Inspection of local authority arrangements for the protection of children

Blackpool Borough Council

Inspection dates: **18 June – 27 June 2012**
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Age group: All

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Contents

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The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Blackpool is inadequate.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Blackpool the local authority and its partners should take the following action.

Immediately:

- Review the work of the duty and assessment team, including the Catalyst and Awaken teams, to ensure that contacts and referrals received by Children's Services are dealt with robustly and effectively. Ensure that decisions are taken by managers that fully take account of the risks identified at the point of contact so that children and young people are provided with an effective level of protection and support at the right time.

- Ensure performance management and quality assurance arrangements are fully in place, that managers have a full understanding of their roles and responsibilities, and that there is robust management oversight of the quality of work undertaken by social workers.

- Improve the quality of information and analysis within assessments, including risk and protective factors to promote effective planning and decision making and ensure that all assessments take full account of children and young people's ethnicity, culture, religion, language and disability.

- Ensure that full use is made of core assessments in child protection cases and these are completed and updated in a timely way with a comprehensive analysis of risk.

- Ensure that children in need and child protection plans are robust, comprehensive, specific and have clear timescales for improved outcomes for children and young people.

- Ensure that core group meetings are attended by agencies involved in monitoring and driving improvements in protection for children.

- Ensure that legal advice is timely to consider those children and young people subject to repeat child protection plans where circumstances are not improving.

- Ensure that all children receive regular monitoring visits and that statutory child protection visits are undertaken within timescales, that children are seen alone at appropriate intervals and their wishes, feelings and views are sought and recorded.

- Improve the timeliness and quality of supervision for social workers and ensure recording is clear and specific with detailed actions to be followed.

Within three months:

- Ensure that family intervention workers can access the electronic recording system so that information sharing is robust.

- Ensure that the use of advocates to support parents and children and young people is actively promoted.

Within six months:

- Review the draft Joint Strategic Needs Analysis (JSNA) to ensure there is a clear understanding and representation of the needs of children, young people and their families to inform service development and delivery.

- Ensure that there is greater consonance between the JSNA and the draft Children and Young People's Plan.

- Strengthen governance arrangements between the Children's Trust and the Blackpool Safeguarding Children Board (BSCB) and ensure there is effective scrutiny of the work of the BSCB.

- Develop systems to routinely collect feedback from parents, carers and children who have been in receipt of social work intervention to inform and develop practice and service provision.

- Improve the quality of performance management and evaluations, including learning from operational feedback and audit activity so that these can be used effectively to drive improvements.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised 111 case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focussed on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of five of Her Majesty's Inspectors (HMI).

8. This inspection was carried out under Section 136 of the Education and Inspections Act 2006.

Service information

9. Blackpool's resort profile, seasonal employment in the town's tourist industry and the large stock of low cost, privately rented accommodation contribute to high levels of population migration into and out of Blackpool, with a balance towards inward migration. As a result, the town experiences one of the highest levels of population mobility of children and young people in the country, presenting considerable challenges for agencies providing services to them and their families. For example, the annual turnover of pupils in some schools can be as high as 30%. The 2010 Index of Multiple Deprivation (IMD) indicates that Blackpool is the 6th most deprived local authority district in England. This ranking indicates an increase in general deprivation levels compared to other authorities since 2007 when Blackpool was ranked 12th, and 2004 where it was ranked 24th.

10. Blackpool Borough Council has approximately 32,900 children and young people (0-19 year-olds) who reside within the authority. The 0-19 population accounts for one quarter (24%) of the resident population, a proportion in line with both regional and national averages. Birth rates are below the regional and national rates, and are outnumbered by the death rate. However the population is projected to increase in the future. There is a relatively low proportion of minority ethnic groups (1.6%) but above regional average of over 65 year-olds (19.1%).

11. Early help for children and families in Blackpool is provided within the Children's Services Department of the Local Authority and located within early years and family support, early help for children and families and specialist school and community support services. Delivery is provided in a number of ways, through a range of settings including 11 children's centres; Springboard, the multi-agency family intervention programme; schools and community settings; youth settings; and via partnership arrangements with, for example children's and adult mental health services, substance misuse services and the youth offending service.

12. Contacts and referrals for targeted children's social care support are managed by the council's duty and assessment team which includes a specialist team for domestic violence (Catalyst) and a specialist team for sexual exploitation (Awaken). Services requiring children in need or child protection plans are provided through three locality offices in the south, central and north of the area.

