Blackpool Council: local authority assessment

Blackpool Council have requested a review of one or more of its ratings.

How we assess local authorities

Assessment published: 6 August 2025

About Blackpool Council

Demographics

Blackpool is a popular seaside tourist destination in the North-West of England. It is a unitary authority which borders one large county council. The local authority area covers approximately 35 square kilometers (described locally as 7 x 3 miles) with a total population of 142,708. It was the world's first mass market seaside resort, with a heritage stretching back over 150 years. In addition to it beaches, Blackpool's major attractions and
landmarks include Blackpool Tower, Blackpool Illuminations, the Winter Gardens, and the
UK's only surviving first-generation tramway.

Blackpool is the most deprived local authority in England ranked 1 out of 153 local authorities, (with 1 being the most deprived and 153 being the least deprived). The Index of Multiple Deprivation score is 10 (10 being the most deprived). 58% of local people live in
areas which are in the most deprived areas in the country. 5 areas (Bloomfield, Talbot, Tyldesley, Claremont and Park) have NHS 'priority wards' status due to the level of deprivation and health inequalities.

Blackpool has a predominantly white population 94.69% which was significantly above the
England average of 81.05%. People who did not identify as 'white' were in the minority with 1.57% of people identifying as 'Mixed or multiple,' 2.61% as Asian or Asian British, 0.63% as 'other' and 0.50% identify as Black, Black British, Caribbean or African. All age brackets for the population are within England averages (Ages 0 to 17: 20.09%, Ages 18 to 64: 59.27%, Ages 65 and over 20.64%, compared to national averages of 20.80%, 60.51% and 18.69%, Office of National Statistics ONS, 2023).

Health Index Scores suggest worse health and poorer outcomes for local people compared to England. People living in Blackpool have a shorter life expectancy than England averages, at 74.1 years for males and 79 years for females and a shorter healthy life expectancy at 53.5 years for males and 54.3 for females (10 years less than the national average).

Drug related deaths in Blackpool are the highest within England. Alcohol use as a reason for hospital admission was the second highest in England.

Blackpool is part of Lancashire and South Cumbria Integrated Care System. The local authority Director of Adult Social Care (DASS) has a dual role as director of place (Blackpool) within the Integrated Care Board (ICB).

The political make-up of the council is 28 councillors representing the Labour party, 12 councillors representing the Conservative party and 2 councillors representing the Reform
UK party.

Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£262,764,000.00**. Its actual spend for that year was **£288,053,000.00**, which was **£25,289,000.00** more than estimated.
- The local authority estimated that it would spend **£67,235,000.00** of its total budget
  on adult social care in 2023/24. Its actual spend for that year was **£71,158,000.00**, which was **£3,923,000.00** more than estimated.
- In 2023/2024, **24.70%** of the budget was spent on adult social care
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through adult social care precept varies from local authority to local authority.
- Approximately **3990** people were accessing long term ASC support, and approximately **1030** people were accessing short term adult social care support in
  2023/24. Local Authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

This data is reproduced at the request of the Department of Health and Social Care. It has
not been factored into our assessment and is presented for information purposes only.

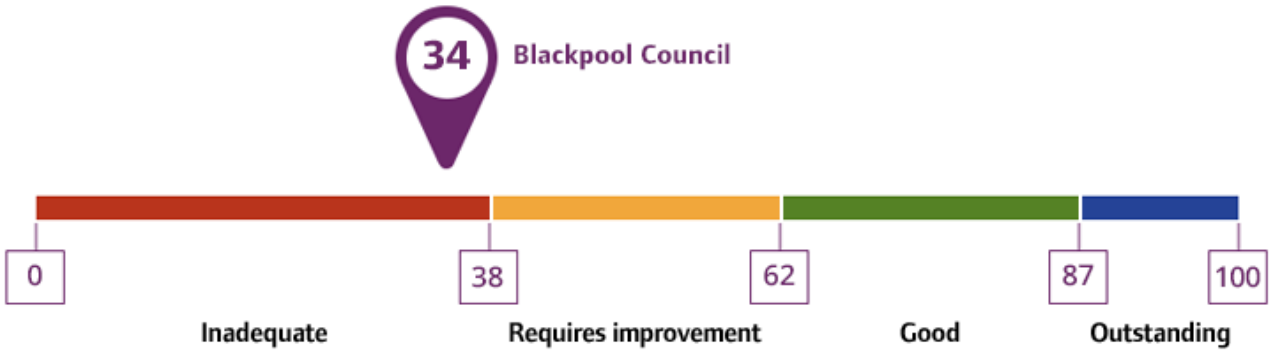
Overall summary

Blackpool Council have requested a review of one or more of its ratings.

Local authority rating and score

Blackpool Council

Inadequate



Quality statement scores

Assessing needs

Score: 1

Supporting people to lead healthier lives

Score: 1

Equity in experience and outcomes

Score: 1

Care provision, integration and continuity

Score: 2

Partnerships and communities

Score: 2

Safe pathways, systems and transitions
Score: 2

Safeguarding
Score: 1

Governance, management and sustainability
Score: 1

Learning, improvement and innovation
Score: 1

Summary of people's experiences

People were not receiving the standard of support described within the CQC quality statements aligned with the Care Act 2014. We found risks to human rights which left people's needs not being met and negatively impacted on people accessing and being supported by the local authority.

We analysed a range of sources to understand people's experiences in Blackpool, including how the local authority encouraged, enabled and acted on feedback.

People who lived in Blackpool faced severe social inequalities, ranking worst in England for life expectancy, causes of death, homelessness, and employment rates, all of which were worsening (Public Health England, 2024).

We found a culture of making decisions for people with care and support needs often with the intention of protecting them rather than allowing them to make their own choices. There were risks to people's wellbeing and not all people had their human rights respected and protected. People told us about their negative experiences of assessment. For example, one person told us they were not involved throughout in decisions, and this was evidenced within care planning.

There was mixed feedback from unpaid carers with some receiving consistent support and others facing delays. Adult social care staff did not effectively recognise young carers of adults with care and support needs. Unpaid carers spoke positively about the commissioned carers service in Blackpool. For example, one unpaid carer told us they felt isolated before being connected to the carers service and they had received essential support to help them continue in their role. However, people and unpaid carers spoke negatively about lack of effective working between adult social care staff and drug and alcohol services. They stated there was a lack of understanding of unpaid carers roles and lack of adult social care staff working alongside services to support the cared for person.

The local authority's efforts to support those at risk did not sufficiently promote healthier lives or reduce future care needs. For example, people and unpaid carers did not have timely access to equipment and did not have fair access to reablement at home.

People were not being treated equally, standards of care and support differed depending on people's individual and multiple needs. There was a serious negative impact on minority groups in Blackpool such as people with needs relating to drug and alcohol use and people who identified within LGBTQIA+. Care and support was not provided or tailored to enable people to live as they wanted to. The local authority failed to recognise minority groups as unique people with skills, strengths and goals. For example, people's accounts highlighted the need for more mental health support in Blackpool that catered for LGBTQIA+ needs to reduce barriers to care and support or safeguard people with these protected characteristics. There was a fear of accessing services and there was a number of recommendations made by people to empower others to engage with current services but also ensure the local authority was knowledgeable about the specific needs of people within the LGBTQIA+ community.

People told us their preferred inclusion and accessibility arrangements were not always followed. For example, a person told us they had significant reading difficulties and preferred to have information shared with them verbally as opposed to in writing, but they continued to get letters in the post rather than telephone calls as agreed from the local authority. Another person with a learning disability and some sight loss communicated using technology, however methods outlined in their support plan were not followed by local authority staff and information was sourced from the care provider instead of the person themselves.

People and unpaid carers were not effectively supported to plan ahead for important changes in their life that could be anticipated. People and their unpaid carers gave negative feedback about individual contingency plans within the local authority. For example, unpaid carers told us the local authority had not considered their caring role and future plans. Most had planned for family to support in a crisis, but this had not been discussed with the local authority. Some unpaid carers had discussed contingency planning however this was not in depth and actions were to call the local authority in a crisis should it arise as opposed to agreeing a plan that would work for them and the person being cared for and prevent avoidable stress where possible. An unpaid carer told us they had spoken to the local authority on a Friday asking for support but found services were over stretched and there was no support available.

Seldom heard groups of people in Blackpool did not feel safe. For example, a person with care and support needs told us they had experienced hate crime, and a local report of people's experiences identified there were seldom heard people with mental health risks or needs who had been victims of hate crime in Blackpool. Responses included 'I think people like us are not accepted by society, and we will not be treated fairly and dealt with if we report,' 'I was afraid' and 'I was attacked and suffered transphobic abuse.' However, for the past two years the local authority had not had a reported safeguarding concern relating to discriminatory abuse. This was an area that needed more attention from the local authority to improve recording and understanding within frontline teams and partners as referrers into the local authority.

There was mixed feedback from people and their unpaid carers who had been involved in safeguarding enquiries. For example, people had felt listened to and involved in safeguarding processes. However, opinions were not always considered, and they had not had regular involvement in meetings. Some people did not feel heard or had not been actively involved, referring to poor communication, lack of empathy, and inconsistent approaches as barriers to effective participation. Advocacy support was not consistently considered for people at the point of agreeing risks that met thresholds for section 42 enquiries. In Blackpool, 75.00% of people that lacked mental capacity around their safeguarding concerns were supported by an advocate, family or friend. This was slightly worse than the England average of 83.38% (NHS Digital 2023-2024). There was more to do to ensure staff and partners understood people's rights, including their human rights, their rights under the Mental Capacity Act 2005 and their rights under the Equality Act
2010 and they were supported to make choices that balanced risks with positive choice and control in their lives.

Summary of strengths, areas for development and next steps

The local authority's vision was not clearly defined or consistently practiced. There were shortfalls in personalised approaches which required corporate leadership to work together across adult social care, commissioning and public health to promote a culture that was person-centred, supported choice and control and aimed to tackle inequalities.

There was a culture within the local authority that led to people more likely to be at risk of avoidable or unintentional harm. There was a need for practice to move from risk led actions to a more strength-based approach that would enable choice and positive risk taking. Staff had not had clear processes to understand and carry out Care Act responsibilities with expected standards. Where guidance, policy or strategy had been created it was too early to evidence any impact it was having.

People accessing care and support were mostly responded to in a timely way. However, senior leaders did not have a clear picture of who could be signposted away from adult social care and whether this decision making was appropriate and effective. There was more to do to reduce any inequity for those people that waited the longest and to understand the impact that waiting for assessment had on people, particularly those with learning disabilities, mental health needs and autistic people. More needed to be done to ensure targets set by the local authority were met and the local authority was consistently applying pro-active checks to ensure people's wellbeing and safety was a priority beyond urgent response work.

There was a lack of local strategy and action to reduce inequalities in people's access to care and support, their experiences and outcomes. There was a need to focus on the experiences of all minority groups in relation to equality, diversity and inclusion in the area. Health and social inequalities were not incorporated into staff operational practice and intersectionality of peoples protected characteristics were not always understood.

Preventative approaches were not strategically aligned and monitored, this meant people were not consistently identified nor had access to services that could prevent, reduce and delay care and support needs. There was a disconnect as to how preventative offers in Blackpool specifically linked into and shaped the adult social care offer. This was a particular challenge for the local authority in relation to drug use where people failed to access services, and drug related deaths continued to increase. National data supported the need for action. For example, the number of people receiving long term support was significantly above the England average. For adults aged 18-64; 1,465 were receiving long term support per 100,000 people compared with the England average of 855, and for adults aged 65 and over 9,185 were receiving long term support per 100,000 with an England average of 5,185. Additionally, 60.46% of people who received short-term support and then no longer required support was significantly worse than the England average at 79.39% (NHS Digital, 2024). The local authority had also seen an increase in permanent admissions to care homes, particularly amongst people with care and support needs aged between 18 – 64 years old.

Senior leaders had some awareness of improvements needed, some of which had been highlighted by external reviews. However, there had been delays in progressing actions impacted by a number of issues such as staff absences and gaps, a lack of clarity about what improvements were needed, and a lack of additional resource to carry out improvements. There were ideas within draft Prevention, Commissioning and newly implemented Workforce Strategy and changes started around the local authority's approach to assessment and intervention. However, a peer review had brought up similar concerns 2 years ago, and on review of the recommendations little progress had been evidenced.

Senior leaders and partners told us investment was needed particularly in community and preventative services in Blackpool. Current partnership arrangements led to some duplication of operational care coordination and support across health and social care, and barriers to evidence any positive impact of joined up approaches.

There was a lack of evidence-based use of information about risks, performance, inequalities and outcomes. This impacted the accuracy of information, evidence to plan effective resource and monitor any effectiveness or learning of delivery of Care Act duties that could be drawn from this.

There were concerns about staff confidence in carrying out safeguarding work. There was no specific induction or specialist training for staff to be deemed competent to undertake any areas of safeguarding work. Local processes had gaps, areas for improvement or were not yet fully embedded. The local authority had created new roles to prioritise improvements and safeguard adults in Blackpool. There had been some conversations started to introduce a Multi-Agency Risk Management framework in Blackpool. However, this had not been progressed at the time of the CQC assessment therefore there remained unmet high risks for people who were not identified as meeting the statutory safeguarding threshold. There was more to do to work with partners and focus on a collaborative, multiagency approach to manage risks before they escalated into a crisis.

Staff and senior leaders consistently told us they were proud to work for the local authority and were passionate about serving the people of Blackpool. Staff were supportive of each other including across teams. However, there was more to do to look at good practice across all areas within adult social care. Senior leaders had feedback from staff about practice, partnership working, learning and wellbeing. However, there was limited progress to act on this feedback and demonstrate any effective outcomes.

The local authority had newly committed to the value and credibility of having a dedicated Principal Social Worker (PSW) within senior leadership to lead, develop and standardise practice through engagement with front line staff. However, it was too early to evidence any impact the role could have on influencing and shaping future practice and strategy. There was more to do, as not all staff were clear about how the local authority was working towards reducing risks to keeping people safe where there were shortfalls in carrying out Care Act duties. Where the local authority had dedicated resource and priority there was evidence of improvement to people's experiences. For example, the Carers Strategy and work within this was beginning to make a positive difference to improve care and support.

There were many areas of challenge where focus was needed that were known in Blackpool. However, although there had been some focus on improvement, it had not led to the level of improvement required to ensure safe and effective services for adults in Blackpool. The CQC were not assured that senior leaders had effective line of sight over frontline practice. The Director of Adult Social Services (DASS) was leading on Blackpool Council's adult social care improvement plan, this included actions planned to implement a quality assurance framework to increase auditing activity and evidence impact that they believed would take them to the next level of improvement.

Theme 1: How Blackpool Council works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 1

1 - Inadequate: Evidence shows significant shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

The local authority had various pathways and roles to process requests for assessment or review of assessment including new information about risk or safeguarding. Business support staff took most calls, reviewed and responded to emails and recorded receipt of online assessment from professionals, unpaid carers, people with care and support needs and members of the public. Information was taken and passed to duty staff within different teams depending on a person's identified needs or if they were already known to the local authority. For example, if a person had a learning disability or a primary mental health need, the request for assessment or review would go directly to those teams. Business support staff could make early referrals to voluntary and health services on behalf of and with advice from duty staff. Staff also told us if a person did not appear to have an adult social care need, business support could signpost the referrer to another service and the information would not need to be reviewed by a duty worker. For example, staff told us if a person appeared to only need help with their bins, they would signpost them to another department and would not record this contact on the adult social care system. Staff also told us 'minor changes' to people's care and support could take place to respond to people's needs without the need for immediate review, this could be actioned by brokerage staff with managers' approval. Processes to respond to incoming requests and information failed to provide assurances. There was no formal audit, limited staff competency checks and limited data collection to evidence any effectiveness of the current function. This meant senior leaders did not have a clear picture of who could be signposted away from adult social care, who waited longer than others for assessment and whether this decision making was appropriate and effective which could lead to negative outcomes including unmet risk for some groups of people.

Staff told us people repeatedly contacted the local authority. There were a number of reasons why this happened, for example people's needs changing or people's needs not initially being met effectively. However, there was no formal monitoring or internal assurance audits for the quality of the contacts and responses to ensure people were consistently directed to the right team or service. There was more to do to ensure any actions taken did not have negative outcomes for people such as understanding an unmet need or risks.

Following the CQC site visit in March 2025, senior leaders updated staff guidance in response to concerns raised. This clarified the role of business support staff was not to make a decision around a person's needs, risks, care planning. Senior leaders told us this was to support any staff misunderstanding. Senior leaders also told us staff were encouraged to attend any training offered that would enhance their knowledge and that staff competency was monitored regularly by line management, and there was a process between the business support and social work manager to share information and address any issues arising. However, there was no evidence this assurance was embedded within staff practice, monitored effectively by senior leaders to address potential risks to people who maybe signposted away from adult social care.

The local authority had commissioned a consultancy organisation to support them to codesign and deliver change across Care Act assessment and interventions. One of the aims was to introduce and embed a more strength and asset-based approach to conversations with people when they contacted the local authority. Despite the roll out spanning over 2 years so far, not all staff were trained to undertake this approach confidently. Following the CQC site visit senior leaders told us the time the roll out had taken was a combination of reasons including pilot stages, evaluation, and issues that emerged were not straightforward to resolve. Most staff told us the changes to how staff were expected to approach assessment and intervention was not effective, particularly for people they felt contacted the local authority with established needs. In contrast, some staff could see the benefit in the change as it helped them to build on links or connect people to their own communities and source solutions to their needs that were individual to them. Senior leaders told us developments through staff feedback was continuing, and they had an aspiration to deliver an effective cultural and systemic change in practice and process.

