents involved in the selling of drugs.

A key aspect of their work is the 'multi-agency information sharing report'.

There is an increased use of this partnership information sharing form, with 19 forms submitted from the Dorset local authority area since 1 January 2018. There are good links between the IMPACT service and the child sexual exploitation leads in the local authority, with positive evidence of a wraparound support for children at significant risk of child sexual exploitation.

The police IMPACT service shares a list of young people at risk of child sexual exploitation with the contraception and sexual health service (CASH) on a monthly basis. The CASH service makes good use of this information, checking every attendance of an under-18-year-old against the list to inform the clinician of any known child sexual exploitation risk.

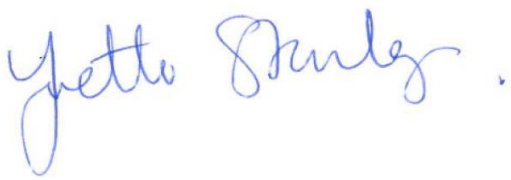
Next steps

The local authority should prepare a written statement of proposed action, responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, YOS, the clinical commissioning group and health partners and Dorset police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

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

The director of children's service should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 16 October 2018. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

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