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Dear Diane Booth

Monitoring visit of Blackpool children's services

This letter summarises the findings of the monitoring visit to Blackpool children's services on 16 and 17 December 2019. The visit was the second monitoring visit since the local authority was judged inadequate in January 2019. The inspectors were Lorna Schlechte, Her Majesty's Inspector, and Shabana Abasi, Her Majesty's Inspector.

Since the inspection one year ago, there has not been enough progress made to improve the quality of social work practice across the assessment and support (AST) teams and the strengthening and supporting families (SSF) teams. Although the model of practice was developed with partners throughout 2019, and work is underway to embed this across the system, it has taken 12 months for the foundations of a new model of practice to be put in place. It will take longer for the model to become fully operational and to consistently drive frontline practice. This has led to delays in delivering the level of improvement required and has restricted the impact on children and young people in Blackpool.

Areas covered by the visit

During this visit, inspectors reviewed the progress made in relation to children in need and children subject to child protection planning. This included the work of the AST and SSF teams regarding the application of thresholds, the quality of assessments and plans, children subject to child protection investigations and pre-proceedings work.

Inspectors considered a range of evidence, including electronic case records, and key documents provided by staff and managers. We also observed social workers and other staff within these teams.

Overview

Since the inspection one year ago, the local authority has worked closely with a range of partners, including three partners in practice (PIP) authorities, and the DfE commissioner, to begin the process of transformational change. This has led to some improvements at the front door, a recent partnership event and some initial training on a new model of practice, with a further programme to be rolled out across the workforce early in 2020. However, at the time of this monitoring visit, the impact of this support had not led to sufficient change in the quality of social work practice.

Strategic engagement with partners has continued to increase so that leaders can understand how practice can be improved. Performance information is closely monitored at the Getting to Good board, and stocktake sessions provide an opportunity for the local authority to regularly review progress. This has led to a stronger Multi-Agency Safeguarding Hub (MASH) and the establishment of a new partnership board, which is due to commence in January 2020.

The progress made by the MASH, which was noted during the first monitoring visit in August 2019, has been maintained.

Significant financial investment in the last 12 months has led to a restructure of children's services and increased capacity in social work teams. The workforce development offer has been reviewed and it is appropriately focused on seeking to attract permanent staff in order to reduce the significant reliance on agency social workers.

Despite these efforts, recruitment continues to be a significant challenge. Some key posts have been hard to fill, and the service is still made up of a largely inexperienced workforce, with high caseloads due to the volume of work coming through the front door. Although frontline management capacity has increased in the AST and SSF teams since the inspection, management oversight is inconsistent, and weak in some areas. It is, therefore, not driving improvement at the rate or quality that is needed. This is a concern given the level of inexperience within the workforce at this time.

The creation of new senior leadership roles since the inspection, including an assistant director, and the recruitment to the existing post of principal social worker are leading to more focused activity on workforce learning and scrutiny of frontline practice. These are positive developments, but such activities are not fully embedded, and they have not led to significant and sustained improvement in the quality of social work practice in the AST and SSF teams.

The development of a strengths-based model of practice has taken too long to design. The new model will launch after social workers have been trained. This training is planned to take place in early 2020.

The neglect strategy has been re-launched, but it is still to be fully embedded. It is concerning that the response and recognition of neglect for some cases continue to be too slow, as was the case at the time of the inspection.

This combination of recruitment challenges and the delays in implementing a new model of practice have hampered the pace of progress. There remain drift and delay and inconsistent social work practice across the service. The director of children's services and senior leaders are honest about these practice shortcomings in the self-evaluation document. Audit findings confirm that there is much more to do to improve the standard of practice and embed cultural change.

The local authority is moving in the right direction, but progress has been too slow; it knows itself well, but it is yet to deliver a more consistent and effective standard of social work intervention with children and families in Blackpool.

Findings and evaluation of progress

Thresholds at the front door continue to be applied well in most cases. Information from partners is gathered in a timely manner at the MASH, and management decision-making on next steps is mostly clear. Consent is still not always sought by all partners, particularly the police, prior to contacting the MASH, and the arrangements to secure consent at a later stage in the referral process lead to some duplication of effort. The local authority has been aware of this issue since the inspection, but has had limited success in addressing it fully with all partners. They expect to resolve this issue with the support of the new safeguarding partnership.

Strategy discussions are usually well attended by partner agencies, and there is evidence of information-sharing to support future action. Recording is not always clear or timely and sometimes lacks analysis. In a small number of cases, neglect had not been recognised, or responded to robustly, prior to a strategy discussion being held. The decision to initiate a child protection investigation took too long in some cases, and information from partner agencies was not always well recorded within the section 47 decision-making, and this impacts on the quality of planning to safeguard children.

