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19 July 2022

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Dear Vicky

Monitoring visit to Blackpool children's services

This letter summarises the findings of the monitoring visit to Blackpool children's services on 14 and 15 June 2022. This was the fifth monitoring visit since the local authority was judged inadequate in January 2019. A focused assurance visit to Blackpool was carried out in February 2021. Her Majesty's inspectors for this visit were Lorna Schlechte and Kathryn Grindrod, and a social care regulatory inspector, Sylvia Eboigbe, shadowed the inspection.

Areas covered by the visit

Inspectors reviewed the progress made in relation to children in need and children subject to child protection plans focusing on the following areas of concern identified at the last inspection:

- Thresholds.
- Step up/step down between child in need and child protection.
- S47 enquiries or strategy discussions.
- Assessments and plans and quality of interventions to support change, including for children at risk of exploitation and going missing or those at risk of neglect.
- Multi-agency partnership attendance at core groups or conferences.
- Pre-proceedings.

This visit was carried out in line with the inspection of local authority children's services (ILACS) framework. This visit was carried out on site. Inspectors used telephone and video calls for discussions with local authority staff and improvement partners.

Headline findings

Blackpool continues to make steady progress and senior leaders remain well sighted on areas for further improvement. Although there continue to be a significant number of less-experienced staff and agency social workers in the strengthening and

supporting families (SSF) teams, the workforce has stabilised in recent months. There are now more permanent middle managers in post. Caseloads have continued to reduce and there is improved morale across the workforce. Staff continue to embrace the principles of the Blackpool Families Rock model of practice and senior leaders continue to review its effectiveness. There is more to do to improve the quality of plans, assessments and pre-proceedings, as the quality of practice remains too variable. This means that some children still experience drift and delay in having their needs met.

Findings and evaluation of progress

Strategy discussions are convened promptly when there are concerns that children may be at risk of significant harm. The relevant professionals usually attend these meetings and information is shared appropriately to support future action. Recording is detailed and provides a clear rationale for next steps. Decision-making following S47 child protection enquiries is mostly appropriate, which is an improvement on previous visits.

Assessments include information from relevant professionals and history is appropriately considered to determine future risks. Children and parents are seen, and spoken to, as part of assessments. Assessments are often detailed and provide a full picture of each child in the family, although they sometimes lack analysis about the impact of parental behaviours on children. They are mostly updated when circumstances change, although there is not always enough exploration of wider family support or contingency planning. Assessments sometimes lead to over-optimistic conclusions when assessing family situations and risks to children. This is sometimes based on parental self-reporting of progress, especially in cases of domestic abuse. This means that a small number of children are left at risk of experiencing further domestic abuse incidents. This is due to over-optimistic decision-making, leading to repeat episodes of social work intervention.

Visits to children are mostly regular and purposeful, and some reports of these visits are very detailed and reflect the child's views well. Direct work is mostly carried out with children by social workers and family support workers, informing assessments and child protection planning. Inspectors saw some appropriately focused work by staff at The Den with children experiencing domestic abuse. However, direct work with children who are subject to child in need plans is not always prioritised or carried out as robustly as it needs to be.

Social workers can articulate the plans for children clearly, although written plans do not always reflect this and are sometimes too descriptive. Plans do not clearly measure progress for children, which means that their effectiveness is limited. Safety plans are not realistic enough and sometimes contain a 'wish list' of what should be done to improve complex family situations, rather than providing clear strategies to reduce risk to children.

The graded care profile tool is sometimes, but not always, used to inform planning in relation to children's experience of neglect. This inconsistent use of tools impacts on the effectiveness of work with children who are living in situations of chronic neglect, where progress can be difficult to sustain for some families. This is significant, as the majority of child protection plans (70%) are due to neglect, and involve large sibling groups.

Child protection plans lack clarity about the 'bottom lines' and contingency options when progress for children is too slow. This means that parents may not always be clear about the benchmarks for improvement, when alternative action will be considered or what that alternative action will be. It also means that some children experience repeat incidents of harm without consequence or a change in plan. This is compounded by frequent changes of social worker in some cases, which has led to drift and delay in progressing plans. However, turnover of staffing has stabilised in recent months, and there is now more evidence of social workers holding cases for longer and forming strong relationships with parents, leading to more effective work with children and the reduction of risk in some cases.