There was mixed feedback about how people experienced advice, signposting, assessment, and intervention in the local authority. Staff gave varied accounts of when strength-based conversations should start and how many times people needed to tell staff their situation. For example, most staff were not clear when a person's 'first conversation' happened. Staff told us people could speak to business support staff first to gather information and some signposting to other services could happen. Other staff felt it would be when a duty worker made contact to establish if a safeguarding or needs assessment was needed. Other staff told us the 'first conversation' did not happen until it was allocated to a worker after duty. Processes to avoid people repeating conversations were not effective. The aim was to allocate ongoing assessment and intervention to the duty worker that initially contacted the person. However, staff told us allocations often took place based on availability rather than familiarity to prioritise demands within teams. Staff and senior leaders consistently told us the new assessment and intervention approach was not yet embedded. We found some staff had created 'work arounds' due to the ineffectiveness of the roll out so far. For example, one staff member told us they used old templates and copied and pasted into the new digital template to move on to the next steps. Other staff told us there were now challenges to see outstanding assessments and reviews on the digital system which led to confusion about who was waiting and for how long. Quality checks of assessments took place on a 1:1 basis with staff through manager approvals on the digital system. However, there was more to do to implement new approaches, templates, training and practice to evidence any positive outcomes for people in Blackpool. There was a draft quality assurance framework which set out all audit aspirations. Current practice audits were focused on safeguarding practice as a priority. Other audits were taking place but were not currently brought together to evidence quality assurance around all areas of assessment including the effectiveness of applying strength and asset-based approaches within staff practice.

People who were offered an assessment had face to face assessments and interventions. There were support workers in teams to meet people's immediate needs such as accessing food banks, supporting with energy payments and carrying out 'welfare checks'. If there was a risk of hospital admission, they could refer for rapid response support. Requests for assessment or review were checked daily by a team manager.

Most people had choice in either a commissioned care home or home care providers to meet their assessed needs. National data showed 67.42% of people were satisfied with care and support in Blackpool. This was somewhat better than the England average (62.72%). And 82.53% of people felt that they had control over their daily life. This was somewhat better than the England average of 77.62% (NHS Digital, 2023-2024). There were options for overnight home care in Blackpool provided by their in-house provider and a commissioned provider, as well as offering the use of direct payments. However, not all staff were aware of these services as solutions for people with overnight risks and care needs at home. Some people were eligible for temporary support options such as the inhouse 24/7 rehabilitation centre. However, there was a culture of making decisions for people with care and support needs often with the intention of protecting them rather than allowing them to make their own choices. For example, one partner told us local authority assessment did not always put people at the heart of decision making and there was a lack of people's voices being listened to. Another partner told us there could be a 'knowing best' approach to assessment from the local authority which led to making decisions without involving people themselves, unpaid carers and partner services. For some people this meant there were risks to their wellbeing and not all people had their human rights respected and protected. For example, one person told us they were not involved throughout in decisions, and this was evidenced within care planning. A second person, who was living in a care home told us they had never had the need for residential care, did not want to be there, and were not listened to. A third person told us they could not understand how they had ended up in a care home and did not feel that their wishes had been taken in to account. A review of their needs stated that the person could make their own decisions, and they expressed a wish to return to their home. However, this had not been acted on and the person felt that others had made a lot of decisions for them. The local authority had more to do to ensure all options to meet people's risks and needs were explored with them, and that a person's voice was at the forefront of all decision making. Whilst senior leaders did not accept this was the culture within assessment practice, they did acknowledge the period of change being an area for further attention including the embedding of strength-based practice and the need for a 'cultural shift.'

Timeliness of assessments, care planning and reviews

According to national data, requests for care and support in Blackpool per 100,000 adults were significantly above England averages (2,980 requests for support for people aged 18 – 64, England average: 1,785, and 15,795 requests for support for people aged 65 or over, England average: 13,285, NHS Digital 2024). Staff told us there was a high volume of contacts coming in, some people would make contact regularly and there was an answer phone facility when people couldn't get through due to the lines being busy. Staff would aim to respond to all calls within the working day. Many people had a quick response to requests for assessment and intervention this was seen in the local authority's own data showing 65% of assessments were identified as 'urgent' and the median wait time for assessment and unplanned reviews was 3 days (February 2024 - February 2025, and again in May 2025). However, there were some groups of people who waited longer. A senior leader told us over the past 5 years the local authority had experienced a reduced workforce capability which had led to increased staff workloads and had impacted negatively on their ability to respond quickly to people's requests for assessment and intervention. Senior leaders told us they had since been in a recovery position and had seen improvements to reduce very high waiting lists. However, data provided by the local authority varied, and senior leaders told us they had some recording issues. Another senior leader told us this meant the local authority could not always accurately understand how many people were actually waiting and for how long. According to data the maximum recorded waits for assessments over a twelve month period were as high as 343 days. 405 assessments (8.75%) were started after 8 weeks. Of these there were waits of 28 weeks or more for 62 people. 13 people waited for 44 weeks or more (February 2024 - February 2025). In August 2024, 150 people were waiting for assessments, this had reduced slightly in February 2025 to 124 people. However, in May 2025 the local authority's own data showed there was a minimum of 244 people waiting for assessment or an unplanned review which was an increase from August 2024. A minimum of 156 people were waiting for assessment within the mental health teams (this did not include any waits within the Primary Intermediate Mental Health team which had the higher median wait times up 42.5 days and maximum wait of 343 days). The Autism team had 24 people waiting, with a median wait time of 3 days but maximum of 321 days. The Learning Disabilities team number of people waiting was not provided, but the local

authority told us it had a median wait time of 0 days but a maximum wait of 374 days which was an increase from February 2025. Senior leaders told us waits for people with learning disabilities reflected the way the local authority recorded transitions between children's and adults services, as young people could be referred before, they turned 18 years old. The local authority had more to do to reduce any inequity for those people that waited the longest and understand the impact that waiting for assessment had on people particularly those with learning disabilities, mental health needs and autistic people. There had been a 'waiting tool' created, however it remained in draft form, waiting for senior leaders sign off before implementation with all teams. In the interim, most staff were 'checking in' with people who were waiting, with no formal process or evidence that this was happening beyond verbal discussions and individual recording. Following the CQC site visit senior leaders told us managers had access to a report that showed allocated assessments that had not started within 28 days. This was to enable managers to support staff and progress any barriers. However, this was not proving effective as the number of people waiting and maximum days waiting was not reducing. Therefore, more needed to be done to ensure there was effective use of resources and robust processes to support staff to ensure peoples wellbeing and safety was a priority beyond urgent response work.

For planned reviews the median wait over the 12 month period was 8 days and the maximum was 335 days (February 2024 - February 2025). 3195 reviews of peoples care and support were started within 8 weeks of the planned review date (89.5%), and 374 planned reviews started more than 8 weeks after the planned date. Of these 42 people waited longer than 28 weeks from the planned date of their review. The local authority had commissioned an external agency to undertake 600 planned reviews. However, despite the additional agency support, there remained 807 people overdue a planned review in February 2025. National data showed 43.70% of people had been reviewed with long term support needs in Blackpool. This was somewhat worse than England average (57.14%, NHS Digital 2024). A senior leader told us the agency was a temporary measure and there was an awareness the reviews would come back. There were said to be conversations happening and senior leaders were evaluating the work to address this as a risk. Following the CQC site visit senior leaders told us annual reviews were being incorporated into a new process that was being developed for the community team. However, it was too early to demonstrate if this would be effective in responsiveness and managing both assessment and review waiting times for people in Blackpool.

Assessment and care planning for unpaid carers, child's carers and child carers

Staff could carry out carers assessments alongside people's care and support assessments. There were also options for unpaid carers to have separate carers assessments if they preferred.

According to the local authority's analysis of its own data in May 2025 215 out of 419 carers assessments started on the day they were identified and the maximum wait was 240 days. Over a 12-month period 59 unpaid carers had assessments started within 7 days of the request for support. In total, 353 of the 419 assessments were completed within 28 days of a request for support. However, 66 unpaid carers took more than 28 days (April 2024-March 2025) this was more than what senior leaders had told us in March 2025 which was 7 people requesting a carers assessment had not met the 28-day target to start the assessment within the past 6 months. In May 2025, the local authority told us the maximum wait had reduced slightly by 5 days to 235 days. The overall differences supported the mixed feedback we heard from unpaid carers, with some receiving consistent support and others facing delays.

The local authority commissioned a service to provide assessment and support for unpaid carers in Blackpool. Identification of young carers and accessible support was part of an early help offer in within children's services and education. Staff within adult social care had referred 2 young people aged between 5 years and 17 years old to the commissioned service for a young carers assessment over the past year, this accounted for 1% of young carers referrals received from a total of 285 referrals across all referrers in Blackpool (including children's services and voluntary and charity sector, April 2024-March 2025). Senior leaders told us a multiagency development group was in place to support improvement in the identification and response to young carers. There had been recent learning around the role of an unpaid carer rolled out with newly qualified social workers, and there were aspirations to expand this to all staff. Senior leaders also told us there were plans to improve sharing of information between children's social care and the carer's services. There would also be development of a system wide memorandum of understanding to formalise joint responsibility to identify carers and offer support. However, these had not yet been implemented.

Unpaid carers and staff spoke positively about the commissioned carers service. For example, one unpaid carer told us they felt isolated before being connected to the carers service and they had received essential support to help them continue in their role. This was seen in national data showing 44.68% of carers were satisfied with social services. This was somewhat better than the England average (36.83%). Additionally, 71.08% of carers felt involved or consulted as much as they wanted to be in discussions. This was also somewhat better than the England average (66.56%, NHS Digital 2024). Some unpaid carers told us they experienced communication issues with local authority staff which had led to disengagement. National data supported this, showing only 16.98% of carers felt that they had control over their daily life. This was somewhat worse than the England average (21.53%, NHS Digital 2024).

Help for people to meet their non-eligible care and support needs

The local authority had an online public directory of services for information on health, social care and community services. Senior leaders also told us people could access face to face information and advice through the local library service for help with non-eligible care and support needs.

There was a flexible approach to meeting people's non-eligible needs once they had been allocated for assessment. Staff told us they could signpost people to other services, and support workers within assessment teams could provide 1:1 support that might be needed. Staff told us they connected internally across teams to build on professional relationships for advice and they found out about different services through talking to each other. They valued the use of digital instant messaging to see if a colleague was online which made connecting more accessible and found colleagues were always happy to help out. One staff member told us 'I love Blackpool I've worked in other local authorities, its different here for example, social workers complete housing applications, we do more and its more flexible. If there isn't an obvious Care Act need, we still do it anyway, it's what we do'. Another told us 'we are so proactive and passionate, genuinely, the conversations we hear in the office, we get that from our managers, I have never been told my time could be better used elsewhere'.

There was staff guidance for meeting people's needs who 'fall below the eligibility threshold'. It provided generic information about signposting people to resources such as 'meals on wheels' or for 'medication dosette boxes'. There was reference to services for social support or caring support such as libraries or joining clubs. However, the guidance was not specific to what services were available in Blackpool and had not yet been formally ratified for implementation with staff.

Eligibility decisions for care and support

The local authority's online assessment tool could be used by people to identify their own eligibility for care and support, it could be accessed 24/7 and had animated videos to guide people through the process.

When staff completed Care Act assessments with people, the templates used showed clear outcomes of eligibility. There was also staff guidance, information and a tool for establishing eligibility produced after learning from a safeguarding adult review. There was mixed feedback from people. For example, one person felt their assessment was not accurate and they had not received a copy. Another person's assessment provided details about the person's needs, how these would be met and clearly demonstrated how the person met the eligibility criteria.

Senior leaders had originally told us they had no appeals for Care Act assessments, or support and care funding over the past 12 months. However, in March 2025 they reviewed their information and told us between 2023- 2024 they had received 5 complaints or appeals in relation to the outcome of care assessments (including eligibility), or the quality of assessment, 2 were upheld, and senior leaders told us 'lessons were noted from all'. From January 2024 they had 3 complaints or appeals related to the outcome of care assessments (including eligibility), 2 were partially upheld with lessons learned.

In Blackpool 73.23% of people did not buy any additional care or support privately or pay more to 'top up' their care and support in Blackpool. This was better than the England average (64.39%, NHS Digital 2024). Senior leaders told us this was a result of people's needs being met by the local authority. There was staff guidance for meeting people's needs who self-funded their own care. It stated there would be no difference for assessment or support planning for people who self-fund. However, the guidance had not yet been formally ratified for implementation with staff.

Financial assessment and charging policy for care and support

There was mixed feedback from people about financial assessments. For example, one person had been incorrectly informed about 'free' care charges and an apology was offered. Another person had been distressed about the communication about outstanding care fees. In contrast, a person with learning disabilities spoke positively about the support with budget plans. Another person was appreciative of advice on deferred payments during a difficult time. In March 2025, senior leaders told us between 2023-2024 they had received 12 complaints or appeals in relation to the outcome of financial assessments including deprivation of asset decisions, 2 were withdrawn, 6 were not upheld and 4 were partially upheld. From January 2024 they had 5 complaints or appeals related to financial assessments, payments and charges. Of these, 2 were withdrawn, 2 were not upheld and 1 was partially upheld. Senior leaders told us there were lessons learned.

The local authority had public information posted on their website providing some information about paying for care and support, financial contributions and options to request a financial assessment. However, the information was limited, and people could not understand their contributions without delay. There were online options for people to contact the social care benefits team including about reviews and appeals by telephone, writing or email, and once a person had been assessed as eligible for care and support additional fact sheets were sent out to people who needed a commissioned service.

Financial assessments were carried out by the social care benefits team who had recently transferred to work within the local authority's adult social care department. Senior leaders told us the social care benefits team move enhanced collaboration with brokerage functions to improve communication and wait times. Some delays were said to be due to some people lacking mental capacity around their finances which could cause challenges in determining financial contributions. In these situations, staff were able to visit people face to face and used national databases to obtain necessary information. At the time of CQC assessment people waited for financial assessment and processes were not consistently meeting the local authority's target of 28 days. In August 2024, the local authority had a total of 203 people waiting for financial assessments, with a median wait of 13 days and a maximum wait of 151 days.

Senior leaders had identified risks around complaints, late provider payments and potential unpaid carer breakdown relating to financial assessment and outcomes. These risks were being regularly reviewed and there were plans to review recent changes to ensure this was effectively increasing activity, as well as offering direct debits as payment options for people receiving care and support. However, at the time of the CQC assessment it was too early to evidence how effective or sustainable any changes had impacted maximum waiting times and people's experiences of being charged for care and support.

Provision of independent advocacy

Where someone could not fully take part in conversation about their needs for care and support and they had no one to help them, the local authority had access to a commissioned advocacy service to support the person's involvement in their assessment and plans. There was no waiting list for independent advocacy services. However, there was more to do to ensure the local authority was referring all people who needed independent advocacy and staff required more support, training, oversight and learning to fully embrace the benefit of people participating fully in care assessments and care planning processes. There had been a recent complaint in relation to the impartiality of a member of staff when assessing a person's needs. This resulted in an apology and referral for independent advocacy.

There was mixed feedback from staff about understanding of when to refer someone for independent advocacy support. Some staff told us how they advocated for the person themselves instead of seeking independent advocacy, other staff told us when referrals could be made to ensure a person's voice would be at the forefront in any decision-making process. A partner also told us there were inconsistencies, as not all staff made timely advocacy referrals. They told us there was an ongoing issue with frontline staff's awareness of advocacy services. Questions within digital assessment templates to prompt staff to record whether advocacy was considered, or referrals were made, were not mandatory to complete. There was an option to select 'yes' or 'no' but we found neither option could be selected. There was more to do to provide assurances through audit and evidencing impact of learning to ensure all people who needed it were offered or supported by advocacy provision.

Senior leaders and partners told us there had been additional resources to support improvement at the local authority for staff to better understand advocacy services. They had recently seen an increase in advocacy referrals for safeguarding. However, there was still an inconsistency among staff referring for Care Act assessment advocacy. Training for newly qualified social workers had been provided and senior leaders told us advocacy referrals for care act assessments had increased by 61%, referrals for IMCAs had increased by 47% and referrals for IMHAs increased by 46% in the past 2 years. Senior leaders told us this was a direct result from the work done so far to raise awareness and the joint work carried out with the provider.

Supporting people to live healthier lives

Score: 1

1 - Evidence shows significant shortfalls

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

People who lived in Blackpool faced severe social inequalities, ranking worst in England for life expectancy, causes of death, homelessness, and employment rates, all of which were worsening (Public Health England, 2024). The local authority's efforts to support those at risk did not sufficiently promote healthier lives or reduce future care needs. Senior leaders told us people moved to Blackpool with established needs linked to people seeking low-cost private housing, which added demand to adult social care services. Whether or how a person's needs could be reduced or other needs could be delayed from arising risks was not considered at every interaction with a person. There was a need for more than a crisis management response to improving people's outcomes.

Staff, senior leaders and partners all identified the need to improve people's outcomes by taking a preventative and community approach to support people to manage their health and wellbeing. Bringing together and developing community offers was needed to support staff to incorporate preventative options into people's support. A senior leader told us more needed to be done to support long term vision and this was voiced within the corporate leadership team. Another senior leader told us the local authority was further along with the vision of a preventative approach than they were 2 years ago as it had taken time for staff to find out what communities had to offer in Blackpool.

There was a draft Social Care and Prevention Strategy, however this had been under review and awaiting implementation for over a year. Timescales within improvement plans had repeatedly not been met. The draft strategy set out 7 key priorities and highlighted how the adult social care department were taking a strength-based approach to the assessment of people's needs. However, it did not provide detail of how 'making every contact count' would be embedded in social care practice and how prevention, delay or reduction in needs for care and support would be effectively measured in relation to this. National data supported the need for action. The number of people receiving long-term support was significantly above the England average. For adults aged 18-64 1,465 were receiving long term support per 100,000 people in Blackpool compared with the England average at 855, and adults aged 65 and over 9,185 were receiving long term support per 100,000 people with an England average of 5,185. 60.46% of people who received short-term support then no longer required support was significantly worse than the England average at 79.39% (NHS Digital, 2024). Therefore, short term support was less effective than other areas at reducing people's long term care needs.

