Blackpool Borough Council

Inspection of children's social care services

Inspection dates: 26 November 2018 to 7 December 2018

Lead inspector: Lorna Schlechte
Her Majesty's Inspector

Judgement	Grade
The impact of leaders on social work practice with children and families	Inadequate
The experiences and progress of children who need help and protection	Inadequate
The experiences and progress of children in care and care leavers	Requires improvement to be good
Overall effectiveness	Inadequate

Longstanding and widespread failures in the quality of social work practice mean that many children are not having their needs responded to in the right way or at the right time. As a result, some children live in situations of chronic neglect for long periods of time. Their situations do not always improve and, for many, they deteriorate, resulting in poor outcomes and increased risk. For some children, the impact is serious, with children suffering additional harm that affects their health and development.

Since the last inspection in 2014, the pace of progress has been too slow, and there has been a decline in strategic leadership. By the time a new director of children's services (DCS) was appointed 17 months ago, standards of practice had seriously deteriorated. Although there has been a focus on improvement since then, it has not led to the level of improvement required to ensure safe and effective services for all children. Strategic partnerships have not addressed key weaknesses effectively, including chronic neglect, which leads to poor outcomes for too many children in Blackpool. Prior to the inspection, the local authority had recognised some of, but

not all, the shortfalls in its practice. Senior leaders have not sufficiently understood the extent of widespread and serious failings when children need help and protection. This means that the issue was not prioritised or challenged for the necessary improvements to be made sooner. Concerns in relation to the quality of decision-making at the front door, the recognition and response to risk when children are exploited, and the drift and delay that children experience when they are subject to pre-proceedings or in the court arena were not fully understood until the inspection. This has resulted in the screening of all child exploitation cases to ensure that there are no unaddressed safeguarding concerns, and the DCS commencing reviews of pre-proceedings work and audit actions.

An improvement board was set up when the new DCS came into post. A new quality assurance framework was introduced and led to an increase in auditing activity. New systems have recently been implemented to improve the quality of management oversight. This has led to some improvements for children looked after, children with a plan of adoption and care leavers.

What needs to improve

- The identification of and response to risk, particularly in relation to long-standing concerns of chronic neglect.

- The response and recording of decisions in relation to contacts, thresholds and issues of consent at the front door to be clear and proportionate.

- The quality of social work assessments and plans and the extent to which they reflect the child's history.

- The response to children at risk of exploitation, and those young people who are homeless, and the extent to which their vulnerabilities are fully recognised and lead to responsive intervention to keep them safe.

- The effectiveness of strategic partnerships to work together to improve outcomes and protect children.

- Oversight of pre-proceedings work and placement-with-parent practice to address drift and delay.

- The quality of decision-making, management oversight and recording of threshold decisions when children come into care.

- Training needs of social workers to ensure that they are prepared for court proceedings.

- The quality and impact of personal education plans for children in care, and the extent to which these children are effectively supported at all key stages.

- A clearer and more consistent approach to agency decision-maker processes for approval and matching of foster carers and adopters.

- The strategic and coordinated approach to providing support for care leavers to improve their outcomes, including in education, employment and training.

- The quality and impact of audit and performance management.

The experiences and progress of children who need help and protection is inadequate

1. Services for children in need of help and protection in Blackpool are inadequate because serious failures leave some children at risk of significant harm. Thresholds are not consistently applied or understood. Many children's needs are not responded to in the right way or at the right time. Children live in situations of chronic neglect for too long before action is taken to improve their circumstances.

2. Children in need of protection are not consistently recognised as needing support and intervention to protect them. Referrals into the multi-agency safeguarding hub (MASH) do not provide sufficient information to inform decision-making. Use of the new multi-agency referral form by partner agencies is inconsistent. Although contacts are responded to in a timely way, recording is unclear and does not provide a complete record of the next steps taken. Evaluation of children's histories is ineffective. Information-gathering is too often focused on the presenting issue, rather than an understanding of the child's lived experience. This means that crucial information can be missed and, therefore, decisions are made on partial information, which may leave children vulnerable and at risk.

3. The need to seek parental consent is not always fully understood and workers often fail to take account of historical information to inform a more balanced understanding of risk. Some children are not receiving the help they need at the right time. This shortfall was recognised by senior leaders during the inspection, and appropriate steps were taken to increase resources and management oversight in the MASH while inspectors were on site. The local authority intends to re-structure the MASH in early 2019 to address this, when a dedicated manager will replace the current duty arrangement of rotating managers and staff.

