

Ofsted
Piccadilly Gate
Store Street
Manchester
M1 2WD

T 0300 123 1231
Textphone 0161 618 8524
enquiries@ofsted.gov.uk
www.gov.uk/ofsted



9 April 2021

Jeanette Richards
Director of Children's Services
Executive Support Team
Blackpool Council
Number One
Bickerstaffe Square
Blackpool
FY1 3AH

Dear Ms Richards

Focused visit to Blackpool children's services

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.

This letter summarises the findings of a focused visit to Blackpool children's services on 23 and 24 February 2021. The inspectors were Lorna Schlechte, Brenda McLaughlin, Nick Stacey, Kathryn Grindrod and Paul Williams, all of whom are Her Majesty's Inspectors.

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 staff, carers, key stakeholders and young people. They also looked at local authority performance management and quality assurance information and children's case records. The lead inspector and the director of children's services (DCS) agreed arrangements to deliver this visit effectively while working within national and local guidelines for responding to COVID-19.

What needs to improve in this area of social work practice

- The consistency and quality of work for children subject to child protection plans, to reduce drift and delay.
- The development of pre-proceedings work, to ensure that the tracking of children's cases leads to timely decision-making, including timely applications to court where appropriate.
- The quality assurance of casework, including case auditing, to ensure a consistent benchmark for practice improvement.

Findings

- The impact of the COVID-19 pandemic has been keenly felt in Blackpool, where much of the population is dependent on employment linked to the tourism sector. Strengthened partnerships have planned and delivered an effective, collaborative response to the challenges of the pandemic, in a town with the highest levels of deprivation in the country and a transient seasonal population. A partnership mailbox was established promptly to coordinate information about the most vulnerable families. COVID-19 risk assessments inform visiting arrangements to see children and families, and staff have been well supported throughout the pandemic. The local authority has continued to focus on its improvement priorities, which are outlined in the social work improvement plan, despite the challenges of the pandemic. This has led to positive changes in some areas.
- Senior leaders know that there is still a lot more work to do to embed a consistent quality of practice across the service. They continue to engage well with three partners in practice, have facilitated a high level of virtual training during the pandemic for social workers and managers, and understand that more support and training is required in relation to the response to neglect and pre-proceedings.
- Recruitment is a continual challenge and does significantly impact on the quality of practice in some parts of the service, especially in those Strengthening and Supporting Families (SSF) teams where there has been considerable staff turnover of social workers and managers. More than one third of the workforce consists of newly qualified staff in their assessed and supported year of employment (ASYE). Although these staff hold complex work, there is additional support on offer to support them. The use of agency staff has reduced in recent months. Staff were positive about working for the Blackpool local authority, which they said is a supportive learning environment.
- A new model of practice, Blackpool Families Rock, was co-produced with families and young people shortly before the pandemic and is beginning to influence supervision and reflective practice discussions. Training in relation to this new restorative approach was initially impacted by COVID-19 but has since been rolled out. More work is planned to embed the approach across the service.
- The judiciary and other stakeholders report positively on the engagement of senior leaders to address court delays linked to backlogs in the family court during the

pandemic. It is positive that a high number of discharges of care orders have been progressed during this period, in accordance with improvement plan objectives and an overarching financial strategy aimed at achieving permanence and reducing the numbers of children in care.

- Senior leaders have a clear understanding of performance data, which supports an understanding of their improvement journey. Auditing activity has continued at pace throughout the pandemic, although the quality of audit varies, and different styles and formats are used. This means that there is an inconsistent benchmark of progress in relation to measuring children's experiences and outcomes. There is more to do to ensure that auditing leads to consistent analysis and prompt remedial action in order to impact sufficiently on practice improvement.
- The Access to Support Hub is now made up of permanent and suitably experienced staff. Decision-making continues to be responsive and timely, identifying risk promptly and applying appropriate thresholds. There is effective consideration of historical information to inform decision-making, consent is sought from parents appropriately and management oversight is clearly recorded.
- The co-location of early help staff and other partner agencies in the hub aids communication, and this has been maintained effectively throughout the pandemic, even when some staff are working from home. Partner attendance at the virtual daily risk meetings has increased, which ensures that the needs of children who are missing and at risk of exploitation are considered promptly within a multi-agency context. Early help pathways are understood and thresholds for stepping cases up or down to early help are appropriately applied.
- Assessments are completed in a timely way and there is evidence of management oversight at the conclusion of the assessment. This oversight is not always evident at the mid-review checkpoint, set by the local authority to review progress. Children are visited regularly, and individual COVID-19 risk assessments inform the frequency and nature of contact. This has mostly been in the form of face-to-face contact since early in the pandemic. There have been some recent improvements in the quality of assessments to support children in need, although there is some evidence of over-optimism regarding parental capacity to sustain change.
- When children need immediate protection, strategy meetings are held promptly and are well attended by a range of partner agencies. However, the rationale for progressing to a S47 child protection investigation is not clearly recorded in some cases, and the consideration of historical factors is inconsistently reflected in management decision-making. This means that there is sometimes too much focus on the presenting issue, without sufficient analysis of historical concerns and their impact on children's experiences.
- The quality of social work practice for children subject to child protection plans is highly variable, especially in the SSF teams where there is significant workforce churn, with high caseloads and a high proportion of less experienced staff. Although most core groups meet regularly, analysis and progress are not consistently measured against the plan. Senior leaders acknowledge that the response to risk for some children has been insufficiently identified, including in the children with complex needs team (CWCNT).