There was more to do to ensure preventative offers were available and accessible when people contacted adult social care including to enhance tailored outcomes of assessment, reviews and care planning to stop needs from escalating, and help people maintain their independence for longer. There was a mix of local authority commissioned services, voluntary and charity sector organisations, or the NHS funded offers in Blackpool. For example, a senior leader told us about a service provided by the local authority that supported independent living for people with a learning disability who had set up a community garden, making planters and bat boxes, this reduced social isolation and supported a sense of community. They also ran a number of café's that were staffed by people with learning disabilities, run art and photography groups and a range of other community projects. There was also a charity was dedicated to offering support and advice with a confidential helpline, welfare benefits advice and hate crime reporting. Another senior leader told us about 'Active into Autumn' and 'Spring into Spring' community health and wellbeing events for people to get involved in. These were public events to display information through stalls and activities, with an aim to improve connections and recognise community strengths to build on people's resilience. However, there was a reliance on staff and people seeking independent knowledge rather than overarching strategic direction evidenced by any impact on peoples' lives.

Senior leaders, unpaid carers and partners told us some people had been discouraged from accessing services due to the fragmentation of the health and social care offer. For example, a carer told us about the difficulties accessing mental health support especially if a person also had addictions. They told us mental health services referred the person they cared for into a substance use service who could not provide the support that was needed to address the causes behind their alcohol or drug use. Another carer told us of the difficulties they had experienced getting support for their family member who had a criminal history and drug use. They felt that there had not been the support in place and as a result the person was left with no money and nowhere to live. In response, senior leaders told us the local authority commissioned mental health support within drug and alcohol services and there was ongoing work with the NHS to ensure health partners provided specialist mental health services that met the needs of people with additional needs. There was a community service commissioned to respond to recovery for people who had used drugs and faced barriers to the services they needed in relation to homelessness and, or a criminal history. There was a 'prison leavers programme' that supported people and national data showed continuity of care had improved.

The number of deaths from drug use in Blackpool was the highest in England (four times higher) and this had increased by over 40% in the past 10 years. Additionally, death from alcohol use was significantly higher than England averages, with Blackpool having the second highest attendances to hospital related to alcohol use in England. It is known that when someone is under the influence of substances and/or alcohol, they are more likely to engage in risk taking behaviours. Senior leaders told us they recognised the impact of drugs and alcohol on sexual activity and other risk-taking behaviour and public health had data to monitor this. Training for staff to discuss sexual health and engaging in sexual activity while under the influence of drugs was also said to be available for staff.

Support for drug and alcohol needs was offered through commissioned services. Senior leaders told us this targeted prevention and early intervention around around sexual health and drugs and alcohol within LGBTQIA+ communities as well as other groups such as sex workers. There was work to encourage uptake of drug and alcohol services. The local authority received national funding to support action needed to reduce health inequalities in Blackpool and senior leaders told us they had an 'unmet needs' plan which aimed to identify and encourage people to be supported. There had been investment in 'lived experience workers' and 'outreach workers' who worked in areas of most concern. The Blackpool Combating Drugs and Alcohol Partnership met quarterly and was made up of professionals across system partners. This partnership had subgroups covering priorities from health and police focused strategy; however adult social care representatives were invited. The partnership had data to monitor any effectiveness of actions taken and had introduced a twice-weekly recovery hub that was now in place. However, it was too early to understand any positive impact this was having on people with care and support needs and their unpaid carers at the time of the CQC assessment.

Provision and impact of intermediate care and reablement services

The local authority's 24/7 physical rehabilitation centre could be accessed from home, care homes or hospital if a person met the agreed criteria. The service was registered with CQC as a care home with a 'good' rating. It had high demand owing to the partnership delivery with the NHS Trust where health and social care professionals could refer directly in. There was mixed feedback from people about the offer. For example, one person was very grateful of the support including support to be re-housed. Another person felt they had not had the level of rehabilitation they wanted to improve their independence.

The reablement at home offer was fragmented and the local authority had seen a decrease of reablement uptake compared to the previous year. The Phoenix Centre was another internal provider service registered with CQC, within this was a home care service to assist people to be as independent as they can be. Therapy input was agreed separately through the NHS Trust, staff told us this could run alongside where needed. There was a mixed picture about the criteria for this service, if a person had an existing care package with a private provider some staff told us they could not access the service, in contrast guidance provided by the local authority showed they could. Staff also told us there was no option to refer to the service to reduce a person's existing care package and this would be a discussion needed with the private provider if that was what the person wanted. Staff told us there was a value for people who could access the service. For example, a person had declined a formal care package of 4 visits a day. The persons main goal was to improve their walking and use the stairs as they were confined to the upstairs of their home. With the support the person was able to work towards their goals and remain at home without long term formal support.

The local authority also had a support offer within assessment teams. Each team had a number of support workers who could support with low level needs (not regulated care) over a period of time and respond quickly to crisis situations. However, staff told us some people could be 'over supported' and this had the impact of 'de-skilling and dis-enabling people.' For example, a support worker had continued to take a person shopping when staff told us they could do this themself. The offer could be different depending on which team the support workers were in. Staff also told us there was not consistent use of reablement and support workers across teams which meant people could have inequitable support.

The local authority had seen an increase in permanent admissions to care homes, particularly amongst people with care and support needs aged between 18 – 64 years old. A person told us there had been a deterioration in their abilities since living in a care home and whilst they were happy in the care home it was not the same as being at home. A partner told us there was a need to shift more resources into the reablement at home offer in Blackpool. National data supported this showing 77.78% of people aged 65 and over were still at home 91 days after discharge from hospital into reablement or rehabilitation offers. This was somewhat worse than the England average (83.70%, NHS Digital 2024). There were aspirations to improve the offer over the next 12 months, but we were told 'it is not there at the moment'. The impact of this was people could miss the opportunity to return home or not go home early enough. Therefore, the local authority's arrangements to identify and support people at risk of a decline in their independence and wellbeing did not maximise all peoples' independence, which is consistent with the national data quoted above about the number of people receiving short term care who then no longer need support.

Access to equipment and home adaptations

People and staff told us most equipment was assessed and prescribed on hospital discharge or through hospital admission avoidance services provided by the NHS. However, there were various ways people could access equipment through the local authority such as self-assessment and self-purchase. For example, there was a commissioned online self-help guide, this provided people with an individual report based on responses to questions. However, once receiving the report people needed to know where and how to access a separate website to find trusted suppliers or contact details to make self-referrals for a therapy assessment as the guide did not provide or link people to this. Other options included a recycling and re-use scheme within Blackpool which gave people the option to access equipment quicker should they want to utilise this service.

The local authority had an in-house service to provide a technology enabled care and response service. Senior leaders spoke positively and shared feedback about the service which offered prompts for medication, provided physical response and welfare calls working closely with partners.. However, there had been recommendations following a funded independent review of people's care in Blackpool to suggest more needed to be done to increase the uptake of technology enabled care. The review identified a wider than average range of support options for most age ranges being available to the authority, and of people reviewed said less than 1% of assistive technology that would have been beneficial to the person was not available compared to the commissioned service average of 16.05% across other local authorities it had worked with. However, the report found barriers to people and unpaid carers using this type of equipment due to 'not knowing how it works' and 'fear of technologies.' There were suggestions to increase practical training on equipment, how it was used, and good practice examples of real-life case studies to enable staff to understand and promote the benefits for people to make informed decisions. In response, senior leaders told us the technology enabled care and response service had demonstrated the kit and its potential to staff teams. The technology enabled care and response service also attended the Spring into Spring and Active into Autumn events which had a wider reach to people, unpaid carers and partners that attended.

However, following the review it was too early to understand any positive impact this was having on people with care and support needs and their unpaid carers at the time of the CQC assessment.The majority of community equipment was assessed by the NHS trust through partnership agreements with the local authority which was managed through joint funding and delivered through the Better Care Fund (including small aids, specialist seating and ceiling track hoists). Senior leaders told us the NHS provision of assessment for equipment was provided as part of their commitment to the Better Care Fund and was not subject to a separate contract. As a system, the local authority and NHS monitored the performance through the BCF process and the Integrated Care Board (ICB) managed a wider contract for community NHS services. However, processes to assess for equipment were having wider negative impacts on people's outcomes. For example, a partner told us the therapy service which aimed to provide community rehabilitation in people's homes had to prioritise the urgent assessments for equipment due to the high level of demand compared to low therapy resource available. The introduction of a lead therapy role within the NHS community teams had made improvements in ensuring staff resource was as flexible as possible and had implemented robust triage processes to ensure people were seen in priority order, which partners and senior leaders said had reduced the length of time people could wait.

According to first submissions of data in March 2025 provided by the local authority to the CQC, 1284 people were waiting for an assessment for equipment by the NHS therapy service. People waited a median of 41 days; however, we were told this had come down from 52 weeks (around 364 days) waiting. The length of time people waited varied depending on geography meaning people had inequitable responses depending on where they lived. For example, the South team had an average wait of 120 days. In contrast, the North Shore team was an average of 17 days. Once assessed, people usually received their equipment within 2- 5 days, and urgent delivery could be within 2 hours. Following the CQC site visit senior leaders told us from May 2025 there no waits in 1 area, and a reducing waitlist of 48 in Central (maximum 6 weeks) we were not provided updates for the South or North team. We were also told in May 2025 there were 64 people waiting in February 2025 which had reduced significantly from 1284 in August 2024. Senior leaders described this change as ‘now the norm’ and had seen a reduction in calls from people asking for updates.

There was mixed feedback about how the local authority analysed the number of referrals that came to therapy services from the local authority. For example, partners told us waits were a shared wait list between the local authority and NHS, and there were aspirations to streamline data to inform future service delivery. In contrast, following the CQC site visit senior leaders told us this data was available and 803 referrals from adult social care teams had been made for NHS occupational therapy assessment between March 2024 – February 2025. There were concerns about the lack of resource to progress local authority aspirations including to reduce formal care needs through specialist assessment and equipment. For example, senior leaders and partners told us about a 'moving with dignity' project. There had been an aim to recruit to new posts across therapy and social care to support progression from care provided by 2 trained people to 1 person (known as single handed care). This can be done through targeted assessment, equipment and training for care providers and unpaid carers. The benefit of reducing support to single handed care is not only cost effective for people who fund their care but can increase choice and control around the frequency and number of formal care staff providing support in peoples own homes and provide more opportunities to manage their health and wellbeing in ways they prefer. However, due to recruitment and funding pressures this project had not progressed. This meant people did not have timely opportunity to reduce their care support from an initial requirement for 2 staff to meet specific mobility needs. Additional care would need to continue that may have had opportunity to be reduced (or reduced sooner).

The local authority directly employed 2 occupational therapists (OTs) however they were not linked directly to Care Act assessments or interventions. As a unitary authority the OTs worked within the housing department adaptations team that led on Disabled Facilities Grants (DFGs). A partner told us there was a high demand for adaptions such as access level showers, stairlifts and ramps in people's homes. Data provided by the local authority following the CQC site visit showed 97 referrals had been made for major adaptations between March 2024 – February 2025. However, current processes did not support coordination between the local authority and commissioned therapy services. For example, a partner told us there could be duplication or unclear responsibilities for occupational therapists which took staff away from providing rehabilitation and therapy assessment in people's own homes. The local authority did not provide the number of people waiting for adaptions nor median or maximum wait times over the past 12 months, however senior leaders told us processing targets were set at 6-12 months. A senior leader told us progress to streamline application processes was not working well within the local authority. This had been a result of delays in agreeing partnership working and financial pressures. Following the CQC site visit in May 2025 senior leaders told us the time to assess and appoint a contractor usually took about 12 weeks with specialist work taking longer. Level access showers had the longest waits taking approximately 12 months from referral and we were told actions were underway to reduce this and people were offered alternative arrangements to bath whilst adaptations were completed.

Provision of accessible information and advice

The local authority had an online directory of services to connect people, unpaid carers, staff and partners to local services in their communities. According to national data 73.61% of people in Blackpool found it easy to find information about support. This was somewhat better than the England average (67.12%, NHS digital 2024). However, the offer lacked links for seldom heard groups of people. For example, a senior leader told us about specific faith led food kitchens and an emerging population of Polish and Lebanese people but information for these groups was not in the directory. The website encouraged services to be included in the directory. Senior leaders told us Blackpool's library service offered information, assistance and advice to support people who need some 'hands-on' help to find what they needed. This offer was grant funded through the 'Know Your Neighbourhood' fund, a package of up to £30 million designed to widen participation in volunteering and tackle loneliness in 27 disadvantaged areas across England. However, there was more to be done to proactively encourage these provisions within adult social care and monitor its impact.

Unpaid carers and staff spoke positively about the commissioned carers service which supported people to access information and advice. This was seen within national data which showed 88.31% of carers in Blackpool found information and advice helpful. This was somewhat better than the England average (85.22%). Additionally, national data from the Survey of Adult Carers in England for 2023/24 showed 66.67% of carers found it easy to access information and advice. This was also somewhat better than the England average (59.06%, NHS digital 2024).

Direct payments

There was more to do to break down barriers to access direct payments and how this should in work Blackpool. There was mixed feedback from people about the uptake of direct payments. Some unpaid carers told us they had heard of them but felt they didn't qualify for the support or felt they couldn't manage them. Whilst others received them and said it had supported their role and people told us when they were referred for support by the direct payments team, they spoke positively about their kind approach and the invaluable support they offered.

The mixed feedback from people was supported by national data, as the percentage of people receiving direct payments was worse than the national average at 17.70% compared to 25.48% for England. 26.73% of people aged 18-64 and 8.84% of people aged 65 and over received direct payments. This was worse than the England average of 37.12% and 14.32% retrospectively. 84.38% of assessed unpaid carers received direct payments, this was lower than expected (NHS Digital, 2024). Senior leaders and the direct payments team had taken action to address the low uptake of direct payments such as refreshed communication and learning sessions for staff.

Staff and senior leaders told us the process of setting up a direct payment was easy once people were referred. However, there was mixed feedback from staff about the criteria for who would be accepted to manage a direct payment. Staff policy said direct payments should be offered to improve people's control about how their care and support needs were met including people who may lack mental capacity in this area. However, given the feedback from both staff and people there was more to do to break down any barriers to access direct payments and how this should work in Blackpool.

According to the local authority's own data over 12 months 23% of people stopped using direct payments. Out of the people who stopped using a direct payment, some had their care moved to a home care or care home provider within the local authority's agreed framework, some people moved to a personal health budget funded by NHS continuing healthcare, and some people no longer required the care. The local authority had identified themes and trends in the feedback they had received when direct payments ended. Some of the barriers found were due to a lack of availability of personal assistants in the area, a lack of understanding amongst people who may be eligible for a direct payment and people's confidence and trust levels in the personal assistants people hire to provide their care and support (August 2023 -August 2024). Senior leaders told us reductions in direct payment numbers compared to new referrals was negatively impacted due to a number of reasons including a lower life expectancy in Blackpool, which had an impact on how long people received support.

A senior leader told us the local authority was linked to national networks around direct payments for sharing learning and best practice and had additional funding to lead on health personal budgets in the area. Senior leaders also told us they had sourced an alternative payroll provider who could facilitate different pay frequencies and a leaflet to promote direct payments had been reviewed by lived experience groups within a local charity in response to improving peoples experiences of direct payment processes. This provided people with access to information, advice and support to use direct payments. The leaflet had also supported staff confidence, recruitment of personal assistants, and had been shared at an engagement event to provide people and unpaid carers more understanding of direct payments as an option. However, the local authority was yet to evidence consistent improvements that positively impacted on people's choice and outcomes. There was an improvement plan, however a senior leader told us they were not seeing the impact they hoped to, partly due to the culture in frontline practice described as 'wrapping services around [people] instead'. Another senior leader told us direct payments had not been at the top of priority lists and there was more to do to support all staff in promoting the benefits of direct payments. Some staff told us there could be a lack of knowledge around what direct payments could be used for, for example options for bespoke home care with a care provider rather than employing personal assistants.

Equity in experience and outcomes

Score: 1

1 - Evidence shows significant shortfalls

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

People were not being treated equally, standards of care and support differed depending on people's individual and multiple needs. These were not new issues for the local authority to address. They had published shortfalls in people's experiences within its own Joint Strategic Needs Assessment (JSNA) and a peer review was undertaken 2 years previous to the CQC assessment that raised concerns about equity in peoples experiences and outcomes. However, there was a lack of local strategy and action to reduce inequalities in people's access to care and support, their experiences and outcomes.

The local authority lacked priority and focus to demonstrate what was being done to address inequalities in the area. There were some actions within an adult social care improvement plan, however they had failed to progress shortfalls. The local authority had a corporate focus to review demographic profiles of staff, but there was no evidence of how this impacted frontline work and people's experiences. Results from both Employer Standards Health Check for Registered Social Workers 2024 and 2025 reports suggested corporate efforts to focus on equality, diversity and inclusion across the workforce had not been effective in improving or challenging discriminatory behaviours.

Intersectionality is a term that can be used to describe how race, class, gender and other personal characteristics 'intersect' and overlap. Staff told us they were increasingly identifying people with multiple needs and risks, however there was a lack of understanding of wider themes that negatively impacted people who were most likely to experience inequality. The local authority's Annual Public Health Report 2024 identified people were more likely to have shorter lifespans than other people living in other areas of the country, and statistically people living in Blackpool experienced higher levels of mental health problems, lower levels of self-reported wellbeing and were more likely to have problems with drug and/or alcohol use. People were almost four times as likely to die from drug use, and mental health needs were identified as a priority, with suicide rates said to be significantly higher in Blackpool than in other local areas.