4. The police triage of domestic abuse notifications has led to some cases being stepped down to the early help hub (EHH) inappropriately, when the threshold for intervention by children's social care had already been met. A manager screens all referrals into EHH, although the effectiveness of this is limited by an insufficient evaluation of historical information. This means that risk is not

always identified to ensure that the right help is provided at the right time, resulting in drift and delay for some children. Early help assessments are completed, although the quality of these vary. This leads to plans that are not always clear or specific about what needs to be done, by whom, and by when. The unique identity needs of children are not responded to, or recorded, well.

5. Children whose needs appropriately meet the threshold for early help are supported well in the families in need (FIN) teams and, in some cases, joint working with social workers leads to purposeful interventions. This is a stronger part of the service, and more complex, high-risk cases are escalated up to children's social care appropriately.

6. When children are subject to child protection enquiries, in most cases appropriate procedures are followed, and children are offered immediate protection. However, the quality of the investigation and the subsequent assessment does not lead to consistently effective decision-making. There are sometimes over-optimistic views about parental capacity to change, despite significant safeguarding concerns. As a result, risks are not sufficiently recognised for some children.

7. Social work practice in the duty and safeguarding teams is variable in both its quality and impact. A preferred model of social work practice is used in assessments, but it is often a list of risk factors rather than an accurate analysis of a child's needs and experiences. There is too much focus on the presenting issue, and assessment sometimes fails to include significant historical information about children's lives. Chronologies are not used routinely to understand contextual information. The needs of older children who have been living in neglectful situations are not accurately evaluated. This leads to decision-making and intervention that is flawed, as it is overly focused on children's behaviour rather than on an understanding of their lived experience and wider circumstances.

8. Children are seen regularly and they benefit from direct work with social workers. Children's views do not consistently inform plans, which are too brief, task-focused and lack clear timescales or contingency arrangements. Regular core groups for children on child protection plans take place but progress is not always well recorded. Some children step down from a child protection plan prematurely at the first review, before change has been achieved and sustained. Child in need plans are not sufficiently outcome-focused and subsequent interventions are reactive to crisis and lack sufficient pace to effect change. This can lead to drift and delay for children and families when concerns re-emerge. A small number of complex child in need cases were allocated to non-qualified staff inappropriately.

9. When children's circumstances do not improve, timely and responsive action is not always taken to protect them. The local authority recognises that the use of the public law outline (PLO) is not robust. It has, subsequently, referred two

cases identified by inspectors to the Blackpool Safeguarding Children's Board for a learning review and has escalated one case into the court arena for action. Decision-making on PLO is unfocused, and cases are stepped up and down without a clear rationale. For some children, this has led to a premature de-escalation of PLO, despite increased risk. Consequently, some children are left in situations where they continue to experience harm.

10. Young people who present as homeless are not systematically offered the opportunity to become looked after following an assessment of their need for support. A small number of 16- and 17-year-olds experience unsuitable accommodation, such as bed and breakfast and sofa-surfing. This increases their exposure to risk and their views are given insufficient consideration, even when they have requested to come into care.

11. Children at risk of exploitation do not consistently receive holistic assessments of their needs and risks. The language used in records to describe children's vulnerabilities is sometimes inappropriate and places the responsibility on children for the risks they are exposed to. The Awaken team specialises in child sexual exploitation and has a more informed understanding of exploitation, although weak assessments and plans undermine this. Direct work is undertaken with children by Awaken, although the impact of this is unclear as the risk assessment tool is not used consistently to evaluate and measure risk. The local authority has appropriate plans to develop the exploitation service to take account of wider contextual safeguarding issues. These issues, however, were not fully understood by senior leaders at the time of the inspection. In light of the concerns raised by inspectors, screening of all open child exploitation cases was undertaken during the inspection, to ensure that there were no unaddressed safeguarding concerns.

12. In a context where child sexual exploitation and children going missing are prevalent and widely known, the absence of a strategy to respond to contextual safeguarding is a significant concern. Children who go missing do not always receive a timely return home interview. There is limited intelligence-gathering to explore risk in more detail or consider wider factors, as the interview is limited to an account from the child. Return home interviews do not include a clear risk assessment or actions to reduce further risk. This means that leaders and managers across the wider partnership do not fully understand the reasons for children going missing. This limits their ability to identify and respond robustly to emerging patterns and trends.

