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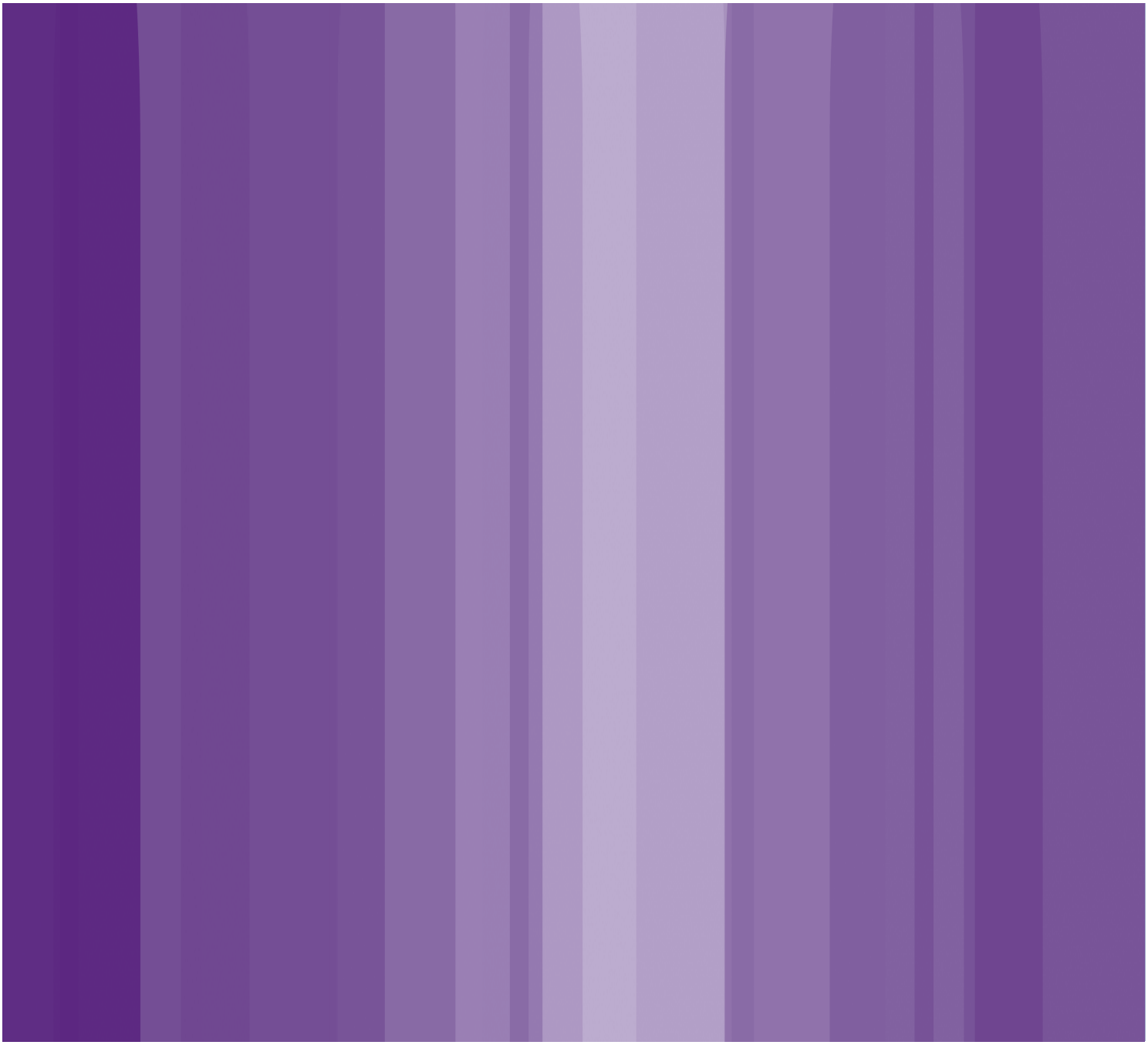
How well do we protect Scotland's children?

A report on the findings of the joint inspections of services to protect children 2005-2009



services for children

HMIe
improving Scottish education
leasachadh foghlam na h-Alba

How well do we protect Scotland's children?