The local authority had a separate Autism Team to provide autistic people in Blackpool consistent and specialist trained assessment and intervention support. The number of autistic people was predicted to rise and senior leaders told us a pathway to join up health and social care services was under development. Data sourced from health partners by the local authority showed there were more people with a learning disability and autistic people in a hospital setting than what had been locally planned and agreed, and we heard people with a learning disability and autistic people waited the longest for community Care Act assessment which could have a direct link to higher hospital admissions as some people were not supported early enough in their communities. A senior leader also told us autistic people were highly represented in transgender communities. An autistic person had stepped forward to share their own transgender awareness presentation.. Following the CQC site visit, senior leaders told us the same autistic person had been involved in developing further presentations with the Autism team and LGBTQ+ awareness was built into the newly qualified social workers programme. It had not been rolled out to wider teams and it was too early to determine how effective the learning had been as staff gave mixed accounts of confidence and knowledge.

The local authority identified Blackpool as having one of the largest communities of people who represent a diverse range of sexualities and gender identities. LGBTQIA+ stands for lesbian, gay, bisexual, transgender, queer (or sometimes questioning), intersex, asexual, and other identities. 4.9% of 16-year-olds and above in Blackpool identified as lesbian, gay, or bisexual (with a further 6.66% of the population choosing not to answer, compared to national data of 3.8% of people identifying as LGB and 7.5% choosing not to answer). 0.58% of people reported having a gender identity different from their sex at birth which was slightly higher than the England average of 0.55% (ONS, 2023). An independent local report had been led by a charity through surveys and face-to-face interviews with local people. It outlined historic isolation from rights and services for people in Blackpool and the need to build trust across professionals and services. A senior leader told us some people within the LGBTQIA+ community presented with more vulnerability and having staff representation of the population was helpful. We found there was a lack of strategic direction within adult social care to reduce barriers for people with care and support needs and their unpaid carers, or safeguard people with these protected characteristics. People's accounts highlighted the need for more mental health support in Blackpool that catered for LGBTQIA+ needs and people did not feel that services were tailored for them. There was a fear of accessing services and there were a number of recommendations from the report made to the local authority and key system partners to empower people to engage with current services but also ensure services were knowledgeable about the specific needs of people within the LGBTQIA+ community. For example, awareness training, a directory of approved services, a local charter mark to show they are supportive and knowledgeable about the LGBTQIA+ community, and strong equality and diversity policies to be coproduced. The local authority had published an action plan on their website that listed aspirations. For example, actions in relation to safeguarding and wellbeing were reliant on funding being approved and some timelines reached 2026. However, following the CQC site visit senior leaders told us some progress had been made. For example, health and wellbeing focused peer and social support groups had been developed, 1 to 1 specialist support which extended to linking people's needs to adult social care assessment, and free counselling for the LGBTQIA+ community if they were accessing formal support. There were aspirations to join up charity services

and adult social care to share knowledge, creating a more accessible and inclusive service for all. However, at the time of CQC assessment there was no evidence to demonstrate any progress that positively impacted people's outcomes.

There was a need to focus on the experiences of all minority groups in relation to equality, diversity, and inclusion in the area. Councillors were appointed in March 2024 as equality champions representing areas defined as women, race, faith, disability, LGBT+, and older people. These roles were described as 'bridging the gap for the community.' For example, councillors had met with community groups and forums and saw themselves as the 'go between, between community and council.' However, there was more to do to evidence any positive impact this was having on frontline delivery of services and outcomes for people with care and support needs. Most staff within adult social care teams could not confidently name who the seldom heard groups of people were in Blackpool. Most staff were not sure how accessible their services were to everyone or how they could meet cultural needs. Staff who worked across children and adults' services had more confidence (than staff that only worked with adults) in recognising diverse communities in Blackpool. They told us they had seen an increase in different nationalities such as Polish, and Portuguese communities and in asylum seekers requiring support. We heard how public health colleagues had begun to deliver a Blackpool demographics learning session to staff teams. Not all staff had attended the session, but line managers had been asked to deliver this to those who could not attend. The session introduced the population of Blackpool such as LGBTQIA+ awareness and local challenges utilising information within the Joint Strategic Needs Assessment (JSNA). Staff had access to corporate equality and diversity training that senior leaders told us had been mandatory for several years. There had been a specific adult social care managers session two years ago. and aimed to build staff confidence and improve identification of unmet needs. However, there was no evidence that this work had been embedded in people's care and support and made a positive difference to people's experiences. Staff consistently told us further training and support in cultural competence would be beneficial. This would aim to empower staff to effectively and respectfully work with individuals and communities from diverse cultural backgrounds. At the time of the CQC assessment health and social inequalities were not incorporated into operational practice and intersectionality of peoples protected characteristics were not always understood.

The local authority did not proactively engage with all people and groups where inequalities had been identified to understand and address the specific risks and issues experienced by them. Senior leaders and partners recognised the need to reach out to more groups of people, for example there had been 'door knocking' through a charity organisation however examples provided were in relation to health led objectives to reduce accident and emergency hospital attendance finding people faced barriers to accessing community services. A senior leader told us seldom heard groups were welcome to contribute to the council, for example there were aspirations to invite people to bring their voice to scrutiny meetings but at the time this had stopped and plans to reintroduce this had not progressed. Another senior leader told us they were aware of tensions and hostility between groups and communities in Blackpool. For example, there were known tensions between ethnic communities and as a result there was some ongoing work through international funding to support a charity group in understanding some of the tensions and how to address them, however this had an environmental focus as opposed to prevention or support within adult social care. Staff and senior leaders gave examples of racism, homophobia, and high rates of hate crime in the area, a senior leader told us as a result the local authority were mindful of communications they published on corporate social media accounts. For example, there had been public disorder in Blackpool related to national misinformation about asylum seekers, hate spread about the use of LGBTQIA+ flag colours used on local authority funded signs, and concerns rising around potential applications to build a mosque. They had sourced national funding to aid community cohesion over the next 5 years working with the third sector to address this. However, at the time partners told us there was a 'struggle' to engage with diverse communities but could not identify specific action or plans to address this. There was more to be done to bring staff, people, unpaid carers, and partners together to take action to reduce inequalities through design, delivery, and evaluation.

All partners told us they were not aware of any recent analysis of social care needs alongside the local population profile and demographics. Senior leaders referenced data within the JSNA however the JSNA had gaps (for example unfinished areas and areas referencing 2014 social care data as its most recent source). Senior leaders told us public health had intentions to work with adult social care to update a social care needs assessment within the JSNA. However, senior leaders and staff told us there were gaps in recording peoples protected characteristics within the adult social care digital system which meant the local authority had further work to do to collect and analyse adult social care data alongside local and national data within the JSNA. For example, recording of people's sexual orientation was described by one senior leader as 'less developed' and there was a reliance on staff inputting personal circumstances within the assessment as 'free text' which could not be collected in data reports. Another senior leader described the importance of utilising data in understanding people's equity in experiences. However, at the time of the CQC assessment strategic planning to understand barriers to care and support and reduce inequalities could be misinformed or not informed by evidence. Therefore, there was more to be done to capture social care information for analysis, progress aspirations with appropriate resource and embed quality of practice within assessment and strategic planning.

Inclusion and accessibility arrangements

People told us their preferred inclusion and accessibility arrangements were not always followed. For example, a person told us they had significant reading difficulties and preferred to have information shared with them verbally as opposed to in writing, but they continued to get letters in the post rather than telephone calls as agreed from the local authority. Another person with a learning disability and some sight loss communicated using technology, however methods outlined in their support plan were not followed by local authority staff and information was sourced from the care provider instead of the person themselves. Staff also told us there were negative impacts on people facing multiple disadvantages, such as people with both mental health needs and needs relating to drug and alcohol use. Staff told us accessing services often relied on people needing to telephone call for support without acknowledging not everyone had access to a telephone or the internet which left them at risk.

There were inclusion and accessibility arrangements in place such as interpreter services so that staff could refer people to engage with their assessments and interventions provided through the local authority in ways that worked for them. Staff told us this was also available outside of usual office hours and they had access to easy read, larger print and some staff had been trained in British sign language. Senior leaders recognised their duty to ensure all people with accessibility needs were identified and supported. For example, 29,700 people aged 18 and over in Blackpool were living with some or severe hearing loss and this was projected to rise. The local authority identified people with hearing loss were at increased risk of falls, dementia, social isolation, depression, and anxiety, as well as reduced physical activities of daily living. Specialist aids and equipment to support the independence of people who had sight loss, hearing loss or dual loss could be provided to people following an assessment by the dual sensory loss and hearing impairment team. Senior leaders recognised it was important when planning for local support and preventative services that the needs of people with hearing loss and those at risk of hearing loss were understood. For example, accessibility of contacting services, training and awareness of people's different and intersectional needs and provision of communication support. Information was available online and people could email or complete an online form to refer to the local authority. Once a person was allocated to a staff member, they also had the option to communicate through text messages. Staff told us this was also helpful for autistic people who may not prefer to speak over the phone.

There were aspirations to work more closely with partners to close the gaps experienced by people by looking at learning, particularly in relation to safeguarding incidents on how best to support people's inclusion and accessibility arrangements. However, it was too early to determine how effective or sustainable this would be.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority had a Joint Strategic Needs Assessment (JSNA) which brought together national data and trends including through primary care surveys and police statistics. The local authority's draft Commissioning Strategy outlined the challenge the local authority faced between people's health outcomes and predicted need for support from social care. The local authority had identified there would be an increasing demand for support for people with Care Act eligible needs over the next 3 years.

Senior leaders and staff told us there was a good understanding of current and future needs for people with learning disabilities. The local authority identified 25% of the population in Blackpool had limited day-to-day activities because of a long-term health problem or disability, which they recognised was significantly higher than the national average of 17.6%. The proportion of eligible adults with a learning disability who had a health check in Blackpool was significantly lower than the England average. 2.3% of working age adults with a learning disability receiving long-term support from the local authority were in paid employment in Blackpool, compared to 5.6% nationally. 21% of supported adults with a learning disability received direct payments compared to 30.3% nationally. Despite this there was no local strategy or strategic plans specific to these identified concerns. However, operationally there were actions taking place to improve people's experiences. For example, there had been joined up working with the local authority's employment services and adult social care staff which identified a need for a regular staff meeting, they met 6 weekly and discussed people's needs. This had seen an improvement in the proportion of people with learning disabilities and autistic people in employment as a result.

Adult social care and commissioning teams told us they worked together and identified changes in need. However, this was based on verbal feedback as opposed to analysed evidence. For example, staff told us people with a learning disability were living longer which meant there was a need for more specialist provision as they aged. Traditional care homes were approached to support these needs. Teams told us they supported care home providers to understand that someone's learning difficulty or disability did not mean they would need support much different from anybody else. Staff referred to the NHS transforming care for people with learning disabilities agenda and they saw the need for additional home care or supported living provision as opposed to traditional care home models particularly for young adults.

At the time of the CQC assessment notification, the local authority's draft Commissioning Strategy had not been co-produced to involve people, carers, internal staff and partners at all stages through design, and there was no reference to coproduction within delivery and evaluation plans. However, following the CQC site visit senior leaders told us the draft Commissioning Strategy had been informed by issues and areas of opportunities that had been raised at provider forums, managers meetings and the Carers Strategy development. There were aspirations to gather more feedback and further shape the strategy including through work with Health Watch and the advocacy and carers services. Staff told us they had built on their relationships with providers to improve input into decisions and be part of solutions. However, there was mixed feedback from partners (which included providers) about how effectively the local authority consulted with their services to understand the care and support needs of local people. The feedback mostly related to individual or very specific needs. For example, one partner was positive about communication with the local authority about specific situations as opposed to strategic planning. Another partner told us staff had made decisions about a person without consultation from the service and the person themselves. Another partner told us a senior leader 'had consultations with commissioners to promote their work' but did not reference any direct work with them. We also heard partners could attend quarterly forums with senior leaders and staff within procurement and contract team. Partners spoke positively about the responsiveness of the local authority when issues were raised. However, there was more to be done around strategic planning to understand local needs within these forums.

Market shaping and commissioning to meet local needs

People had access to support options that were good quality to meet their care and support needs. National data showed 78.29% of people in Blackpool felt they had choice over services. This was better than the England average (70.28%, NHS Digital 2024).

The local authority was aware people developed long-term health conditions earlier in their lives in Blackpool. However, there was a lack of alignment with health and public health to meet local needs. For example, there was no reference to equality or prevention in the draft Commissioning Strategy submitted to us. Although the local authority aspired within the draft Commissioning Strategy to support research and work more closely with partners (including providers) this had not yet been implemented. A senior leader told us progress around commissioning strategies and an overarching framework was something that was not working well for the local authority, there had been aspirations to create a new place-based commissioning strategy, but this had not happened. Instead, the local authority had market position statements and had focused on a carers strategy. One partner told us there had been a lot of change within health commissioning and the local authority had not started their own commissioning strategies because they wanted to commit to a partnership approach. However, it was said in hindsight they were behind with progress by 2 years as a result of this approach.

There had been consideration for the provision of services to meet the needs of unpaid carers this was seen within the carers strategy and utilisation of the accelerating reform fund. There was mixed feedback from unpaid carers most felt listened to but struggled with choices and suitable support to replacement care for the person they cared for, in both planned and unplanned situations. For example, one unpaid carer had relied on family whilst they were hospital with another said they also received support from family members. The commissioned carers service had discussed carers breaks with one carer, but they had not been eligible due to the benefits they received. National data showed 26.21% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency. This was significantly better than the England average (12.08%). Additionally, 33.98% of carers accessed support or services allowing them to take a break from caring for more than 24 hours. Again, this was significantly better than the England average (16.14%, NHS Digital 2024). Senior leaders told us a commissioned 24-hour monitoring and emergency response at home service was excellent in responding to emergencies and dementia awareness training provided by a commissioned carers service had been invaluable in understanding the person's needs they cared for. In contrast, one partner told us there was more to do around dementia support following diagnosis and despite there being a local forum they felt Blackpool had gaps and could benefit from more provision in the community such as dementia cafes.

The local authority had separate market position statements for day services (2023-2026), home care (2024-2027), care homes (2023) and supported living (2021). One of the local authority's market position statements identified a housing pilot project carried out between November 2020 and March 2021. It showed there were 36 supported housing providers with 138 known schemes. The local authority aspired to improve the quality of their supported housing market, increase value for money and tackle ongoing issues with the provision in Blackpool. There were two large extra care providers in Blackpool. A senior leader told us the commissioning model had changed over time due to needing to meet people's multiple and additional needs. However, the local authority did not have plans to increase extra care housing and instead was progressing development of traditional housing accommodation such as sheltered schemes. Staff told us their market position statements supported them looking at patterns and to understand what services could be needed going forward. However, whilst staff could tell us what the statements could support with, they had no examples of how this had recently been applied. Following the CQC site visit senior leaders told us the market position statement for home care was developed through an operational working group in 2024 which included representatives from different teams and services including Commissioning, Adult Social Care (representing social workers), Social Care Purchasing Team (operational commissioners and brokerage) and Quality Monitoring. The working group worked together through meetings and virtual communication. Joint work was undertaken at the home care provider forum with partners to reflect their views, and then before publication the document was shared wider to ensure any final comments and views could be reflected.

Ensuring sufficient capacity in local services to meet demand

There was adequate home care and residential care home provision available to meet the demand when sourced through the local authority. However, there were less resources available for nursing and mental health provision. Senior leaders and partners also told us there was a need to change assessment culture within adult social care which would result in a need to increase home care options and reduce care home demand overall. Staff consistently told us there were gaps in support for overnight care at home which impacted decision making and as a result opted for care home support.

The local authority had started to use information gathered by a commissioned agency to undertake 600 reviews of people's needs that were being supported by either home care or a care home. Although the strategic analysis had not yet taken place, the first 200 reviews showed 21% of people receiving home care received 4 home visits per day compared to a comparable 9.27% benchmark across other local authorities held by the agency. Ongoing work was taking place to understand and analyse what this meant for the local authority. However, on first reflections senior leaders felt this was due to assessment and review practice issues rather than people having additional needs in Blackpool.

Data provided by the local authority showed 88 people waited a median 3 days and a maximum 20 days for residential care home support, this allowed time for people to research, choose a suitable home and avoid out of hours admissions. (December 2024-February 2025).

For home care, 53 people received same day offers and 258 people waited an average of 4.6 days, this allowed time for choice and assurance the provider could meet people's needs. There had been a delay to home care provision due to a location having a lack of accessible parking, the local authority had resolved this by providing carer parking permits to allow provider's staff to park in residential only parking areas (June- August 2024). The local authority had a system for tracking home care demand and had seen a slight decrease in the previous year of long-term residential care home placements per 10,000 population (213.5 to 203.1). The local authority was facing increased demand for home care services. They had added a further 3 providers to their framework to meet current and medium term demand the next 3 years. Future aspirations involved working closely with the Blackpool place-based partnership and continuing to maintain good relationships with the provider sector.

There were substantial waits for supported living options. 15 people were being supported to find supported living accommodation with an average of 550 days wait. The local authority gave various reasons why people in Blackpool waited this long. For example, inaccurate data particularly if planning started at a young age before a person became an adult, and challenges meeting additional needs such as mental health or physical disability support, as well as choice. Senior leaders told us 5 people had successfully moved into supported living accommodation and the longest period for the 5 people was 365 days (June- August 2024).

Length of waits and reasons for delays in hospital discharge were not specifically provided by the local authority, however staff told us delays were usually due to lack of service availability for people with specific additional needs.

Some services were commissioned jointly with health funding. In these instances, there were funding panels and joint monitoring of the services being provided. 28 people waited a median 3 days and a maximum 105 days for nursing home support, people who required nursing with dementia support was more challenging to source and processes for joint funding could impact delays. However, the local authority were seeing improvements in reducing waiting times (December 2024-February 2025).

There was a need for people to use services or support in places outside of their local authority. In August 2024, 169 people in Blackpool were being supported in out of area placements, which the local authority identified as 15% of people in long term care or accommodation. The neighbouring local authority was a significantly larger area and 111 of the people out of area were being supported in this bordering local authority. However, whilst 89 people were said to be out of area due to choice or to be closer to family, 80 people accessing support outside of their local area were not. For example, this was due to lack of nursing dementia support or other specific needs, or timeliness to meet a persons need that could be a crisis situation or hospital discharge opposed to actual choice.