13. Children who are missing education, who are educated by alternative providers or who are in receipt of part-time education are monitored appropriately. There are procedures to monitor children who are educated at home. This means that half of all children are visited. The number of pupils being educated part-time or by alternative providers is high. The pupil referral unit, for example, is over-subscribed and not enough has been done to address the complex challenges faced by many children and families.

14. Children who are privately fostered receive a sufficient level of support, and the local authority is compliant with its statutory responsibilities. Allegations against professionals working with children have led to appropriate involvement of the designated officer. Disabled children benefit from a safe, timely and outcome-focused service, provided by a stable and experienced complex needs team. Clear criteria are applied to assess need and respond appropriately to safeguarding concerns.

The experiences and progress of children in care and care leavers requires improvement to be good

15. Senior leaders have recognised the need to improve services for children in care and care leavers. The DCS has led some focused improvement, especially in relation to permanence. The service is now more compliant and timely than it was. Further work is required to strengthen the service to ensure that outcomes for all children in care continue to improve.

16. Children live in neglectful circumstances for longer than they should, resulting in their needs often becoming more complex. This means that it becomes more of a challenge to find a suitable placement for them. A recently formed 'becoming looked after' panel has improved senior managers' understanding of children coming into care. The rationale for children being taken into care is not always clearly recorded.

17. In most instances where children come into care by agreement with their parents, Section 20 of the Children Act 1989 is used appropriately in the short term. This can result in suitable decisions for them to return home, but the rationale for these decisions is not consistently recorded. Children reunified with their families are not offered a consistent level of support. Placement with parents regulations are poorly understood. In a small number of cases seen during inspection, the assessment underpinning the plan to return home was weak, sometimes based on inaccurate information about parental responsibility or the level of risk. In such cases, management oversight lacks rigour.

18. Most children in care are living in stable placements within the North West region. This means that social workers can keep in touch and develop a detailed understanding of their needs. Some children, however, experience too many placement moves, and stability is often reached by remaining in a short-term placement, instead of through careful matching. Children's circumstances are regularly reassessed as part of their statutory review, although their identity is given insufficient consideration.

19. Children in care have care plans that are routinely completed and updated, but these are not always tailored to the needs of individual children, and lack clarity in relation to a plan for permanence. Social workers undertake direct work with children who are generally engaged well in their own care planning.

Social workers have clear aspirations for children, but these are not reflected in the plans. Although workforce stability is improving, young people told inspectors that they had experienced too many changes of social worker, which makes it difficult for them to develop stable relationships with their social workers.

20. Social workers are not being well prepared to confidently present the plan for permanence to the court to achieve appropriate outcomes for children. Chronologies are not sufficiently updated or used effectively. This means that social workers are not always able to present a detailed understanding of children's histories to the court. Although most proceedings are completed within 26 weeks, they can sometimes be delayed due to requests for adjournments to understand case history. In addition, there are missed opportunities to explore wider family alternatives earlier, and the possibility for permanence through that route during pre-proceedings. This means that relatives often emerge late in the proceedings to ask to care for the child. Some children's circumstances are not assessed with sufficient rigour and have to be reassessed. Concurrent planning is insufficiently robust. The delay in achieving permanence for some children can negatively affect outcomes for them in the longer term.

21. When children have a plan for adoption, a timely referral is made to the adoption team to begin family finding. Although children who need adoption do not have a wide choice of placements, assessment and matching results in stable adoptive families being identified, and they are increasingly placed with adopters in a timely way. Introductions are effective for children, and post-placement support ensures that they are secure and settled. Adoption support ensures that challenges are identified and swiftly addressed, preventing further disruption to children's lives. Adopters spoke highly of the support provided to them.

22. For a small number of children with a plan of adoption, there is delay. This is due to ineffective work with families prior to proceedings, leading to lengthy care proceedings. Life-story books are not always completed in a timely way for children with a plan of permanence and this undermines an understanding of children's backgrounds and sense of identity. Agency decision-making takes place at the right time, but the quality of recording is weak. It does not fully demonstrate consideration of issues, or give the rationale for adoption being in a child's best interests.