Overall effectiveness

Inadequate

13. The overall effectiveness of Local Authority arrangements for the protection of children is inadequate. Some children and young people are not adequately protected at crucial points in their journey through life. When children and young people require help and protection, insufficient risk management and decision making at the point of contact means some do not receive a timely service and are left at continued risk of harm. Too many referrals to children's services are closed prematurely with no further action. Management oversight has not been sufficiently robust in assessing risks in these cases. This means that a significant number of cases inevitably require a re-referral for further action and some children have not been provided with the help they need in a timely way which has left them subject to risk. During this inspection inspectors had to refer an unacceptable number of cases back to children's services that, in full agreement with service managers, required prompt, further action to ensure that children and young people are being adequately protected.

14. When children and young people are clearly and appropriately identified as at risk of potential harm, child protection enquiries are prompt and result in timely strategy discussions and child protection conferences, with good multi-agency attendance, although probation services and general practitioners (GPs) are noted as absent from some conferences and this is an omission, particularly when they could hold important information relating to adults.

15. Early help services provide good support to children, young people and families which is highly valued by parents. On occasions this has ensured cases are not escalated to statutory services too soon or unnecessarily. However, the help provided is not based on a thorough understanding of both the population and the needs of children, young people and their families. A comprehensive needs analysis has not yet been undertaken and there is a lack of coherence between the draft Joint Strategic Needs Analysis (JSNA) and the draft Children and Young People's Plan (CYPP). Therefore, information has not been strategically gathered to ensure that the needs of children, young people and their families are known, that gaps in services are identified and that a coherent plan is in place to meet those needs. Currently, the draft CYPP is the main strategic document in place to drive developments and improve outcomes for children and young people. However, plans are in place to develop a comprehensive early support and intervention strategy, although this is in its early stages.

16. Leadership and governance arrangements have not been sufficiently secure to ensure that there is appropriate strategic oversight to improve the help and protection offered to children and young people. The level of challenge and accountability between the Blackpool Safeguarding Children Board (BSCB), and the Children's Trust has not been robust. Clear protocols are in place to support these arrangements but they are not consistently followed. Consequently, the lack of scrutiny of the work of the Safeguarding Board leaves them less accountable for their actions. This has been compounded due to the absence at board meetings of the previous Director for Children's Services and the Lead Member. Some key partners have also failed to attend meetings consistently. The recent re-structure of Children's Services and changes to key senior leadership

posts has resulted in a renewed vigour to tackle these issues. Evidence was seen of improved attendance and involvement of the Chief Executive, newly appointed Director for Children's Services and the newly elected Lead Member at key strategic meetings, although the impact of these were not yet evident. The council and partners seek to promote, and work within, a learning culture, for example they are currently part of a peer review and have recently been part of a Local Government Agency (LGA) review from which an action plan has been produced which is currently being implemented. Learning from serious case reviews has been disseminated widely both from a multi-agency perspective and also within children's services.

17. Performance information is not used effectively to inform learning and development of the service. Data reporting using national and some local indicators is extensive, although not consistently focused on comparators with similar authorities. Specific issues and themes are identified and some are subsequently pursued, although there is limited senior managerial capacity to maintain a sufficient and effective oversight and qualitative analysis of performance. Performance management and management oversight is poor, and there is insufficient management focus on the experiences of the child, the current risks and needs and the difference that intervention is making. Evidence of challenge is inconsistent and the quality of both strategic and operational management oversight does not routinely lead to improved outcomes and service provision for some children and young people. Auditing of social care practice takes place regularly, but the audits are not completed to an adequate standard, with a lack of findings and actions to ensure that case work is robust, inform improvement and aid social workers' development and practice.

The effectiveness of the help and protection provided to children, young people, families and carers

Inadequate

18. The effectiveness of the help and protection provided to children, young people, their families and carers is inadequate. When children require statutory intervention from children's services, the response has not always been sufficient or consistent to address the risks and needs identified and not all children and young people have been sufficiently well protected when they have needed help and support at crucial stages in their lives. In some cases seen by inspectors, there has been too much focus on supporting adults and the experiences of children have been lost. Some cases of repeat high risk domestic violence incidents, or multiple events of children being missing from home, have led to either insufficient or no action, or premature case closure. As a result, some children have been re-referred by other professionals and effective responses have been either delayed or absent. Consequently re-referral rates are high, as are the rates of children subject to second or subsequent child protection plans and it is clear that some of these children are not receiving the right level of help when they need it.