Staff told us people who needed to seek refuge from domestic abuse and also had additional care and support needs were negatively impacted in Blackpool due to a gap in provision. For example, one staff member told us an autistic person at risk of domestic abuse couldn't find refuge in the area due to their needs, the staff felt they were 'screened out' based on their diagnosis as opposed to what they could do. The staff said the person had low level needs, but as a result had to be placed approximately 270 miles away.

There were processes to avoid moving people out of Blackpool, such as ensuring availability in Blackpool was offered as a first option and only if the person's needs couldn't be met then they would look at options elsewhere. When people did move out of area, staff told us there was careful consideration of people's wellbeing particularly the impact of longer term decisions about future care costs and the implications this could have on people. When they were making decisions about short term care, they supported people with decisions to avoid them needing to move again on review of their needs or financial situation. Senior leaders recognised lack of mental health provision meant people were at risk of crisis in the community. Risks were monitored strategically with controls in place to work with the NHS trusts and Integrated Care Board (ICB) and implement an agreed escalation processes where needed. When support was being accessed from outside of the area, the contracts and quality staff met with the neighbouring local authority monthly to monitor people's needs.

Ensuring quality of local services

When considering the quality of services, local authorities must facilitate markets that offer a diverse range of high-quality and appropriate services and have regard to ensuring the continuous improvement of those services. There were 99 active adult social care provider locations registered with CQC in Blackpool (CQC data, March 2025). CQC assess and monitor registered adult social care services in the Blackpool market, services had an overall rating on the quality of care using 4 descriptions: outstanding, good, requires improvement, or inadequate.

People spoke positively about the local authority's in house provider services. For example, feedback showed the support to be personalised, and people were treated with dignity. However, there was mixed feedback about the quality of care from the wider care market in Blackpool. For example, we heard home care services did not always follow peoples care plans, there could be poor record keeping and responses to feedback, staff turnover was having an impact and lack of meal options in care homes. In contrast, people told us there were options to independently make food in a care home outside of set mealtimes if they wanted, and home care and short breaks for respite could promote peoples independence building social skills and basic living skills such as cooking, cleaning etc.

Home care in Blackpool had 68.00% of services rated good compared to England average of 59.45%, 8.00% required improvement and 24.00% were awaiting an overall rating (CQC data, March 2025). Blackpool local authority had 1 in-house home care service with 4 registered managers due to the variety of services it provided this was rated good in all areas.

Blackpool local authority also had 3 in-house care home services. 2 provided short breaks for respite, and 1 was an intermediate care service for hospital discharge and hospital or care home admission avoidance. All 3 were rated good in all areas. Residential care homes in Blackpool had 3.64% rated outstanding, 74.55% rated good, 12.73% rated requires improvement, 1.82% rated inadequate and others were awaiting an overall rating. 25% of nursing home provision was rated outstanding, 43.75% rated good and 31.25% rated requires improvement (CQC data, March 2025). Senior leaders told us there were 1,461 people living in residential or nursing care homes. The majority were funded by the local authority and the availability of support meant people had choice to find a care home of their preference.

The local authority had quality monitoring staff who had a portfolio of services who they met with regularly and carried out risk assessments to plan monitoring schedules. Staff and partners spoke positively about the supportive relationship they had and responsiveness where immediate actions were required. Consistency in staff meant that they understood providers strengths. Senior leaders told us between August 2023-August 2024 they had no embargoes on regulated and registered care provision, and as of March 2025 they had 1 service they were working with around quality concerns. There were internal governance processes to act on information about providers who required additional support and oversight and as a response the local authority could pause new people from being supported by the service. There were 5 care homes in Blackpool that did not have a contract with the local authority and senior leaders estimated about 20% of people living in residential care homes in Blackpool were self-funding. One partner told us there were challenges around poor standards of care faced by people they supported in some care homes. They told us they had a good working relationship with quality monitoring staff in the local authority and knew when and how to report any concerns about care home quality directly to them. Staff that carried out organisational safeguarding enquiries or individual safeguarding enquiries within care providers told us this did not obstruct the support the local authority could provide to a non-contracted provider. We heard quality monitoring staff took all issues seriously, worked to improve conditions and support offers to providers were said to be inclusive of all providers operating in Blackpool irrespective of whether they were currently contracted with the local authority.

Not all services commissioned by the local authority were CQC registered care providers. For example, advocacy and the carers service. A partner told us contract monitoring the impact of people's experiences by the local authority could be improved, to promote services importance and recognise the differences made. Commissioned drug and alcohol services were contract monitored by the local authority and rated good by the CQC. However, people and unpaid carers spoke negatively about drug and alcohol services. They stated there was a lack of understanding of carers roles, missed appointments and lack of working alongside adult social care staff to support the cared for person. The local authority undertook regular monitoring and service development discussions with these organisations. However, there was more to be done to build on working relationships across all commissioned services.

Ensuring local services are sustainable

A market sustainability and cost of care exercise had been produced in response to the Department of Health and Social Care requirements for local authority's to know what the cost of care was in the area. There was mixed feedback about the fee levels paid by the local authority' and the impact of the cost of exercise. The average residential care cost per week was below the England average.

Providers told us fees had a negative impact on services being able to sustainably provide quality care and at times there was a need to negotiate costs outside of standard rates set. We also heard lower fees set in Blackpool meant that other local authorities who ordinarily pay higher fees in their own areas requested to pay the lower Blackpool rates instead, which partners told us had not felt fair. In contrast, providers spoke positively about consultation and communication with the local authority prior to the fees being fixed. They told us their feedback did not always bring about change but they were able to share concerns and input into discussions.

Senior leaders told us the local authority was part of trailblazer sites for the Fair Cost of Care exercise and fee consultations were transparent and evidence based. They worked with providers who had specialist provision or were meeting specific needs that were beyond the fee structure. They were aware of the challenges around the cost of care on providers but profits had been agreed with providers. The cost of care exercise showed the local authority had mapped the number of care services in the area, fees and current and future sustainability plans. Another senior leader told us cost of care fees was having a negative impact on progress to develop service provisions in the area.

There was a stable market in Blackpool and senior leaders told us they were not seeing providers failing in financial sustainability or quality. According to CQC data, in March 2025 there were 2 deactivated provider locations or had left the market in the last 12 months. There was 'managing the closure of a residential home providing services for adults' guidance for staff. However, this had not been reviewed since 2014 and the local authority did not provide the CQC with any examples of this being implemented or tested to evidence effectiveness. Senior leaders told us no contracts had been handed back due to providers being no longer financially viable. For the period March 24 to Feb 25, there were 11 packages of care that were handed back by care providers these were due to inability to meet new times due to increase in needs, inability to meet specific people's requests for male or female only carers and some inability to meet people's specific additional needs. In all cases, another framework agency was able to take over care.

Gaps in provider recruitment and retention was also a challenge and at times the local authority experienced issues with delays in care and choice due to this. There was a newly implemented Adult Social Care Workforce Strategy which set out vision and priorities to improve coordination of services, recruitment, career development and retention. Senior leaders told us there was an estimated 5,700 roles across adult social care providers including within the local authority's in-house provider services and personal assistants. National data showed 0.19% turnover of adult social care employees (all jobs, all sectors). This was somewhat better than the England average (0.25%). Providers reported that recruitment was increasingly challenging due to competition from other sectors.

There was a lack of skilled staff within the adult social care provider workforce, particularly to provide quality support to people with multiple and additional needs. 45.86% of the workforce had a care certificate in progress, partially completed, or completed. This was somewhat worse than the England average (55.53%) highlighting the need for enhanced training and development opportunities (Skills for Care Workforce Estimates 2024). This had a negative impact on people's experiences. For example, a senior leader told us people with high forensic needs were placed out of area due to there being no local providers who could effectively support this gap in provision. Remote management and supervision to out of area providers had not been successful and meant peoples support had broken down. They were working to address this within their skills academy offer to understand and support providers in how to meet needs of agreed and individualised care plans. However, they had not been able to develop services in Blackpool to a level where they had suitable accommodation and a care provision locally as yet.

The local authority told us they had 100 volunteers working across a range of care provider services including short breaks for respite, day services, and sitting and befriending schemes. They also had a peer support network and emergency workforce team to ensure safe care could be delivered at all times. There was ongoing partnership working with the local health and social care academy. Partners told us the benefit of qualifications offered and college recruitment drives including a 'speed dating' type event for candidates and recruiters. Senior leaders told us they had engaged with social care providers across Blackpool in 2023 on the Workforce Strategy. Providers were issued with a link to a survey and their feedback was included in the Strategy. However, not all providers were aware of the support available. There were aspirations to deliver the new Workforce Strategy action plans and improvements together with health, care and education partners. However, at the time of the CQC assessment more could be done to proactively share the benefits and encourage providers to engage around social care workforce development plans to better meet the needs of people in the area and understand the impact on people's experiences of any actions taken.

Partnerships and communities

Score: 2

2- Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

Challenges were not limited to the local authority within partnership working arrangements. The local authority worked with the Integrated Care System (ICS) and demonstrated a commitment to the ethos of partnership working. Senior leaders and partners told us the ICS faced significant challenges particularly around fragmented services, workforce challenges, poor outcomes and overspend of budgets. The NHS integrated care board (ICB) had been placed at the highest level of NHS oversight indicating a requirement for mandated intensive support, and the NHS acute trust was in special measures and hospital rated inadequate overall by CQC. Key system partners consistently told us they took a shared responsibility for the situation and spoke positively about working relationships with the local authority. However, these collective difficulties were negatively impacting people's experiences and outcomes in Blackpool. There was a real risk there could be further negative impact on service delivery due to pressures around resource capacity and capability. All senior leaders and partners told us investment was needed particularly in community and preventative services in Blackpool.

Blackpool had an all-age joint local Health and Wellbeing Strategy (2024-2028) held by the NHS integrated care board and the local authority. All partnership organisations that contributed to Blackpool health and wellbeing board were aligned to the published strategy as a common purpose and members of the public could see where action would be focused. Many of the priorities remained as set in the last strategy including housing and tackling addiction. The strategy highlighted people experienced significant disadvantage in Blackpool, and this could be seen across many determinants of health. It acknowledged Blackpool to have significantly higher levels of harm for people particularly around drug use and poor housing quality, than England averages. The four priorities were starting well, education, employment and training, living well and housing. There were no overarching objectives around early intervention and prevention, and optimising technology and data. There were aspirations to enable the health and well-being board to monitor delivery and link with the integrated care partnership place-based partnership board around this. However, there was mixed feedback about board attendance. For example, one senior leader told us some key system partners were 'slipping away.' Whereas a key partner told us attendance had improved and there were partnership discussions across the police, NHS trust, Healthwatch, adult social care, integrated care board (ICB), citizens advice, housing, public health and commissioning.

Arrangements to support effective partnership working

The Director of Adult Social Services (DASS) in Blackpool held a dual role as the NHS Integrated Care Board place (Blackpool) director. This had started from 2022 when the ICB was formed, the aim was to bringing funding and services together to improve outcomes local people. However, arrangements to align governance, accountability, and strategy had not progressed as planned. The DASS believed in the benefits of partnership working within Blackpool and had awareness of the health and social care challenges local people in Blackpool faced from an all age perspective. The local authority had some pooled budgets and jointly fund services through the use of the Better Care Fund (BCF) to achieve better outcomes for people. The DASS was the chair of the partnership emergency care board and told us agreements around joint working and funding had been in place even prior to the introduction of BCF. Senior leaders told us partnership working was based on some key shared values including trust and respect, communication, shared vision and goals, flexibility and shared accountability.

There were inconsistent experiences and outcomes for people and unpaid carers. Senior leaders, staff and partners told us more needed to be done to integrate with health, the voluntary and charity sector and progress preventative approaches to make a difference to people's outcomes. A senior leader told us there remained to be some 'silo' working although relationships had improved from 'tense' to 'from strength to strength'. The local authority was leading a research project to better understand the overall health of the community and what they and partners could do to improve it. However, there was more to do to ensure current partnership working was effective and care and support was coordinated. For example, senior leaders and partners were aware more needed to be done to improve mental health services in Blackpool. Senior leaders told us the mental health transformation in Blackpool was an ongoing programme of change, improvement and commitment to an integrated approach from key partners across health, social care and the voluntary and charity sector. There were 5 mental health transformation social work roles working across community and hospital health services to reduce barriers to joined up working and improve people's outcomes. This included an enhanced weekly meeting where people and unpaid carers could attend (virtually) to support people to access services. There was a draft Community Mental Health Team Transformation Collaboration Agreement which aimed to address the need to improve mental health services. The collaboration aspired to transform the way mental health services were delivered by improving colocation of teams and creating new community based integrated multi-disciplinary mental health teams to lead to greater integration of across partners.

There were examples of current partnership working not being effective. For example, the local authority's Joint Strategic Needs Assessment (JSNA) had identified sight loss as a concern in Blackpool. An estimated 4,890 people in Blackpool were living with sight loss in 2022 (3.5% of the population), which had been projected to rise to 5,500 by 2032. The local authority identified sight loss could be linked to deprivation and poor health. Additionally, high levels of deprivation and poor health could also increase people being affected by sight loss. The JSNA referenced a report from a multi-agency project, identifying priority issues and strategic recommendations for action to improve eye health and prevent sight loss within the integrated care system. The JSNA stated work paused due to the COVID 19 pandemic, however in 2023 the NHS trust had made a specific recommendation for further work needed. Senior leaders told us engagement with people with disabilities including people with sight loss had been a long-term corporate priority. There was a new Disability Forum, which was chaired by a person with sight loss and a councillor was a champion for 'disability' and was said to maintain links with a sight loss support charity. Despite this there was currently no joining up of resource to ensure support was coordinated and everyone worked well together to improve outcomes for people. In contrast, there were examples of more positive partnership arrangements. There was a local Learning Disability Partnership Board and Autistic People Partnership Board with a joint-funded strategic plan. The board was co-chaired by people with care and support needs and membership extended to unpaid carers. However, adults within this board told us their impact was limited.

There was also good operational partnership working across police and safeguarding, health and learning disabilities, intermediate care and hospital discharge services. Approved Mental Health Professionals (AMHPs) had agreed partnership working processes with local authorities within the area to carry out assessments on behalf of each other. The learning disability team had access to health databases, and health used the local authority digital recording system so everyone could use the same records and contribute to assessments together. However, staff told us this was due to end and the learning disability nurses would not be using this going forward. Staff told us there was more to be done to maintain working partnerships and without this future arrangements could have a negative impact on people's outcomes.

There were health neighbourhood teams aligned to primary care networks and health led priorities. These were not specifically aligned to local authority community or specialist adult social care teams, but they did have a local authority social worker assigned to each to support partnership working such as taking referrals, and sharing expertise and information as required. There was adult social care staff also aligned within the health led 2-hour response team. Senior leaders told us joint visits could take place and staff had direct access to Blackpool's in-house home care provider to avoid unnecessary hospital or care home admissions. Staff and partners gave negative feedback about how effectively the neighbourhood models were working, and it was felt more needed to be done to align strategic aims and evidence of any positive impact of partnership working in this way. For example, a partner told us, there was duplication of care coordination and support, and data issues which was a barrier to evidence any impact. Staff told us there were improvements needed to include social care priorities and values such as strength-based approaches and a home first ethos.

Impact of partnership working

There was mixed feedback from people and unpaid carers about the impact of partnership working in Blackpool. For example, a person told us that different agencies involved in their care and support worked well together. They felt that information shared between agencies was done appropriately and they understood why the information needed to be shared. In contrast, an unpaid carer told us communication between services had been poor and this had resulted in services that did not meet need and the cared for person being unsafe.

The joint Health and Wellbeing Strategy had been approved within the last year. However, there had been no formal monitoring or evaluation around priorities that impacted adults with care and support needs or their unpaid carers at the time of the CQC assessment. The Health and Wellbeing Board chair told us there were plans for every quarterly meeting to look at one of the priorities, and this had only started in the last week around priority 1 'Starting Well' which focused on pregnancy, infants and children.

Priority 3 ‘Living well’, had more of a focus on adult social care than the other priorities. It set out ambitions to influence system change by supporting effective commissioning and sustainability. It focused on better meeting the needs of people experiencing multiple disadvantages alongside drug and alcohol treatment services, working towards being a trauma informed town, and providing equity in support for people (with drug and alcohol addictions, people with mental health needs and people with learning disabilities, and isolation particularly young adult males). In terms of monitoring to inform ongoing development and continuous improvement, there was a considered target to ‘maintain’ deaths from drug use acknowledging it being a significant cause of premature mortality in Blackpool. This was to be evidenced alongside ensuring the quality and accessibility of specialist substance misuse services. There was an ambition to decrease alcohol consumption as a contributing factor to hospital admissions and deaths, however there was no action aligned to this. There was an ambition to increase the number of people in contact with specialist substance misuse services identifying there were more people living in Blackpool that could benefit from support from specialist services, however there was also no action aligned with this. There was an ambition to reduce the proportion of people with a low ‘life satisfaction’ score to improve people recovering more quickly, and positively impact people’s physical and mental health, however there was also no action aligned to this.

Actions to monitor priority 3 overall included public health ambition to undertake a suicide audit, evaluate local mental health support, develop a trauma-informed charter mark and co-production of service provision, mobilise a service for people living with multiple disadvantage, and develop a recovery from addiction hub. Following the CQC site visit there was an interim monitoring summary published on the JSNA website. The local authority had estimated the rate of drug related deaths in Blackpool was likely to increase. Therefore, identified it was not meeting targets set within the Health and Wellbeing Strategy so far. For people with needs relating to alcohol use, this was a more negative trend identified by the local authority, they had seen a rise in alcohol related hospital admissions over 2023- 2024 and based on the trend analysis targets would not be met. For people with a low 'life satisfaction' score the local authority also predicated this target may not be met. The update also stated the milestone 'Develop a trauma-informed organisational charter mark with [a local university] and people with lived experience to support trauma-informed service provision' would be removed from plans. Senior leaders told us the partnership decision was made not to proceed with establishing a charter mark but to work more closely with the Violence Reduction Network (VRN) Trauma Informed toolkit. The Violence Reduction Network is a Pan-Lancashire programme with participation from all key stakeholders including the Police, Local Authorities, Health and Education providers. All other actions listed had been completed despite the strategy aiming to span until 2028, and there was no current analysis of impact.