23. Unaccompanied asylum-seeking children (UASC) are appropriately accommodated in places that meet their immediate needs for support and protection. There are gaps in assessment, for example in establishing whether the child has a clear sense of identity, or whether they have experienced trauma following loss of family, trafficking and modern-day slavery. This means that the children's needs are not fully understood.

24. Reviews of children's circumstances are generally timely and result in care plans that are suitably updated. Independent Reviewing Officers (IROs) write review templates directly to the child, which means that they will understand in future why decisions were made about their lives. In complex cases, there is less evidence of the IRO and supervising manager driving the plan for permanence forward and making sure that it is effectively progressed.

25. Members of the fostering team are knowledgeable and experienced. Foster carer assessments are timely and of good quality. The mandatory training offer for carers is wide-ranging, but there is limited monitoring or evaluation of carers' training needs. The agency decision-making process is weak and does not ensure the integrity of the assessment and approval process of foster carers.

26. Children's health needs are routinely assessed by health workers located in the social work teams. Health assessments and plans are not always completed in a timely manner. Child and adolescent mental health services (CAMHS) are available and are seen to be making a positive difference to some children looked after.

27. There has not been a leader in post for the virtual school until recently. A year ago, only 14% of children looked after had a personal education plan (PEP). This situation is improving and at the time of the inspection, 68% of children looked after had a PEP. The quality of these plans varies, and many are poor with targets that lack aspiration. Senior leaders have recently prioritised the development of the virtual school, and improved leadership in this area has already secured improvements to the behaviour and attendance of children looked after. At the time of the inspection, the impact of the virtual school on children's educational progress and attainment was very limited. For example, a significant number of children (52%) in care who left Year 11 at the end of the previous school year are not in education, employment or training. The complexity of their needs means that some require greater support than is currently available to enable them to access education, employment or training.

28. Young people spoken to feel supported by the recently restructured leaving care service and feel that services are improving. A care leavers' charter now sets out expected standards of practice. The absence of a care leavers' strategy is a gap as the overall vision of how to improve and develop the service is unclear. The leaving care service has increased capacity to support care leavers, but the introduction of personal assistants (PAs) to 15-year-olds is very new. Current 18-year-olds have only had a PA from their eighteenth birthday, and this is too late to provide them with the necessary support and skills for adulthood at the earliest opportunity. Staff are empathetic and outcomes for many young care leavers are more positive due to the level of support they receive from their PA. The service is working with young people who have highly complex and challenging needs, some of whom have

experienced placement breakdown. Progress in reducing risks for some of these young people is a challenge.

29. All care leavers seen have a current pathway plan, although they are not always completed soon enough, or updated when a young person has experienced significant change. More recent pathway plans completed by PAs are better quality and reflect the lived experience of young people.

30. Care leavers have access to information about their health needs. Those in higher education are well supported, with others benefiting from apprenticeship and job opportunities in the council.

31. Most care leavers are in appropriate accommodation. PAs have good relationships with housing schemes in order to support young people in transition to independent accommodation. Housing options remain limited, however, with the range of options having only recently begun to improve. A few care leavers have experienced periods in bed and breakfast accommodation and this represents an unnecessary risk. The risk of sexual exploitation of care leavers is not sufficiently considered.

The impact of leaders on social work practice with children and families is inadequate

32. The standard of social work practice in Blackpool has declined since the last inspection. Help and protection are inadequate. Services have not sufficiently met children's needs for help and protection at the right time. This has sometimes led to unsafe decision-making, which places children at risk of harm. Widespread and serious failures were identified in some areas of practice during the inspection. This is because of an insufficiently robust approach to thresholds, drift and delay for the most vulnerable children and insufficient management oversight at all levels. The response to risk has been fragmented, and at times, too slow (such as within the MASH, pre-proceedings work and children at risk of exploitation).

33. Senior leaders, including the chief executive (CE) and political leadership, have had an optimistic view of practice improvement and have under-estimated the impact on children. This is a serious failure in leadership. The decline in practice was recognised by senior leaders and the current DCS was brought in to post 17 months ago. The DCS and CE set up the improvement board, which is chaired independently in order to offer additional scrutiny and challenge. A shadow board was created to involve the wider children's workforce in the roll out of improvement plans, but the impact of this to date is limited. Despite the work of these boards, leaders did not fully understand or recognise the level and extent of concerns in some areas of social work practice until this was

raised by inspectors during this inspection. This means that they have been unable to effectively address some of the serious issues that negatively impact on children's lives. The local authority presented an updated review report of their improvement journey to inspectors on the final day of the inspection and acknowledged some of the deficits that had been highlighted during the inspection.