19. The quality of assessments is variable and in some cases poor, they do not consistently inform planning and planning does not always adequately focus on the risks and needs identified in assessments. As a result, these assessments do not fully identify the risks to some children and young people, resulting in them

not getting the help and protection they need at the right time. Poor account is given to the consideration of children and family's ethnicity, religion, language or disability and case files do not routinely record ethnicity. In some cases, for example, inter-generational domestic violence has occurred and professionals do not identify the impact of this when assessing parent's ability to protect their children or on the prognosis of parents ceasing this behaviour. Children's views are not routinely taken into account in assessment and planning and therefore their voice is not heard sufficiently. Some children who have been affected by domestic violence are well supported by children's independent domestic violence advisors (CIDVA) as well as through the effective use of child protection case conference consultation packs.

20. Most children are seen regularly, although inspectors identified a small number of cases where children who are subject to a child protection plan have not been seen for extended periods of time between case conferences reviews. In these cases there was a lack of management oversight to ensure that statutory visits had been undertaken and it was unclear if children had been exposed to unnecessary harm. In some cases, particularly in the Awaken team, it was often unclear whether young people were consistently seen following referrals of concern about their welfare.

21. Arrangements to identify and monitor child protection plans vary in their effectiveness. Initial child protection case conferences are mostly well attended, particularly by the police, and there is evidence that almost all agencies work well to ensure that targeted help is provided to improve the circumstances of children and young people. While core group meetings also take place regularly, there is limited evidence that they are effective in monitoring and developing the protection plan. Insufficient consideration of contingency planning for children and young people contributes to some delays in seeking legal action. However, once legal advice is sought this is of good quality and results in clear and effective plans to secure permanency for children. Core groups are mostly well attended. However, attendance by the probation service and GPs is consistently poor. Consequently, some plans and services for children and families are not well coordinated. Additionally, 'step down' monitoring arrangements and interventions through child in need arrangements are not always sufficiently robust or rigorous and some cases are subsequently closed prior to sustained improvements.

22. Vulnerable children and young people generally receive a timely offer of early help through universal and targeted services, although the early help strategy is still under development and there is a need to ensure improved coordination of services and the establishment of a clear link to an overarching service strategy. Children's centres, student support services, parenting support and the family intervention project deliver a range of effective and supportive services for children and families at times of need or in crisis. Services have been evaluated regularly and staff use feedback to improve practice. Parents spoke with confidence about how much help they had received from children's centre staff, for example to become better parents, to grow in self confidence and to build emotional resilience. Parents and children who receive services from the family intervention project reported how much they valued this service and how the support had helped to improve their circumstances and move forward positively. However, family intervention workers to do not have access to the electronic

recording system used by social workers, and this inhibits effective information sharing between professionals.

23. The common assessment framework (CAF) is embedded and used effectively across services although the quality of assessments seen by inspectors ranged from good to barely adequate. In most cases, issues and needs are identified clearly. However in some CAFs reviewed by inspectors, actions, timescales, and success criteria were not specific and there is currently no centralised system for monitoring and assuring the quality of CAFs overall. Arrangements for family group conferencing are effective and well targeted and have clearly delivered improved outcomes for children and young people as well as raised awareness within their families of their needs and wishes.

The quality of practice

Inadequate

24. Quality of practice is inadequate. Agencies have a clear understanding of the thresholds and procedures for referrals to children's services. When agencies have concerns that children are at risk of harm or require services they share information promptly and appropriately. However, management decision making in the duty and assessment team is not consistently robust or appropriate to ensure that children are safe, particularly when they are referred to the specialist domestic violence team (Catalyst) and specialist team for children at risk of sexual exploitation (Awaken). Inspectors identified too many cases where contacts and referrals were signed off by managers for no further action, with no explanation of the reasons for the decision, when it was quite clear that there were risks to some children and young people. Consequently the duty and assessment team receive high levels of repeat contacts and re-referrals on these cases highlighting that appropriate and effective action had not been fully undertaken at the point of first contact. Inspectors saw evidence where children experienced significant delays before an appropriate decision was made to undertake a child protection enquiry and a number of these children and young people were eventually made subject to child protection plans. Some responses to concerns involving children who go missing from home lack effectiveness in addressing risks and concerns.