Working with voluntary and charity sector groups

There was a lack of market shaping with the voluntary and charity sector groups in Blackpool and missed opportunities around shaping a prevent, reduce and delay offer. The local authority understood that working together with the voluntary and charity sector was central to their efforts in helping to improve people's outcomes in Blackpool. However, there was no unified strategy for engaging with the sector, and partners told us the level of support often depended on which team was involved. When partners had raised concerns, the local authority acknowledged that their relationship with the voluntary sector could be improved but noted a lack of funding to improve these relationships. There were voluntary and charity services, facilities and resources in Blackpool, not all were listed on the local authority's online directory of services. Senior leaders told us they held virtual meetings that all members of the voluntary and charity sector were able to attend to understand and meet local public health needs and hear updates about the local authority. Senior leaders and partners told us the local authority did not actively seek out organisations to attend and the meetings were not specific to social care. However, it was said that every organisation was welcome.

The local authority provided funding and grants. For example, grants for the sector to start 'warm hubs' as warm places for people to come to during the day particularly for people who experienced social isolation. Staff told us men's health was a concern in Blackpool and we heard about the value of the organised support groups run by the local football club and men's suicide prevention and talking groups they could access.

Senior leaders told us about joint work with the voluntary and charity sector around hospital admission avoidance processes and how there was further work to be done with partners to evidence impact on people in relation to all health and care services.

Partners gave negative feedback about the extent to which the local authority involved or made use of them. For example, a partner told us there were ambitions for the local authority to work with the voluntary sector, but this was not being done extensively. Another partner told us, the voluntary sector was not supported well by the local authority. Although charitable organisations had good relationships with the local authority, they told us that support did not extend to the broader voluntary sector, and as a result many voluntary organisations in Blackpool did not have meaningful connections with the local authority.

Theme 3: How Blackpool Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 2

2 - Evidence shows some shortfalls

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

People and unpaid carers had access to the local authority 24 hours a day and 365 days a year. There had been changes in October 2022 to the duty function within adult social care. Where there once was an initial contact team, there was now a rota system for all teams to provide cover to their specific areas. This consisted of business support answering and responding to external contact via telephone, online forms, and email. A registered social worker, manager or non-registered social care assessor screened the information provided by the business support function and acted on the level of risk and needs the person presented with (which included all safeguarding concerns). The person would either be seen that day, a referral for crisis support through admission avoidance pathways could be made, they were allocated to an assessor to make arrangements for assessment, or the referral was triaged to wait for assessment. During evenings, nights, weekends and bank holidays there was an emergency duty team that covered both adults and children's social care functions. Similar to the day teams they had a support function that took initial calls.

Different teams had different processes to act on individual people's risks. For example, the autism and learning disabilities teams had processes to manage positive risk assessment and plans. These promoted a person-centred approach to assessing risks posed to them, including risks to their families, unpaid carers and service providers. Processes supported staff to consider factors when assessing risk, such as the risk of harm or abuse and the level of someone's needs. Providing detail on factors which could increase or maintain risks to people's safety or wellbeing, as well as those which can reduce them. For people waiting for assessment, teams dealt with waiting lists differently, for example the autism team ran twice weekly meetings to review the waiting times and offer signposting. In contrast, duty managers reviewed waiting lists daily in the community team and prioritised allocations based on information available to them.

Who acted on information could also differ and we found inconsistencies in support, training and oversight depending on the roles and functions within different teams. For example, in some teams support workers could carry out Care Act reviews, and unregistered social care assessors could carry out safeguarding enquiries. However, where staff had autonomy or flexible responsibilities the local authority was unable to provide assurances that there was robust and specialist induction and training, regular and quality supervision, and evidence audit and learning to ensure this was safe and effective practice.

There was a staff and partners codeveloped 'Serious Incident, Escalation of Deaths and Post Incident Review' escalation process and training had rolled out to promote transparency of risks and oversight of safety plans and learning. Senior leaders also had plans to develop a risk management tool to better understand and identify any issues and areas of development. However, due to other priorities this had not yet been progressed and was not in place at the time of the CQC assessment. There was a lack of evidence that processes were effective and being routinely monitored to keep all people safe. Therefore, there was more to do to embed governance around the new processes, progress plans and ensure a consistent approach across all teams and roles.

The local authority had information sharing agreements to share personal information in ways that protected people's rights and privacy. This was particularly key between staff and external partners such as the NHS and Police. There was the need for some staff to access multiple systems such as health or provider records, and we were told this was provided.

Safety during transitions

Transition is a time when the differences and gaps between services and support can be particularly evident and problematic. A joined-up approach across relevant partners and agencies is critical to achieve the best outcomes for young people, adults, unpaid carers and their family and reduce risks of any loss of continuity in care and support. The local authority had processes to support pathways when people moved between services and agencies that included children into adulthood, hospital discharge, moving to another local authority, transferring between services and for people who could no longer fund their own care or meet criteria for continuing healthcare funded care.

Unpaid carers had mixed feedback about young people transitioning into adult services. An unpaid carer told us the person they cared for had unmet needs and risks that had regular police and mental health involvement as a child, once they turned 18 years old, they were treated very differently and felt a gap between services with no support for 18 months. In contrast, another unpaid carer told us the transition from children's into adults services had been smooth and plenty of time was given for the cared for person to adapt to new services which was helpful and felt seamless. The local authority had set up an operational social care adults and children's professionals' group as single point of referral for young people who may have care act needs. However, there was more to do to ensure young people known to services received holistic and person-centred planning from age 14 and to ensure transitional safeguarding processes included young adults without obvious care and support needs (such as care leavers) are well supported and do not fall through gaps in services. For example, a partner told us there were challenges and growing demand in young adults with additional needs transitioning into services and requiring therapy assessment and equipment. The local authority and NHS agreements funded 'episodic' support as opposed to specialist longer term support. Young adults who had an Education, Health and Care Plan (EHCP) and parent carers were requesting assessment and support that current prevention, assessment and equipment services were not prepared for. We heard young adults needs often presented very individual to the person and requests for 'something different' in terms of equipment and use of equipment in ways that staff and services were not confident in. NHS neighbourhood teams worked with local authority social workers to support peoples transitions to adult services, however we heard families in Blackpool were used to 'wrap around services' from childrens services and expectation management was a challenge when it came to moving to adults services. There was some work being done with another NHS trust to gain ideas in how to improve this area, and therapists had recently completed 'train the trainer' training to share the new knowledge.

The Care Act places a duty on local authorities and the NHS to work together to ensure the safe and timely hospital discharge of people with care and support needs. The NHS and local authorities should use the best evidence available, develop and apply local processes that ensure all people with care and support needs to achieve appropriate, timely and safe hospital discharge. Local authority staff worked in the Accident and Emergency (A&E) department of the physical health hospital. They sourced referrals via a daily walk round with a health safeguarding team, as well as notifications from the ambulance service and community social workers, and direct bleeps from doctors or nurses. This supported people's needs being identified that might not otherwise be recognised, timely discharges from the hospital as well as immediate response to people's needs such as acting on environmental issues or caring responsibilities including finding care for pets. Support workers could start conversations around consent and planning for home early rather than waiting until people were medically optimised. People could also avoid being admitted to a hospital ward by staff utilising discharge to assess pathways including intermediate care if they had accessed A&E for purely social reasons. Referrals to arrange physical health hospital discharges went to the 7 day Transfer of Care Hub (ToCH) this ensured all referrals had a consistent approach to monitoring and promoting safer discharges A ToCH is a health and social care coordinating centre linking all relevant services to aid discharge and recovery decisions, and the local authority was a key partner in effective delivery and also funded carers service link workers to advice and support unpaid carers when the person they cared for was admitted to hospital. Staff told us once a person had been triaged by the transfer of care hub and a plan was in place they always followed up with a telephone call to the person the day after discharge to ensure their needs were being met. If there were any concerns staff would carry out a face to face visit including at weekends. If someone accessed a discharge to assess pathway including through the local authority's internal home care provider, they would also receive a call from the team within 3-5 days to check in, then 2 weeks later a full assessment would be carried out. If a person was transferring or returning to an external care provider at the point of discharge, there were timely processes to support this. Senior leaders and staff told us there were processes for people in physical health hospitals who initially had not been informed of all support

offers or declined support offered to them for a safe discharge. Local authority staff took referrals from ward staff and could visit or call people that may pose a risk to themselves if they were discharged without support. The local authority had rapid response processes separate to NHS rapid response processes to provide support and avoid another hospital admission.

For mental health hospital discharges, local authority staff recognised the importance of building early relationships when people were admitted to hospital and understanding peoples experiences particularly when it was their first time back in the community from being in hospital or their first experience of psychosis. Local authority staff were located in the mental health hospital in Blackpool, they also had dedicated staff for when people from Blackpool were admitted to out of area hospitals. For those out of area staff made initial contact via video calls to start processes to bring them back into Blackpool. Staff began working with people as early as possible and had access to support workers within the team who could work with people for up to 4 weeks to support their recovery out of hospital they could help with housing, appointments and linking with early intervention services. Following hospital discharge joint reviews with health would then take place. However, there was mixed feedback about the internal transitions between the local authority's under 65 and over 65 community mental health teams. Some staff told us people could be transferred based on their age as opposed to whether needs were stable or being met, which had resulted in some people being distressed around the change. Whereas other staff told us teams could be flexible in their approach to continue to work with them and support a safe transition. There were also inconsistencies in the community support work offer and some staff told us lack of enablement support at home meant they had to rely on commissioned longer term care as a result.

People and unpaid carers gave negative feedback around the local authority's effectiveness to identify, communicate and manage risks to people between hospital discharge arrangements. Particularly in relation to people with mental health needs, and people with needs relating to drug and alcohol use. People told us the systems in place did not always manage risks, lacked transparent processes and evidence of learning to keep people safe. In contrast, staff and partners consistently spoke positively about arrangements for safe hospital discharge. A partner told us local authority staff often prevented unsafe discharges and were described as 'champions for effective discharge'. Another group of partners told us local authority staff worked well with them to share support plans and ensure there was access to support prior to people being discharged from hospital. This supported people's experiences of hospital discharge and minimised their length of hospital stay.

Contingency planning

Contingency plans, also known as emergency plans, agree and show what support is needed if an unpaid carer, paid services or local authority were unable to look after the person or groups of people with care and support needs. The local authority undertook contingency planning with care providers as contracted organisations commissioned by the local authority, and individual business arrangements with people who managed their own direct payments to ensure plans were in place in the event of a crisis or disruption in care delivery. There was an adult social care department business continuity plan for overall delivery of Care Act responsibilities to ensure plans were in place in the event of failure or threats in critical statutory functions. However, not all documents had review dates and those with dates had not been reviewed as planned.

People and their unpaid carers gave negative feedback about individual contingency plans within the local authority. For example, unpaid carers told us the local authority had not considered their caring role and future plans. Most had planned for family to step in if there was a crisis, but this had not been discussed with the local authority. Some unpaid carers had discussed contingency planning however this was not in depth and actions were to call the local authority in a crisis should it arise as opposed to agreeing a plan that would work for them and the person, they cared for and prevent avoidable stress where possible. An unpaid carer told us they had spoken to the local authority on a Friday asking for support but found services were over stretched and there was no support available.

Staff told us improvement was needed to effectively plan for emergencies with unpaid carers and within individual care and support plans. Staff acted on requests for crisis support and acknowledged pro-active contingency planning could help to avoid issues arising from situations. For people with mental health needs, mental health staff told us they documented relapse signs and how to contact initial response services within contingency planning for people. This helped a person access community support before needing hospital. Senior leaders had carried out 'case file' audits around contingency planning within people and unpaid carers individual care and support plans and found risks and contingency plans were not always identified and an action had been recorded as completed to remind staff of correct processes. Following the CQC site visit, senior leaders also told us they had aspirations to explore further how staff should describe, confirm and improve recording of contingency planning with unpaid carers, as well as people with care and support needs. However, at the time of the CQC assessment action taken was not effectively embedded. More needed to be done to evidence effective contingency processes around people's experiences and ensure consistency of preparedness for possible interruptions within people's individual care and support.

Safeguarding

Score: 1

1 -Inadequate: Evidence shows significant shortfalls

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

Safeguarding is the process of ensuring people at risk are not being abused, neglected or exploited. The local authority had several ways to report a safeguarding concern this could be through telephone, email, or online form. Mostly, business support staff took initial concerns and referred information to duty staff and managers to triage. All social workers in Blackpool undertook section 42 enquiries, unregistered staff (case assessors) could also carry out enquiries. Section 42 enquiries could not be closed without management approval on the digital system, however concerns or risks raised that did not reach enquiry stage did not receive the same oversight or assurance. Staff within brokerage, commissioning, and contracts also received quality concern information that could transpire into safeguarding concerns. Partners told us they knew how to refer safeguarding concerns, and the systems were accessible.

Adults at risk reported varied understanding and explanations about what was a safeguarding concern and how to raise these. Some reported clear explanations, particularly those with previous experience in the health and social care sector. However, an equal number did not receive any explanation, resulting in uncertainty and confusion. A person told us they had raised financial abuse concerns but had not been listened to and they were not offered support until a different social worker became involved at a later date. Staff told us there was a danger not all information was recorded if information shared was not an obvious risk. Staff told us referrers often used 'buzz' words to progress the need for support which could deter trust in information being shared. For example, staff told us this often applied to referrers reporting 'people were hoarding', when staff found they were not. However, in another example a staff member had been allocated to investigate self-neglect concerns, and we found they did not follow the local authority selfneglect framework and provided no rationale for the steps they took to not record as a safeguarding concern. During the site visit the CQC spoke with senior leaders about these concerns and leaders immediately updated staff guidance to provide further clarification to staff around indications of potential safeguarding and staff responsibilities. Whilst this showed senior leaders were responsive, it was only actioned as a result of CQC identifying this as a concern and it was too early to understand or evidence how effective any action had been.

Previous to the CQC site visit there had been process developments such as a draft Adult Social Care Guidance created for staff and partners to identify and respond to safeguarding concerns. This was an update from the existing Pan-Lancashire policy and clear threshold matrix already in place. The local authority had also created new roles to prioritise improvements and safeguard adults in Blackpool. This included 3 safeguarding adults practice development leads who had been in post a few months, and a Principal Social Worker dual role as Head of Practice Development and Safeguarding Assurance which had started 2 months prior to CQC site visit. There was a focus on improving section 42 enquiry waiting times, embedding 'making safeguarding personal' approaches and increasing staff confidence to carry out and complete section 42 enquiries.

There had been recent developments to the Blackpool Safeguarding Adults Board (SAB) following separation from a previous Pan-Lancashire model alongside two other local authorities. There was an independent chair with clear governance structures and plans, subgroups and direct links to key system leaders within the local authority including the Director of Social Services (DASS). Senior leaders, staff and partners consistently told us about the positive impact this was having to progress improvements and partnership working for safeguarding adults work in Blackpool.

We had mixed feedback from people with or at risk of care and support needs and their unpaid carers about how safe they felt. For example, national data showed in Blackpool 90.71% of people who used services felt safe, this was the similar to the England average of 87.82% (Adult Social Care Survey, 2023-2024). Additionally, 84.91% of unpaid carers felt safe which was somewhat better than the England average of 80.93% (Survey of Adult Carers in England, 2023-2024). However not all felt safe for example, the LGBTQIA+ community, migrants and ethnic minorities in Blackpool did not.

Safeguarding training promotes an understanding of what preventative actions can be taken to reduce risks to adults. It also aids the quality of referrals made and the skills and knowledge required to investigate concerns for people with care and support needs and their unpaid carers. National data showed 56.01% of the social care workforce (independent and local authority staff) in Blackpool had completed safeguarding adults training, whilst this was somewhat better than the England average of 48.70% it demonstrated 43.99% of staff in social care roles had not completed or recorded safeguarding training (Adult Social Care Workforce Estimates, Skills for Care 2024). The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions for people who may lack the mental ability to do so for themselves, 32.25% of the social care workforce in Blackpool had completed Mental Capacity Act and Deprivation of Liberty Safeguards (MCA, DoLS) training. This was somewhat worse than the England average of 37.58%. Partners told us Blackpool Safeguarding Adults Board had not had a multi-agency training offer or plan until recently. However, there was now a new and accessible website which offered the social care workforce (independent and local authority staff) and voluntary organisations in Blackpool options for training and the board was beginning to monitor who was accessing this. However, it was too early to understand or evidence how effective this was and what impact it was having on peoples outcomes.

Staff consistently told us there were staff confidence issues around carrying out safeguarding work. Staff assurance processes around taking information, triaging risk, carrying out enquiries and closing concerns and enquiries had areas for improvement or were not yet fully embedded. Senior leaders told us all staff involved in safeguarding work had completed mandatory level 1 safeguarding training within the past 12 months. Blackpool Safeguarding Adults Board defined level 1 training as basic awareness for healthcare receptionists, volunteers, carers, taxi drivers, maintenance workers, sports coaches, and police staff, as examples. Senior leaders told us staff also had access to 'undertaking effective section 42 enquiries (level 3)' 'designated safeguarding lead (level 3)', and domestic abuse as additional training but these were not mandatory to complete. There was no specific induction or training for staff to be deemed competent to undertake any areas of safeguarding work. However, staff and senior leaders told us all staff had shadowing opportunities, oversight of a safeguarding lead (usually a manager) and only confident and willing unregistered staff carried out section 42 enquiries. For newly qualified social workers there was a holistic training programme and assessment of their abilities to support them in their first year. There was evidence of safeguarding discussions taking place in 1:1 supervision with staff that carried out section 42 enquiries. The local authority had also prioritised dedicated safeguarding 'learning circles' and a safeguarding peer support group with staff to promote best practice which staff spoke positively about. Staff and senior leaders told us there was more to do to provide assurance all local authority staff involved in safeguarding work had effective supervision and training to increase staff confidence and provide quality assurance to evidence learning was being embedded and making a difference to people's outcomes.