When children step down from a child protection plan this is sometimes based on reasonable progress, and the number of repeat child protection plans have reduced in the past year. There is usually clear evidence of management oversight, use of reflective supervision to highlight strengths and risks, and updated assessments prior to a review child protection conference to inform decision-making. Despite this, step down decisions sometimes evidence over-optimism about the sustainability of recent progress, leading to repeat interventions at a later date.

Core groups are regular and attended by relevant professionals. Information is appropriately shared to inform reviews of progress, although the impact of actions and support for children is not always clearly evaluated. Child protection chairs regularly review progress and offer appropriate challenge on the direction of planning in the child's case record. This is not always effective, as the quality of plans is not as robust as it needs to be.

The children with complex needs team has benefited from some additional staffing since the previous visit, with a new deputy team manager now offering support to social workers alongside the team manager. Disabled children and their families are sometimes well supported through the child in need planning process. In the cases sampled during this visit, social workers took time to get to know their individual children and had a good understanding of their specific needs.

The response to pre-proceedings has been strengthened in recent months. There is now more effective senior management oversight of this cohort of families, including from the director of children's services. This has resulted in regular reviews of some intensive support packages aimed at helping families sustain the necessary improvements. Reflective discussions are held prior to legal gateway meetings and

reviews of progress are captured on the Public Law Outline tracker. When there are changes in circumstances, some families step out of pre-proceedings appropriately and in a timely way, and when it is safe to do so.

Despite this progress, there are a small number of longstanding neglect cases in pre-proceedings, which have been subject to drift and delay. This has sometimes been compounded by several changes of social worker. Plans lack sufficient detail and specificity to ensure consistent direction to families on what work needs to be progressed, by when and by whom. Some children who have come into care more recently have not been subject to pre-proceedings, which is potentially a missed opportunity to intervene and bring about change earlier. In addition, it sometimes takes too long before a decision is made to escalate into care proceedings when progress is not sustained. This means that some children are left in situations of neglect for too long. Senior leaders recognise these shortfalls and have made this area of practice a strategic priority in the revised social care improvement plan.

Children at risk of exploitation are subject to regular and detailed risk assessments by the Awaken service, which reviews effectively the circumstances of some of the most vulnerable children in Blackpool. This work is supported by regular multi-agency meetings, held with relevant professionals, to discuss concerns and develop an awareness of local hotspots in the town. Return home interviews are routinely undertaken for missing children, although some are more detailed than others. There continues to be routine sharing of information and intelligence in the daily exploitation meetings at the 'front door'. Plans for children at high risk sometimes lack clarity about contingency plans when children fail to engage with services.

There continues to be regular scrutiny of performance indicators and data trends, including at team and service level, which informs quality assurance audit activity across the service. For example, the rise in recent months in large sibling groups coming into care due to neglect has led to a thematic audit to gain a broader understanding of practice issues. The findings from this audit identified that there is more to do to improve the analysis of cumulative harm and capacity to change in assessments, and to involve family networks in contingency planning. Senior leaders acknowledge that thematic auditing now needs to be complemented by regular benchmarking of practice in routine full-case audits. The moderation of audits adds value, challenges audit gradings appropriately and provides detailed reflection on the child's lived experience. There is still more to do to ensure that audit actions are followed through and that they improve practice, as highlighted in previous visits.

Senior leaders continue to prioritise workforce stability, which has been a focus for improvement since inspection three years ago. There continue to be a significant number of agency workers and less experienced staff in the SSF teams, holding some of the most complex work. Despite the challenges in relation to recruitment and retention, turnover has reduced more recently, and there is additional capacity across this part of the service. Most team managers are now permanent, and the leadership academy is starting to offer development opportunities to new managers.

The practice development service has been expanded to deliver more support to staff, to build their confidence and improve the variability of practice through learning circles, mentoring and other opportunities.

Staff value the supportive culture, the training and the model of practice, Blackpool Families Rock. They continue to say they enjoy working in Blackpool and their views are represented at the getting to good improvement board. Caseloads have reduced and are more manageable. Supervision is mostly regular, with some good evidence of reflective discussions, although this is not always impacting sufficiently on the quality of plans and planning for some children.

I am copying this letter to the Department for Education.

Yours sincerely

Lorna Schlechte
Her Majesty's Inspector