A report on the findings of the joint inspections of services to protect children 2005-2009

HM Inspectorate of Education 2009

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Foreword

In the first few years of the 21st century there has been a series of reports and reviews of the circumstances leading to the deaths of several children. In each case the conclusions and recommendations were depressingly similar. There was a need for improved information-sharing between services and for improved recognition and assessment of risk. Poor decision-making by staff resulted from inadequate training or supervision. They focused on processes rather than outcomes. Beginning with *For Scotland's Children*[1] a series of authoritative reports made similar recommendations for the improvement of children's services. They identified effective joint working as critical to underpinning improvements in child protection services.

In response to the concerns and recommendations in these reports Scottish Ministers announced a programme of reform which included the introduction of multidisciplinary inspections of child protection services. HM Inspectorate of Education (HMIE) was given the responsibility of leading this work in close cooperation with partner scrutiny bodies. On 10 September 2009, we published the final report in the first series of inspections.

This report, *How well do we protect Scotland's Children?*, draws together the main messages from these inspections. Overall, around a quarter of the inspections showed serious weaknesses in aspects of child protection which would increase the risk of harm to children. In those areas the inspection process acted as a significant catalyst for change. Inspection was followed by prompt action to reduce the level of risk.

Across the country we found important strengths in how services were working together, individually and collectively, to protect children and meet their needs. We know it is vital that services intervene quickly when children are identified as being at risk of abuse and neglect. Effective and timely support will help reduce risks to vulnerable children and prevent their situation from deteriorating. It was encouraging to find that support for vulnerable children and families and young people's awareness of keeping themselves safe emerged as key strengths nationally.

The protection of vulnerable children is a shared responsibility which requires a high level of commitment to partnership working and strong and effective leadership and direction. I am encouraged by the extent to which Chief Officers are increasingly demonstrating their personal commitment to, and accountability for, child protection. It is vital that they continue to do so and that they ensure that systems are in place to monitor the effectiveness of child protection services through improved management and performance information. Staff across

1 *For Scotland's Children* – Report of Action Team on Better Integrated Children's Services, Scottish Executive, 2001

services, who work directly with the most vulnerable children and families on a daily basis, do a difficult and demanding job. They need to be appropriately skilled and supported well by their immediate and senior managers. It was reassuring, therefore, to find across the country, key strengths included a high level of commitment to the training and development of staff and the provision of policies, procedures and guidance to support them in their work.

Statutory and voluntary services have specific responsibilities for child protection, but their effectiveness depends on the help and support of the wider public. Every citizen has an important role in protecting children and keeping them safe. I was, therefore, pleased to note that in most areas considerable efforts had been made to promote public awareness of child protection.

Effective information-sharing, within and across services, is critical in ensuring the safety and welfare of children. Where children have been seriously injured or died as result of abuse or neglect, a contributory factor to the failure of services to take prompt and effective action has often been poor or delayed information-sharing. Although we reported positively on aspects of information-sharing, more needs to be done to ensure that all staff who have contact with children and families are clear about the requirement to share information quickly when there are concerns about the safety or welfare of children. Across Scotland, significant improvements are needed in the quality and rigour of assessments of risks and needs. Similar improvements are required in planning to keep individual children safe. Assessment of risks and needs and planning to meet needs are key areas for development nationally. Along with information-sharing, deficiencies in these areas carry a high degree of risk of failure to adequately protect children. As we know, the consequences of such deficiencies can be life-threatening.

We must not forget the importance of listening carefully to what children and young people are able to tell us. The effectiveness of staff communication with children and families and the establishment of trusting relationships are areas of strength across the country. However, more needs to be done to ensure the appropriate involvement of older children when important decisions are made about them and to seek the views of vulnerable children and families in order to help develop child protection services.

The findings of this report reinforce the importance of services which work together to protect children maintaining a relentless pursuit of improvement, including sustaining and building on the good practice which already exists.

Graham Donaldson
HM Senior Chief Inspector
26 November 2009

Section One: Introduction

1

The background

In March 2004 Scottish Ministers announced there would be a new multidisciplinary children's services inspection team, based in Her Majesty's Inspectorate of Education. The team's first task would be to undertake inspections of child protection services in all 32 local authority areas across Scotland. The work of this team both complemented and reinforced other aspects of the child protection reform programme. It was to be led by HMIE working in partnership with other scrutiny bodies, including the Social Work Inspection Agency (SWIA), the Scottish Commission for the Regulation of Care (Care Commission), Her Majesty's Inspectorate of Constabulary (HMIC), the NHS Quality Improvement Scotland (NHS QIS) and Her Majesty's Inspectorate of Prisons for Scotland (HMIP).