Responding to local safeguarding risks and issues

The local authority reported on safeguarding risks and issues in the area. The most common types of abuse in Blackpool were neglect and acts of omission, physical, financial or material and psychological. The Safeguarding Adults Board (SAB) had a strategic vision, aims, priority objectives and a 3 year plan which focused on safeguarding effectiveness, workforce development and making safeguarding personal. Between 2024 and 2027 the board planned to carry out a multiagency audit and training alongside the agreed work programme to evaluate and inform strategic actions and future plans to reduce risks and to prevent abuse and neglect from occurring. A partner told us there was more to do around taking strategy forward as the priority focus had been on getting the basics of the governance structures and partnership working right.

There was not an independent scrutineer for the SAB, however the independent chair had scrutiny experience and gave examples of this working well with police and health partners as part of their role. The work of the SAB was reported to council scrutiny committee. There were recognised discrepancies or gaps in data to inform strategic understanding, however improvements were beginning to be evidenced. For example, a partner told us 12 months ago the SAB did not have a data set informed by local authority safeguarding data. They were aware there was understaffing and high levels of sick absences in the local authority impacting performance in Blackpool. It had taken time for the local authority to respond to requests for access to safeguarding data however the SAB could now see improvements per quarter around concern to enquiry conversion rates, the length of time financial abuse enquiries was taking, and outcomes and satisfaction rates. There was more to do and plans for a ‘deep dive’ focus to understand peoples outcomes.

Staff told us homelessness, drug and alcohol use, mental health needs, and hoarding were all concerns that put adults at risk in Blackpool. There had been some conversations started to introduce a Multi-Agency Risk Management framework in Blackpool. However, this had not been progressed at the time of the CQC assessment therefore staff told us there remained unmet high risks for some adults at risk of harm some who were not identified as meeting the statutory safeguarding threshold. Staff did have processes to guide them to carry out 'A Multi-Agency Case Conference/Risk Assessment Planning Meeting (where applicable)' as a means to reduce risks of harm or abuse reoccurring in the future. However, there was more to do to work with partners and focus on a collaborative, multi-agency approach to manage risks before they escalated into a crisis.

Senior leaders and partners told us recent digital system changes had supported improvements to recording, for example previously they had issues with unrecorded domestic abuse which had now been resolved. However, there was more to be done to ensure accurate identification and reporting of concerns was reflecting people's experiences and risks within Blackpool to prevent or protect people from abuse and neglect. For example, discriminatory abuse is a form of abuse and neglect and can take many forms whereby people's individual circumstances should always be considered it can include forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion. The local authority had clear guidance about discriminatory abuse within their safeguarding policies and listed examples of risk indicators that could lead to a section 42 safeguarding enquiry. Staff and senior leaders were aware of racism and homophobia in the area, and key partners told us hate crime was a concern. We heard from a person who told us they had experienced hate crime, and a local LGBTQ+ Futures Report identified there were seldom heard people with mental health risks or needs who had been victims of hate crime in Blackpool. Responses included 'I think people like us are not accepted by society, and we will not be treated fairly and dealt with if we report', 'I was afraid' and 'I was attacked and suffered transphobic abuse'. The Pan Lancashire Hate Crime Strategy 2022-2025 was supported by Blackpool Council and set out the tone and direction for a range of public bodies and organisations across Blackpool and two other local authority areas to collectively address hate crime in all its forms, by educating, promoting, and implementing hate crime legislation through a cohesive partnership approach. In 2024 hate crimes in Blackpool were recorded by the police as 242 being race related followed by 94 related to sexual orientation and there had been a reduction since the implementation of the strategy. However, for the past two years the local authority's public data showed they had not had a reported safeguarding concern relating to discriminatory abuse. Senior leaders told us where lower than 5 concerns were reported in a defined period these were reported as 0. Staff, partners and senior leaders spoke positively about a pilot taking place where one social worker was working directly within the police Vulnerable Adults Team. However, senior leaders and partners told us this was something that needed more attention and aspired to work more closely with voluntary

and charity partners, and the police to encourage reporting, address and reduce crime and end discriminatory abuse. Partners told us there was a need for improved recording or understanding within frontline teams and/or referrers. Data quality was an area for improvement on the SAB risk register as an area to monitor and scrutinise the local authority's performance.

A Safeguarding Adult Review (SAR) takes place following the death or serious injury of an adult as a result of harm, abuse or neglect. The review looks at whether partner agencies could have worked more effectively to protect the adult. There had been 1 SAR concluded within 2022-2024. A young adult with a learning disability had died at home as a result of neglect. Senior leaders and partners had identified missed opportunities and the need for improvements around professional curiosity, understanding of consent where there is risk, role of unpaid carers, mental capacity and independent advocacy, and partnership working with other local authorities to ensure information is shared and escalated where required. Partners, staff and senior leaders told us there had been system learning and processes put in place to ensure there was improved cross local authority working when people moved in or out of Blackpool. An action had been a safeguarding voice report commissioned with Healthwatch to understand people's experiences of safeguarding and provide the local authority more information to act on as learning.

The local authority had processes to agree lessons to be learned when referrals did not meet criteria for a SAR, but harm or death had already occurred. The local authority had introduced a 'post incident review form' which promoted staff reflection on their practice, and key learning points had been monitored by senior leaders. For example, a senior leader told us a person with both learning and physical disabilities had died within a supported living setting. It was found there was learning for both the care provider and the local authority particularly around missed opportunities to raise safeguarding concerns. There had been a lack of professional curiosity which had led to risks being dealt with in isolation. A SAR referral was made but a formal review was not needed as learning had already been identified. Senior leaders had put together an action plan with legal team support. Actions included refreshed safeguarding training and lessons learned conversations for those involved, and a summary to all teams. However, at the time of the CQC assessment it was too early to evidence the impact of the learning and ensure this would reduce future risks.

Responding to concerns and undertaking Section 42 enquiries

Section 42 enquiries are the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. There was a multi-agency 'safeguarding matrix threshold' which provided clarity for referrers and staff when a safeguarding concern should be raised, when section 42 enquiries maybe carried out, and to support staff applying judgment consistently. National data showed initial concerns and section 42 enquiries rose year on year in Blackpool between 2019- 2023 which was similar to national trends, but then numbers dropped in from 2023. Between 2023-2024 Blackpool had 1375 initial concerns referred and of these 535 converted into section 42 enquiries (NHS Digital, 2024). Senior leaders and partners told us the drop was likely due to a more proactive use of the safeguarding matrix threshold to aid decision making and determine whether a concern met section 42 criteria.

When safeguarding enquiries were conducted by another agency such as care providers, mental health or acute physical health hospitals, staff told us the use of a daily duty huddle (internal) was where duty staff could dynamically risk assess the situation to agree if delegation to carry out the section 42 enquiry outside of the local authority could take place. In Blackpool approximately 36% of safeguarding concerns were related to health or social care providers. 22% of concerns were related to neglect and acts of omission and 6% were recorded as organisational abuse. Staff told us there was a lack of recording around organisational abuse and instead it could be recorded solely as neglect for individuals as opposed to identifying the bigger picture. However, section 42 enquiries were taking place and there were plans to improve this further by practice development leads working more closely with commissioning and contracts staff to ensure information was more robustly shared.

There was mixed feedback from partners about responses and support from the local authority in relation to rationale and outcome from safeguarding enquiries, including those which did not progress to a section 42 enquiry. Partners that referred into the local authority to report a safeguarding concern did not always hear back and they did not always receive recommendations or lessons learnt to take forward to prevent any potential future risks or concerns to the people they supported. However, when concerns were investigated under a section 42 enquiry, we were told staff provided support through the process. Staff told us decisions around outcomes and whether a case had met thresholds were not always being communicated with referrers. Staff and partners were not aware of any external work that had been done with potential referrers about the appropriateness of referrals. However, senior leaders had plans to improve this area by working with staff to ensure that referrers were kept up to date on progress and ensure they had an understanding of the safeguarding process. They stated that timeliness had been an issue with cases not progressing due to staff absence and practice development leads were working on this area. However, this had not yet been embedded, for example one partner told us they had suggested a face-to-face session between staff to gain a better understanding of the safeguarding work the local authority carried out. However, this had not yet been acted on and they told us there remained communication challenges. According to the local authority's own analysis of its data, in February 2025 there were 31 people who were awaiting an outcome following an initial concern. Between February 2024- January 2025 the median wait time was 1 day; however, the maximum wait time was 125 days. Of the people waiting over a 12 month period 91.7% waited up to 4 weeks and 2.7% people waited over 8 weeks. Senior leaders told us delays were mostly due to delays in information gathering including seeking consent if not confirmed by referrer. Senior leaders told us this could be because a person was too unwell, a person's representative was not available, support was not provided to people alongside police enquiries or referrers or parties involved had not provided sufficient information. The volume of concerns and staffing capacity also had an impact. Staff took a priority approach to responding to concerns depending on the assessed level of risk and taking into account whether the person has been made safe. According to the local authority's data in March 2025 they had seen a 50% reduction in

the conclusion of safeguarding concerns not concluded within 5 days from a peak in December 2024. In October 2024 they had 19 people waiting over 5 days for initial triage of concerns compared to 11 people over 5 days in February 2025.

There were 14 people awaiting allocation for section 42 enquiries. Between February 2024- January 2025 the median wait time was 2 days; however, the maximum wait time was 135 days. Senior leaders told us delays could be related to obtaining peoples consent and awaiting key feedback and outcomes from the police and health partners, joint work was said to be underway to address this and ensure that wherever possible, consent is established promptly, and enquiries can run concurrently. The local authority had received feedback from the coroner in 2023 following the outcome of an inquest. The coroner had found an enquiry had taken 4 years to conclude, concerns were raised that since the persons death no internal investigation under section 42 enquiry had been held by the local authority. Therefore, no recommendations or learning in response to the persons death had been made. Since the coroners outcome in 2023 the local authority had made changes in processes and improved practice audits, learning and support in response to the findings. Current data on wait times showed this had significantly improved, but over the past 12 months there remained a number of people waiting for longer than the local authority had set targets for. According to the local authority's data in March 2025 they had seen a 24% reduction in section 42 enquiries that were not concluded within 60 days since November 2024. In October 2024 they had 190 people waiting over 60 days for section 42 enquiries to be completed compared to 147 people over 60 days in February 2025. However, the length of time to conclude a section 42 enquiry could negatively impact peoples wellbeing, and at the time of the CQC site visit the local authority did not evidence they were sufficiently reducing abuse or harm to all adults at risk.

All section 42 enquiries came to senior leaders for closure, mostly due to managers being the lead within the safeguarding enquiry and processes ensured staff could not 'sign off' their own work to ensure robust oversight. However, a senior leader told us these processes were also a cause for delays in wait times and something the local authority was aware of and working to improve. Staff and senior leaders also told us delays in staff recording outcomes on the digital system and data quality issues contributed to inaccurate wait times. Senior leaders told us monthly meetings to review progress were now in place with a set agenda and a tracker for all enquiries that was reviewed at each meeting. Managers had been supported to focus on the top 20 safeguarding enquiries over 60 days each period and all safeguarding concerns over 5 days. They told us clear targets on data and performance had been introduced and shared with all teams. However, there was more to do to evidence this was having a positive impact on people's outcomes and sustainable to provide strategic assurances it was effectively reducing risks to people.

Deprivation of Liberty Safeguards (DoLS) are legal protections (authorisations) that ensure people who are unable to consent to their care and support arrangements either in hospital or in care homes, are safeguarded. The local authority had a 1 dedicated Best Interest Assessor (BIA) and 2 business support roles to support DoLS. Social workers could access qualifications to become a BIA and join a rota to cover assessments. The local authority did not have data to understand how long a DoLS application took from receiving a request to authorisation. However, they did monitor the length of time to allocate a request for a mental capacity assessment to be carried out by a doctor, this was a median wait time of 6 days and a maximum of 65 days between February 2024- January 2025. One senior leader told us waiting times for allocation of a BIA (which was needed after a doctors assessment) had been consistent over the last 12-18 months at approximately 5-7 weeks however evidence of this was not available to the CQC. We were told if the wait time reached 8 weeks or more the local authority had access to agency staff as independent BIA's to address this. In August 2024 the number of DoLS requests waiting to be completed was 281. Senior leaders told us they were committed to respond flexibly to the demand and were working with the local university to train more staff to carry out DoLS assessments. However, by February 2025 this had only dropped slightly to 263 requests awaiting completion despite being told new requests were ‘relatively static’ over a rolling 12-month period. A senior leader told us care providers and the acute hospital trust were educated in the use of DoLS and submitted requests when appropriate and the local authority did not anticipate any unprecedented or unexpected level of demand. Therefore, the current processes to manage usual demand were not reducing wait lists and whilst there had been improvements to utilise best practice tools and aspirations to increase staff resource there was still more to do to evidence any positive impact of future plans on people waiting.

There were safeguarding quality monitoring audits taking place. These included quality monitoring of initial safeguarding plans and actions to reduce future risks for people were in place and acted on. Audits were carried out on a dip sampling basis by senior leaders monthly, with an oversight report every 2 months. Due to improvements made to digital forms and mandatory options for staff to record, senior leaders were able to see quality improvements in safeguarding practice. However, there was more to do to embed learning and demonstrate effectiveness. For example, staff told us they were having audits of their safeguarding work, but these were new and sometimes the lessons drawn out lacked guidance about how to improve practice. Some staff who completed safeguarding work were aware of safeguarding audits but had no direct experience of them or learning as a result. A senior leader told us there was not yet a formal feedback route that assured leaders that feedback was actioned and was making a difference. However, feedback from individual audits went to managers via various methods such as email or telephone call to share with frontline staff.

Making safeguarding personal

Making safeguarding personal is an approach to safeguarding to keep the wishes and best interests of the adult at risk at the centre of the safeguarding enquiry and any plans to reduce future risks to them. The principle is to support and empower a person to make choices about how they want to live their own life, seeking to improve quality of life, wellbeing and safety. In Blackpool, where possible, staff who knew the adult at risk best would carry out an enquiry. This reduced the amount of times people needed to share their experiences and promoted an approach to align actions with the care and support needs they had.

There was a subgroup of the safeguarding adults board (SAB) dedicated to driving improvements to making safeguarding personal in Blackpool. The local authority commissioned a safeguarding voice report by Healthwatch in 2023, this was alongside two other local authorities in the area but broke down specific feedback and outcomes in Blackpool. There was mixed feedback from people and their unpaid carers who had been involved in safeguarding enquiries. For example, people had felt listened to and involved in safeguarding processes. However, there was an emphasis to ensure their opinions were always considered and they had regular involvement in meetings. Some people did not feel heard or had not been actively involved, referring to poor communication, lack of empathy, and inconsistent approaches as barriers to effective participation. There were audits taking place to monitor the compliance of recording people's desired outcomes and the quality of plans to ensure safeguarding responses were appropriate. Whilst there was improvement and business plans, there was not a specific action plan to address concerns raised within the safeguarding voice report and progress was not evident. For example, within the adult services improvement plan the local authority had wanted to strengthen the process of capturing feedback and experiences following section 42 enquiries from the person, unpaid carers, advocates, and partners. However, targets set had not progressed at the time of the CQC assessment.

Advocacy support was not consistently considered for people at the point of agreeing risks that met thresholds for section 42 enquiries. However, there were processes to refer for advocacy support if an adult at risk did not have a family member or friend to support them, and they lacked mental capacity around the concerns. Advocacy support prioritised safeguarding referrals depending on the level of risk. In Blackpool, 75.00% of people that lacked mental capacity around their safeguarding concerns were supported by an advocate, family or friend. This was somewhat worse than the England average of 83.38% (NHS Digital 2023-2024). This showed there was more to do to ensure staff and partners understood people's rights, including their human rights, their rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives. A senior leader told us there had been developments to improve referrals and recording of these by creating mandatory fields within digital forms. However, audits showed there remained a challenge to ensure consistency in practice in people always having a voice in safeguarding meetings and embedding principles across staff practice. As a result, the Principal Social Worker and practice development leads had created a business plan with priorities and actions around this. Actions had been started such as carrying out 'learning circles' with staff groups specifically around making safeguarding personal principles. We also heard there had been a redesign of the newly qualified social workers first year in employment which now had a focus on making safeguarding personal. There had been some demonstratable improvements shown. However, at the time of CQC's assessment, learning and improvement around people's experiences in safeguarding work remained limited.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 1

1 - Evidence shows significant shortfalls

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

The Chief Executive and councillors oversaw the local authority's leadership and management structure. The Director of Adult Social Services (DASS), and Director of Public Health reported into the Chief Executive. Some roles that supported Care Act responsibilities such as business intelligence, people's finances, feedback and complaints reported into a resource directorate as corporate services. Social care commissioning had an 'all-age' approach and reported directly to the Chief Executive. The Principal Social Worker (PSW) reported into the Assistant Director of Adult Social Care who reported into the DASS. Key senior leaders lived in Blackpool and had worked for the local authority for a number of years within various posts. There was a sense of pride in serving the local people in the area.

There was a lack of robust governance. For example, there were shortfalls in coproduction, implementation of aspirations and monitoring of guidance, policy or strategy to ensure standards and actions were effective and making a difference to people's outcomes in Blackpool. Where there was staff guidance, policy or strategy submitted to the CQC, most was in a draft format, very newly created or in some examples out of date. This demonstrated staff had not had clear processes to understand and carry out Care Act responsibilities and expected standards. Where guidance, policy or strategy had been created it was too early to evidence any impact it was having.