25. When appropriate action is taken to respond to contacts and referrals, there is good information sharing between the police, schools and almost all health providers. The exception to this is the absence of effective communication with GPs and some adult related services, for example, adult mental health services. The quality of decision making and recording in social care teams, who hold cases where longer term support is required, is of better quality with, in most cases seen, good direction by managers.

26. The CAF is used well by schools and early years settings when there is a request for early intervention. Information sharing across early help services, including children's centres and schools is extensive and appropriate, with substantial efforts made to gather and interpret information so that the right decisions are made for action.

27. Where child protection concerns are clearly identified there is a timely and effective response. The police public protection unit is co-located with the children's services duty and assessment team and this enables strategy discussions to be held promptly with good use of multi-agency information sharing. Child protection enquiries are carried out by qualified and experienced social work staff supported by other agencies, particularly the police, but also schools and community and hospital health services. Initial child protection conferences take place in a timely manner.

28. Assessments vary in quality. CAFs showed good evidence of effective multi-agency working when necessary, although it is not always clear from the documentation whether actions have been completed, what stage the action plan has reached or when the next review meeting is to be held. Initial and core assessments are not always sufficiently detailed and decision making is not based upon sound and considered information, a thorough analysis, or a focus on risk and protective factors. For example, assessments undertaken when there are concerns relating to domestic violence often fail to consider the impact of this on children and young people.

29. Social workers endeavour to ensure that children are seen and seen alone and their views are recorded within assessments, but this is not always the case and some children subject to child protection plans do not receive their statutory visits consistently. The use of conference packs to support children in expressing their views is effective when they are used to gauge children's views during case conferences. However, the views of young children under five years of age were inconsistently represented and not recorded within assessments or on the electronic recording system. Whilst advocacy arrangements are in place for parents to access, these are not routinely in place to support the effective participation of children in their assessments or within formal settings, such as child protection conferences. Some good work is undertaken by child protection chairs and independent reviewing officers (IROs), to promote advocacy and to ensure that the views of children and young people are heard within initial child protection conferences and review child protection conferences. Arrangements for the routine gathering of children's views as well as those of parents and carers subject to social work intervention have not yet been fully embedded across children's social care.

30. Arrangements for conducting initial and review child protection conferences are mostly good. Most outline child protection plans produced at case conferences were sufficient to ensure that children were protected with specified actions addressed in a timely manner. However, in too many cases plans were not sufficiently specific and some failed to identify what improvements were being sought from parents. Some very effective work, facilitated by conference chairs, was observed, with a clear focus on the needs of the child, consideration of the views of all involved and effective involvement of parents. Whilst child protection conference chairs regularly audit child protection case work and regularly highlight deficiencies in practice, these findings are not used effectively by managers to drive improvements.

31. Attendance at core group meetings does not consistently include key agencies, particularly probation and adult mental health representatives. Recording of core group meetings did not consistently consider all key protection plan issues and

groups did not always enhance outline child protection plans into fully developed plans with clear timescales and action. Therefore, these meetings do not always provide sufficient direction and planning for the investigation and could therefore significantly detract from a full consideration of relevant information in considering risks to children. These gaps also have the potential to impact adversely on the timely and rigorous pursuit of child protection plans. Most parents seen understood the plans for their children, the expectations of changes sought and the reasons for these, although some expressed frustration at the change or turnover of social workers. Some child in need plans were not specific and did not contain measurable actions, but in others seen, there was good practice, with plans clearly focused on the needs of the child and the actions required to bring about improvements.

32. Case recording is mostly timely, although workers acknowledged that this can drift when they are subject to other work pressures. This can result in essential information being overlooked to assist in protecting children should additional concerns be raised and does not ensure that the child's journey can be clearly evidenced. Much of the recording tends towards the description of events and activity rather than being evaluative. The production and use of chronologies is not well embedded in practice although these are significantly better in cases within the public law outline.