There is timely allocation of work from the MASH to social workers in AST teams, with clear direction regarding the areas to be considered within the child and family assessment (CAFA). However, the mid-review checkpoint within the CAFA is not always completed within the 10-day timescale set at the start of the assessment process. This means that social workers are not always benefiting from management oversight at key points in their work with families, in accordance with the local authority's own practice standards.

The quality of CAFAs is variable. As noted at the last monitoring visit, most provide detailed information about historical concerns, and this has been maintained, but they continue to lack robust analysis. They are sometimes limited to the presenting issue rather than being a consideration of the cumulative impact of historical risks on the child. They are not always updated regularly in line with changing circumstances, and, at times, there is an over-reliance on self-reporting by parents. This leads to an

over-optimism about parents' capacity to change. These were all issues identified in the inspection as needing to improve.

The local authority has recognised that the quality of assessments is an area for improvement in its audit findings and self-evaluation. It is seeking to address this by rolling out a programme of training on a new strengths-based model of practice early in 2020. It has also deployed staff from its audit team into the AST teams, to actively assist and guide social workers in improving the quality of CAFAs. These are positive steps in the right direction, but we saw limited impact of this work during this monitoring visit.

Direct work is completed with children who are seen regularly, and the observations of non-verbal children are well recorded. The voice of the child is clearly sought and reported verbatim in the case record. However, there is limited analysis of children's views to make the assessment and plan more child-focused.

Plans for children lack specificity regarding clear timescales for actions to be completed, or contingencies if progress is not sustained. Plans are often prefaced by a long list of risk indicators, but the plan itself is often quite brief and lacks detail regarding key objectives for supporting the child and family. This means that the quality of social work intervention is not always purposeful and there is still evidence of drift and delay for children, as there was at the time of the inspection a year ago.

Core groups and reviews, where information is appropriately shared, are held regularly and most are attended by relevant partner agencies. However, inspectors did see some examples of attendance declining over time. It is not always clear how plans are updated following these meetings, and inspectors saw limited evidence of child protection chairs challenging cases of drift and delay. The local authority recognises that this needs to improve and has started to implement a new model of child protection conferences in partnership with their improvement partner. It has recently re-designed the service, split the role of child protection chairs and independent reviewing officers, and secured additional management capacity to ensure a more consistent approach going forward. A weekly resolution panel has been recently introduced to the service, although the impact of these changes is to be fully embedded in practice improvement.

Since the inspection, a new public law outline (PLO) tracker has been introduced and it is supporting more effective management oversight of cases than at the time of the inspection. Inspectors have seen appropriate escalation into PLO or pre-proceedings, although in some cases the decision could have been made sooner given the lack of progress on a child protection plan. Some families are still subject to drift and delay in PLO, due to meetings being cancelled and a lack of challenge by frontline managers.

The recently introduced weekly permanence and care planning panels, chaired by the assistant director, provide detailed consideration of plans for children in pre-proceedings, requests for children to become looked after and the progress of children in care. This has improved management oversight at a senior level, and is

beginning to hold frontline managers to account and drive forward the necessary cultural change to ensure that there is a tighter grip on practice in this area.

Social workers report that supervision takes place regularly and is very supportive, although the supervision record lacks reflection and is sometimes too descriptive. Caseloads are still too high in some teams, including for some ASYE social workers. This can feel overwhelming for them and leads to delays in case recording.

Despite this, ASYE support was valued by new social workers, with peer group supervisions held regularly by new ASYE coordinators. Most social workers reported positively on the improvement journey, embraced recent changes and were enthusiastic about a new strengths-based model of practice to be implemented.

Staff were positive about working in Blackpool, but the pace of change has been hindered by a combination of recruitment challenges, an inexperienced workforce and insufficient management oversight in frontline teams. There has been instability in some teams due to significant churn in agency social workers covering vacant posts and leaving after a short time, the internal promotion of staff to newly created management posts and a high level of less experienced staff holding complex cases. The workforce development strategy and offer have been reviewed and enhanced to secure more permanent staff in the light of these challenges, but gaps remain. This places pressure on the whole service, which is continually coping with high levels of demand at the front door. It also has a detrimental impact on children who continue to experience changes of social worker.

Auditing work continues to identify appropriate practice issues, including where drift and delay have occurred. Audits moderated by the principal social worker provide additional context and challenge, but there is much more to do to embed a strong audit framework to evidence that audit actions are progressed in a timely way and lead to improvements in practice.

I am copying this letter to the Department for Education. This letter will be published on the Ofsted website.

Yours sincerely

Lorna Schlechte
Her Majesty's Inspector