34. A revised quality assurance framework has recently been introduced and has led to a significant range of audit activity, which is externally moderated. While it is positive that a quality assurance framework has been implemented by the DCS, the local authority has acknowledged that the quality of audits is too variable. Audits do not always lead to timely completion of actions to ensure that learning is embedded and leads to effective change.

35. In the absence of a performance management framework, the DCS has recently introduced one, and performance meetings are now held to review key performance information. However, this does not sufficiently address the quality of practice or lead to sustained improvement. Neither the quality assurance framework nor the performance management framework have assisted the local authority sufficiently so that there is a clear and accurate understanding of the gravity and level of concerns for children as identified at this inspection. The DCS was broadly aware of some of the deficits and was entirely honest and transparent throughout the inspection about her understanding of the quality of practice and what needed to improve. However, this was based on partial information. The extent of what needed to improve, and how widespread the concerns are, was not fully known, or understood, by the senior leadership team in Blackpool.

36. The DCS acknowledged throughout the inspection the support received from the chief executive and political leadership, but the support has not been effective in bringing about sufficient change. The support and commitment from some partners is weak, with limited evidence to show consistent joint-working that leads to positive change for children.

37. The Blackpool Safeguarding Children's Board (BSCB) is more closely aligned with the improvement board than it was, but attendance of key partners has been a constant challenge at both strategic boards and further work is required to hold partners to account.

38. The DCS has been pro-active in taking prompt remedial action during the inspection to address practice deficits. For example, additional management resource has been provided in the MASH due to the concerns raised about the quality of decision-making at the front door. A review of cases where families are subject to public law outline (PLO) processes is underway due to the concerns about risk, drift and poor management oversight. In addition, screening of all open child sexual exploitation cases was undertaken during the inspection to provide assurance that risk assessments of children's needs are

appropriate. However, this action was only triggered by the inspection process and was not identified sooner through robust audit and performance activity.

39. The response to long-standing neglect for some of the most vulnerable families in Blackpool has not been fully addressed since the last inspection. A refreshed neglect strategy is planned, but at the time of the inspection the current Safeguarding Board Neglect strategy (2016–18) had not led to an effective, coordinated response to neglect.

40. The local authority understands its corporate parenting responsibilities and has listened to children's experiences. However, the care leaver offer has not translated into a clear, ambitious care leaver strategy. This is a significant gap. Figures of care leavers not in education, employment or training are too high and this means that some young people have not had the right level of support. Leaders have only recently prioritised the development of the virtual school, and improvements in relation to attendance and attainment are still below national comparators.

41. A new model of social work practice has been introduced to help social workers recognise risk. This is leading to more focused consideration of risk factors, but there is still too much variability in the quality of plans and assessments, and management oversight is weak. There has been significant management turnover in the last 12 months due to concerns about the quality of management oversight and response to escalating risk. Leadership capacity has been stretched due to staff turnover. Some senior managers 'act down' to model good practice. New systems and processes have recently been introduced to improve the quality of management oversight on key decisions, but these are not sufficiently well embedded to ensure sustained and effective change.

42. Staff turnover has created a level of instability and uncertainty in the workforce, which has begun to stabilise as vacancies are filled and the reliance on agency workers reduces. A comprehensive workforce strategy has been implemented since the DCS came into post. Despite this, children have experienced too many changes of social worker due to the legacy of high turnover in some social work teams.

43. Social work capacity has been increased in some parts of the service and practice development roles are starting to become a feature of teams. Staff report that they feel positive about working in Blackpool, although some caseloads are still too high. Social workers require more training and support, including in the court arena, where they are often ill prepared to deal with complex court proceedings. This creates significant drift and delay for some of the most vulnerable children.

44. There is an emphasis on bringing about positive cultural change in the organisation, driven by the DCS, in order to create an environment that is both

supportive and challenging to staff. Supervision of social workers and support staff is mostly regular, and staff report that they feel well supported. However, the record of supervision is too task-focused and provides limited reflection, which is a missed opportunity to provide clearer direction to social workers who are working with challenging and complex families. Overall, social workers are not working in an environment in which good social work is encouraged and able to develop and flourish.

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