33. Clear protocols are in place to ensure that staff receive regular supervision from their managers. In some cases supervision is carried out monthly, however, this is not the case for all workers and two or three month gaps were seen in some records, particularly in the duty and assessment team where recording did not always demonstrate management challenge or reflective practice. The quality of supervision records seen within the locality teams is adequate, with evidence of challenge to social workers in cases where limited progress is being made. Almost all supervision records included information on training opportunities and expectations. Recording of support for newly qualified social workers was good with detailed records of training, development and support provided to them.

Leadership and governance

Inadequate

34. Leadership and governance arrangements are inadequate. There has been insufficient strategic political and senior management oversight to ensure that child protection services are effective in protecting some of the most vulnerable children and young people in Blackpool. A recent re-structure in children's services has resulted in a new senior management team, coupled with a new Lead Member for children's services. The newly appointed Director of Children's Service, the Lead Member and Leader of the Council have demonstrated that they have a good understanding of the strengths and weaknesses in the service, reporting that there is a stable workforce, with front line staff protected from financial cuts. However, they are clear that much work has yet to be done to strengthen the service. This includes improving the management structure, coordinating the offer of early support and intervention, improving the role of the BSCB and introducing more effective challenge and robust governance arrangements between the Safeguarding Board, the Children's Trust, elected members and senior managers.

35. A comprehensive needs analysis of children, young people and their families has not yet taken place and there is an absence of a local strategy to help and protect children and young people. Therefore, the mapping of needs and gaps in service delivery for children and young people has not been identified. This has been identified as a key priority for the DCS and partners over the next year. There is a lack of coherence between the draft JSNA and the draft CYPP and the JSNA does not fully identify the needs of children and young people in the area.

36. Governance arrangements between the BSCB and the Children's Trust are not robust. Whilst there is a clear protocol in place which sets out the working relationships between these two key strategic forums, there is little evidence to demonstrate that they work together appropriately to effect change and help to improve safeguarding arrangements for children and young people. The chair of the board regularly attends Children's Trust meetings but there is limited evidence to demonstrate that this has had an impact in terms of support, challenge and accountability of both boards.

37. The BSCB is appropriately constituted with key partner agencies involved, however, attendance at board meetings is inconsistent and therefore members are not always fully up to date on the work of the board. In addition, the poor attendance of the previous Director of Children's Services and Lead Member has resulted in a lack of strategic drive to take forward the core business of the Safeguarding Board. There has been weak oversight and challenge with regards to understanding and tackling key social care performance information relating to rising referrals, re-referrals, child protection plans and repeat child protection plans which has led to a lack of focus on the core business. Some good work has been undertaken in key areas, for example, reducing child deaths through raising awareness of the risks of parents sleeping with babies, an extensive multi-agency training offer to children's services and partner agencies, supporting partnership work and the promotion of learning from serious case reviews. Elected member scrutiny of social care and child protection functions is under developed. The absence of a chair of scrutiny of children's services for a significant amount of time has further impacted on the ineffectiveness of this function.

38. Performance management arrangements are not effective. Management oversight of child protection work is insufficiently focused on the experiences of the child, the current risks and needs, and the difference that intervention is making. Evidence of challenge is inconsistent and the quality of management oversight does not routinely lead to improved outcomes and service provision to children and young people. There is little evidence of managers taking an overview of strengths and weaknesses in practice across duty teams. Managers are therefore unable to demonstrate how improvements are identified, remedied and then sustained. The quality of case auditing undertaken by managers is poor. The audit tool is adequate, but in the majority of cases is not fully completed and consequently there is no qualitative information to support the audit findings. The safeguarding and review team undertake regular audits of child protection activity. Findings are collated over a six month period, but there is a lack of clear reporting mechanisms to ensure that the findings are shared with the BSCB or with senior managers. In some cases, the team have identified poor quality core assessments that need to be re-written or statutory visits that have not been undertaken. Operational managers are made aware of these

issues, but they do not consistently complete the response forms which should indicate what steps they are going to take to rectify poor practice.

39. Workforce planning is effective and reflects the diversity of the population. There are sufficient numbers and balance of suitably experienced and qualified staff in place. Capacity in some teams, however, remains challenging and some workers have demanding caseloads given the complexity of much of the work. Training and development needs are identified for social workers in their annual reviews and these findings inform the training plan.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Inadequate
The effectiveness of the help and protection provided to children, young people, families and carers	Inadequate
The quality of practice	Inadequate
Leadership and governance	Inadequate