This has sometimes led to avoidable drift and delay. Action is now being taken in the CWCNT to address the improvements needed.

- There is evidence of routine monitoring and challenge by child protection conference chairs and independent reviewing officers (IROs), although this is stronger in some areas of practice than others. When it works well, this provides important checks and balances to decisions about children's welfare, but it is not always making the necessary impact to reduce drift and delay.
- The quality of pre-proceedings work within the Public Law Outline (PLO) is of an inconsistent standard and this has led to some drift and delay for children. Although some specialist assessments have been delayed due to COVID-19-related issues, other delays are due to the timeliness of assessments of family members by social workers. There are different panels which provide management oversight of this area of work, and there is evidence of reflective discussions prior to escalation to panel. However, the quality of decision-making is hampered by staff turnover and levels of experience. Further training on pre-proceedings and the preparedness of social workers for court is planned but has been delayed due to COVID-19-related issues.
- For those children who go missing or who are at risk of exploitation, the co-location of a dedicated, multi-agency Awaken team has led to reliable and responsive information sharing and effective disruption activity. Relationship-based work, compatible with the Blackpool Family Rocks model of practice, is making a positive difference in this area of work. Multi-agency mapping meetings help identify, track and plan interventions to protect children.
- The number of children being electively home educated has increased during the pandemic. Leaders have developed a suitable monitoring process so that children's well-being can be tracked and monitored. The local authority's work, in collaboration with school leaders, has also been successful in promoting children's attendance at school. Staff diligently follow up reports of children missing education. They are persistent in tracing the whereabouts of all children, particularly those who have moved away from the area.
- Threshold decision-making for children who come into care is appropriate. However, despite appropriate efforts to divert children from coming into care, some children do not come into care quickly enough. This is sometimes due to legacy issues in relation to long-term neglect. There is also an over-optimism about parental capacity to sustain change in some current cases. The new Families Together Intervention Team, which offers support to vulnerable children on the edge of care, has been launched in recent months during the pandemic.
- Children in care have their physical and mental health needs attended to appropriately and family time is thoughtfully planned and promoted. The lack of choice of suitable foster placements limits the ability of social workers to identify the best possible match for children. Placement planning meetings take place appropriately, and the IRO footprint is clear on the case record.
- During the last year, virtual school staff have developed increasingly effective relationships with headteachers and designated teachers in schools. As a result, children in care have received appropriate help to continue learning during the

pandemic. Despite this, the proportion of children who do not achieve a place in employment or training when they leave school remains high.

- Care leavers were overwhelmingly positive about the support provided by their personal advisers during the pandemic. The service responded quickly, and adapted its offer, in recognition of the vulnerability of those care leavers who were at risk of isolation during the first lockdown. This ensured that a minimum level of weekly contact was offered, although contact was often more frequent, depending on need. The introduction of a monthly clinic attended by various partners, including mental health services, also ensured that care leavers were prioritised for mental health support promptly.

- While 95% of care leavers live in suitable accommodation, there are some vulnerable children at risk of exploitation living in unregulated settings who are not always as ready for independent living as outlined in their plan. The management oversight and monitoring of these placements is not always sufficiently robust.

Ofsted will take the findings from this focused visit into account when planning your next inspection or visit. I am copying this letter to the Department for Education. It will be published on the Ofsted website.

Yours sincerely

Lorna Schlechte
Her Majesty's Inspector