There were adult social care senior management team meetings and senior leaders told us feedback from staff meetings and periodic checks and audits fed into these. All frontline staff had assigned managers, and these managers attended joined up management meetings to support working together. The DASS told us there had been some changes to improve leadership capacity and address gaps in resources to carry out key actions needed over the past two years. There had been investment in an Assistant Director of Adult Social Care role, a PSW role had been created (previously split between two operational heads of service), and 4 practice development leads. They had experienced high turnover in management positions and longstanding gaps but they were now filled. We heard the additional leadership and management capacity had directly led to a reduction in much higher wait lists experienced post-pandemic (COVID 19).

A crisis intervention approach was found at all levels within the local authority. Staff and partners consistently told us senior leaders were approachable and responsive to individual safety concerns. However, they also told us there was ambiguity and a lack of staff engagement. The leadership approach had resulted in lack of clear strategic direction and delayed pace around necessary actions needed to ensure effective governance, management and accountability arrangements. For example, the local authority had been rolling out a new adult social care assessment model for over 2 years. Senior leaders consistently told us this had taken longer than expected to implement and there was mixed feedback as to why it had not yet been successful. We found there was a lack of quality assurance embedded around the roll out including staff supervision assurances, a broad range of thematic audits, effective staff guidance, robust data analysis and commissioned resources to deliver the vision. Senior leaders consistently told us the delayed implementation was mostly due to workforce confidence and performance issues. This was a key priority for the PSW role to address by further building on staff confidence and demonstrating the positive impact the changes to assessment and intervention would have on people's experiences. The DASS and PSW had held staff briefings to listen to staff challenges and promote the change needed to assessment and intervention. The PSW had open lines of communication with the Safeguarding Adults Board (SAB) chair and DASS and was aligned in the senior leadership structure as independent from operational management. This showed the local authority's commitment to the value and credibility of having a PSW to lead, develop and standardise practice through engagement with front line staff. The DASS felt the PSW role had already begun to make a difference particularly reviewing and refreshing the offer of learning circles to build on foundations with staff. However, it was too early to evidence any impact the role could have on influencing and shaping future practice and strategy. There were examples of how the PSW linked with senior leaders around risk and practice considerations. However, there was more to do, as not all staff were clear about how the local authority was working towards reducing risks to keeping people safe where there were shortfalls in carrying out Care Act duties.

Staff communication was not robust within the local authority. Staff told us team meetings were not always regularly held or attended; however, staff did always engage and value daily duty huddles to discuss assessment practice and individual risk to people with care and support needs. Attendance for supervision was also sporadic. Depending on roles some staff received 6 monthly 1:1s, others had targets for 6 weekly but staff told us these did not always happen. A senior leader told us the department struggled to deliver on supervision targets as when teams were busy supervision would be compromised. To tackle this there was a supervision tracker for managers to complete and monitor compliance. For newly qualified social workers senior leaders were assured supervision was more frequent. There were plans to develop an electronic supervision monitoring system and roll out across teams to support performance monitoring. However, this still needed to be implemented.

The DASS visited team to team once a year to talk to staff in detail and emails went out to share in daily duty huddles. However, there was mixed findings as to how effectively key leadership messages were shared with staff. There were plans to develop a newsletter and an adult services library for staff to improve communication, however this had not yet been implemented.

There had been changes to ensure adult social care had its own focus in cabinet and to support councillors to be informed about risks facing adult social care. Challenge and scrutiny formally took place where senior leaders could be held to account through questions and papers. However, the effectiveness of scrutiny and local government representatives was inconsistent. A senior leader had sourced a Local Government Association (LGA) mentor which had empowered them to further understand adult social care challenges and drive forward best practice to make positive changes in Blackpool. The local authority held a risk register which was regularly monitored by senior leaders. Not all risks found during the CQC assessment were identified within the risk register or improvement plans. However, there was enthusiasm by some senior leaders to improve and learn from open and transparent practice. For example, progress had been made around carrying out post incident reviews, this was having a positive impact around understanding the effectiveness of risk management and escalation arrangements. However, there was a need to further embed this approach across all areas to further understand local risks before they occurred and evidence effectiveness.

Strategic planning

The local authority's vision was not clearly defined or consistently practiced. There was a heavy focus on improved finances and funding being the solution to the challenges we found. This may have distracted focus and vision on what could be done. There were ideas within draft prevention, commissioning and new workforce strategy and changes started around the assessment approach. However, we found a peer review had brought up similar concerns 2 years ago, and although the peer review had led to an action plan, on the CQC's review of the recommendations little progress had been evidenced.

The corporate leadership board met weekly, and this was where development of strategy, vision and actions were overseen. However, at the time of the CQC assessment staff and senior leaders did not have clear direction informed by adult social care strategy and vision. For example, the vision for adult social care 'Live Well' was developed within the corporate leadership board and aimed to support staff in identifying their role within the vision. There were practical examples of how staff carried out the vision, such as conversations with managers in daily duty huddles. Whilst the vision linked with generic themes across health partnerships it was not directly underpinned by adult social care strategy, frameworks, target operating models or strategic planning to influence change and monitor any action needed to be taken.

Senior leaders and partners consistently told us dealing with crisis and financial pressures significantly hindered the local authority's pace to deliver actions needed to improve care and support outcomes for people and local communities. Senior leaders and partners consistently told us there was a greater need for partners to come together but there was a lack of sustainable action to effectively enable this. There were partnership forums and boards where senior leaders from key partners came together. Senior leaders told us there was multi agency work underway to prevent or address health and care issues earlier in a person's journey in the most deprived areas of the town, and to avoid conveyance to hospital where health and care needs deteriorate, requiring intervention, bringing together community health and care services in a more responsive closer to home approach. However, there were significant system challenges and difficulties to find adequate resource to ensure effective delivery in joint plans particularly to move to a preventative approach to prevent, reduce or delay people developing care and support needs at the time of the CQC assessment.

There was a lack of evidence based use of information about risks, performance, inequalities and outcomes. A senior leader told us corporately the local authority was flexible to change what was needed and if something didn't work, they would change it. Strategic planning from data was a challenge for the local authority. We found and senior leaders, partners and staff consistently told us there were data quality issues and gaps. This impacted the accuracy of information, evidence to plan effective resource and monitor any effectiveness or learning of delivery of Care Act duties that could be drawn from this. The local authority had plans to address this for example through progressing recruitment to dedicated data support for adult social care department.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems. Staff had access to mandatory training

Blackpool Council reported quarterly about personal data breaches and corporately provided an overview of compliance within areas of data protection legislation. This was intended to provide visibility of breaches to members of the committee and provide opportunity to discuss trends and actions to mitigate the likelihood of reoccurrences. The local authority had a record and understanding of failures of data security. Data showed a slight reduction in personal data breaches and that none-posed a significant risk to the rights and freedoms of the data subjects or the Council in terms of financial or reputational risk.

There were local authority staff who used systems outside of the monitoring of corporate governance processes. For example, staff in teams that accessed multiple digital recording systems including health systems told us there was some inconsistencies around access which at times resulted in staff needing to find 'work arounds' to access information needed. The CQC reported this to senior leaders who addressed this with health leaders responsible for these agreements.

When there was an information breach, action was taken to understand why it had happened and how it could be prevented in the future. An example was given that a questionnaire had been sent to the address of a deceased person. Information governance completed an investigation into this, understood what information had been made available and the actioned risk reduction measures. In this case, a slight change was made to the process of linking into a commissioned service to ensure they would feed back to the local authority when changes occurred.

Learning, improvement and innovation

Score: 1

1 -Inadequate: Evidence shows significant shortfalls

The local authority commitment

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

There was an adult social care improvement plan which included some areas highlighted by a peer review in 2023. Whilst we found there had been a more recent priority to resource improvement around safeguarding responsibilities, there was a clear lack of resource and pace needed to prioritise shortfalls around prevention, early intervention, strength based approaches and equity in peoples experiences. Senior leaders told us the delays in progressing actions within the adult services improvement plan had been impacted by a number of issues. For example, staff absences and gaps, leadership changes, a need to focus on safeguarding as an area of high risk, a lack of clarity of what improvements were recommended or needed, issues with version control and generally a lack of resource such as project management to carry out improvements alongside business as usual which was said to result in a lack of 'buy in' or time from managers to contribute. A senior leader also told us there was a lack of engaging staff in leadership posts to respond to a needed culture change, some had left the local authority, but some remained in post.

Where the local authority had dedicated resource and priority there was evidence of improvement to people's experiences. For example, the carers strategy and work within this was beginning to make a positive difference to improve care and support. The Carers Strategy 2023-2028 demonstrated coproduction with adult carers. Engagement sessions with 17 unpaid carers were held to understand what was working and what was not working, how needs could be best met and what potential gaps in current services there was. People and staff told us the strategy reflected feedback from these unpaid carers it gave descriptions of what success would look like and actions for each listed priority to address concerns. Staff told us this had resulted in improvements to identification and effective signposting of unpaid carers, and unpaid carers consistently told us the positive impact the carers service was having to support their role.

Co-production within adult social care was developing in Blackpool. There was a 'resilience revolution co-production' team developed from children's services, this included experiences of young people with Special Educational Needs and Disabilities (SEND) and their unpaid carers. The Integrated Care Board (ICB) had funded a project and worked with the local authority and SEND partnership board to plan to help young people with special educational needs and/or disabilities achieve their ambitions within a strategy which spanned 2024–2028. This plan was co-produced through a series of face-to-face sessions with young people, professionals, parents and adults with SEND to help those aged 14-25 who have special educational needs and/or disabilities to live the life they choose. The model of working together shaped the strategy and set out a promise to help young people to do what is important for them and provided a foundation for all Blackpool services supporting young people to prepare for adulthood.

Blackpool Researching Together was an all age programme to establish a health determinants research collaboration. The collaboration included a local university, the NHS Hospital Trust and an empowerment charity. Funding had been awarded between 20222027 from the National Institute for Health Research's public health research programme. There was a national network of 30 local authority-based research partnerships. The 4 priorities in Blackpool were First 1001 days (conception to age 2), Education, Employment and Skills, Mental Health and Housing. The collaboration aimed to bring together the knowledge of local people including those that were seldom heard, the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, councillors, academics and data analysts to work towards a co-produced goal ‘Together we create and share knowledge that creates health equity for the Blackpool community and beyond’. At the time of the CQC assessment the programme had recruited a team, carried out community engagement, developed a model of co-producing research, and led a national workshop on co-production of research.

A senior leader also told us work had started with an aim to reduce HIV transmission and stigma in older people. This project was not yet able to evidence any positive impacts on people's experiences. However, Blackpool had signed up to a global initiative and was meeting regularly to work with care home providers and encourage providers to have training on the subject.

However, there were missed opportunities for co-production. For example, the creation of the adult social care vision, draft Prevention Strategy and draft Commissioning Strategy. There were aspirations to engage in co-production at a wider scale and a plan to develop a co-production statement for July 2025. People, staff and partners told us there was more to do to embed coproduction across all areas of adult social care, and evidence any impact it was having. People with lived experience felt that there was a limited understanding of co-production within the local authority but the senior leaders wanted to understand peoples experiences and were 'not afraid to hear the challenge.' They recognised change could be a long process and there had been involvement of people and unpaid carers at some strategy level such as areas within children's services and the Carers Strategy. However, this now needed to be extended to all stages through design, delivery and evaluation, rather than simply requesting 'feedback.' For example, there was an autism partnership board which included a co-chairing model and people with lived experience set the agenda. However, adults within this board told us they had not been involved in the autism service development following outcomes from the board, meaning their impact was limited. In response, senior leaders told us strategy and service development pre-dated the development of the Autism Board which had been developed as a result of feedback from people, unpaid carers, partners in recognition that Autism Board was needed to be separate from the established Learning Disability Partnership Board.

There were shortfalls in personalised approaches which required corporate leadership to work together across adult social care, commissioning and public health to promote a culture that was person-centred, supported choice and control and aimed to tackle inequalities. We found a culture within the local authority that led to people more likely to be at risk of avoidable or unintentional harm. For example, senior leaders told us staff were making decisions for people with care and support needs often with the intention of protecting them rather than allowing them to make their own choices. Senior leaders told us there was a need for the culture within adult social care practice to move from risk-led actions to a more strength based and enabling choice and positive risk-taking approach. However, there was no evidence of any strategic work to address identified workplace culture or behaviours nor additional transformation support to ensure risks were mitigated during the change in processes and practice.

The local authority had commissioned a consultancy organisation to support them to codesign and deliver change within assessment and interventions. The approach aimed to promote a single worker model to avoid people needing to repeat themselves, promote active listening towards people and unpaid carers, and a focus on empowering people's individual strengths and community assets to understand and support their situation. The organisation had worked in partnership with staff as 'innovators,' senior leaders and people (through a feedback survey). The consultancy organisation and senior leaders measured the success of the change and there were examples of positive impacts on staff practice. However, there was more to be done to monitor and embed a consistent application of good practice. The local authority had prioritised quality assurance within safeguarding section 42 enquiries as a risk-based decision to ensure statutory duties in this area were prioritised, but this currently had not had the same impact on initial conversations, needs and unpaid carers assessments, and interventions to evidence it was improving outcomes for people with care and support needs. Senior leaders had developed a draft Quality Assurance Framework to support this approach, and managers were carrying out dip sampled audits however this had not been fully embedded at the time of the CQC assessment. The adult services improvement plan showed this was being monitored by senior leaders with a target to provide future assurances.

Staff consistently told us they were proud to work for the local authority and were passionate about serving the people of Blackpool. However, there was mixed feedback about continuous learning and improvement culture in Blackpool. Staff told us that line managers supported them well, and there were opportunities to learn and develop, such as accessing social work apprenticeships, Approved Mental Health Professional and Best Interest Assessor qualifications. Students and newly qualified social workers were well supported and there was a buddy system for new staff. Staff had membership for online research resources and senior leaders told us staff could protect two hours of continuous development time each month. This showed the local authority's commitment to embed evidence-based practice and expertise in the organisation. However, there was more to do to improve induction and training offers to ensure staff felt confident and senior leaders were assured staff were competent. There was a clear and formal programme for newly qualified social workers which aimed to support them while encouraging development. There was training from external and internal partners such as advocacy services and local authority legal services, however there was more to do to understand the workforce training needs and the effectiveness of training carried out in relation to improving people's outcomes. Staff were supportive of each other including across teams and staff members could easily contact staff in other teams with queries and there were opportunities to learn from each other.

Senior leaders told us they were proud of areas they considered best practice within adult social care. For example, connecting people with learning disabilities to person centred interests such as a photography group. People with care and support needs having a catering service in the community which brought about experience to gain qualifications. There was recognition that autistic people could be underserved in Blackpool and the local authority was proud of the dedicated autism team and its development to meet a specific set of needs. However, the team and service design had not joined up with health pathways this meant areas of partnership working could be disjointed and people could wait longer. For example, there was a need to request the mental health team to provide specialist support where there were gaps in expertise. Senior leaders told us there were ambitions to improve this. There was more for senior leaders to do to understand and respond to their own practice and to assure themselves that their systems and practices were effective. There was mixed feedback from senior leaders about whether they did enough to look at good practice in other areas. There were examples of collaborative work and research within the area but more to do to evidence how this improved practice and peoples outcomes within adult social care.

Learning from feedback

There was a lack of proactive gathering of peoples feedback. The local authority had formal feedback and complaints procedures and commissioned the local Healthwatch network to support people to share their experiences of care and had carried out a specific safeguarding project. However, there was no consistent evidence that all feedback translated into changes and developments to practice to effectively improve people's wellbeing and outcomes.

There were some examples of positive changes occurring after serious incident feedback. For example, as a result of a coroner's report, there was training for Approved Mental Health Practitioners, and the local authority had responded to feedback from carers which had resulted in training being delivered to practitioners. Some partners had noticed positive changes as a result.

Senior leaders had feedback from staff about practice, partnership working, learning and wellbeing. However, there was limited evidence of action to address all concerns, and where action was noted, there was limited progress. In one example, the local authority had reports from the Employer Standards Health Check for Registered Social Workers over the past 2 years. It showed some social workers had directly experienced racism or discrimination towards themselves or colleagues. Following the CQC site visit senior leaders told us there had been efforts to ensure that staff were aware of expectations within the workplace and were able to access support when they needed it. Over the past 12 months, 93% of adult social care staff had undertaken equality and diversity training and sexual harassment training. New 'active bystander' training had also been introduced over the past 18 months corporately to support staff to intervene when they witness harassment or abuse. Senior leaders told us the new training focused on reducing the number of people in the community, including staff, who experience power based abuse and harassment. There were aspirations to actively promote the training across adult social care services, however this had not taken place at the time of the CQC assessment and therefore there was not yet conclusive evidence of any effective impact this could have.

The local authority's annual feedback and complaints report 2023-2024 showed there were 276 sources of feedback relating to adult social care. There was 182 sources of queries or positive feedback, and 77 complaints, which was less than the previous year. 36 sources of feedback were from Members of Parliament (MP) enquiries, 11% of complaints were upheld and 50% partially upheld with 16 complaints referred to the Local Government Ombudsman. The majority of complaints related to the quality of service. The local authority broke complaints into themes and acted when a complaint was upheld. Senior leaders told us that there was no formal mechanism for adult social care staff to learn from peoples' feedback and there was limited evidence of this informing strategy and planning. However, there were examples where learning influenced practice and delivery. For example, the local authority had several complaints about financial assessments. As a result, there had been a change to procedures so that financial assessments started sooner and staff were reminded to be clear when advising about financial assessments and means tested cost of care with people. There had been some changes to staff structures to address this but there was more to be done to evidence how effective this had been as some people still waited for financial assessments. Senior leaders aspired to develop a way to bring all feedback together including national data to produce learning and strategy development but this had not progressed at the time of the CQC assessment.