A strategic group involving representatives from these scrutiny bodies was established and extended to include representatives from Audit Scotland and policy colleagues from the Scottish Executive. A reference group involving representatives from the services delivering child protection complemented the work of the strategic group. Both groups provided expert assistance in considering and refining the approaches adopted to developing the inspection model.

Some of the first decisions were to establish the scope of child protection services and to decide on the unit of inspection. Although there were some pre-existing models of inspection of specific services provided by local authorities and police forces which considered the effectiveness of partnership working in delivering public services, there were no precedents for inspecting the collective impact of child protection work undertaken by services including police, health, education, social work and the Scottish Children's Reporter Administration (SCRA). There were 32 local authorities in which there were 30 corresponding Child Protection Committees (CPCs), 15 health boards and eight police forces while SCRA was a single, national body. Exciting work was undertaken in the remainder of 2004 and early in 2005 to establish a team with the necessary range of experience and to pilot multi-agency inspection of all services providing child protection within a local authority area. Services in two local authority areas volunteered to work in partnership with the inspection team in pilot inspections.

The legislation

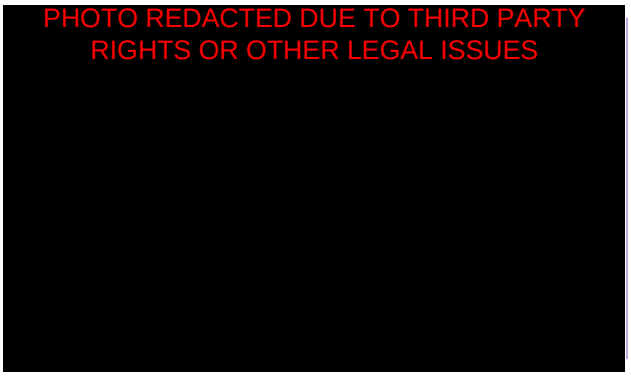
While the pilot inspections were well received and supported by the wide range of staff involved, they also identified the need for the introduction of a new legal framework to underpin the work of the multidisciplinary or joint inspection teams. During the pilot inspections access to health records was problematic for the

health boards involved for reasons of confidentiality. Specific legislation was required to provide the inspection team with a clear right of access to personal information, including health information.

The inspection programme was suspended during the period when legislation was being considered. During this period staff continued with development work. A significant feature of this work was to consider responses to consultation on the proposed legislation and develop a Code of Practice for the inspection process.

The delay in the inspection programme brought significant benefits. As well as allowing for a period of further review, it allowed members of the inspection team to visit each CPC across Scotland. Discussions during these visits increased familiarity with the framework for inspection as well as helping staff in services prepare for the forthcoming programme of joint inspection. This engagement with each CPC reinforced the partnership approach to inspection and underlined the increased role and responsibility of CPC members, consistent with the aims of the reform programme.

In order to provide the child protection inspection team with the powers required to work jointly and access and share information, the Joint Inspection of Services for Children and Inspection of Social Work Services (Scotland) Act 2006 was passed and received Royal Assent in February 2006. This Act, together with its regulations and Code of Practice, provided the framework for the conduct of Joint Inspections of Children's Services and the lawful exercise of powers to access and share information by members of each inspection team.



The inspections

Between May 2006 and March 2009, inspections took place in each of the remaining 30 local authority areas. Both pilot areas were revisited during that period as part of the follow-through inspection programme. The scope of the inspection was broad, covering three levels of service: the strategic level of leadership and planning; the delivery level of systems and processes; and the outcomes for children and their families, including the experience of the service users.

A focus on a sample of children's cases was at the heart of the inspection process. This sample included cases where early intervention had taken place, cases where current interventions were protecting children and cases where longer-term outcomes for children and families were identified.

During inspections, inspectors read a range of case records, including social work, education, health, police and SCRA records. They interviewed key staff involved in some of the cases and as many children and families who were willing to be involved. Inspectors also observed children's hearings, child protection case conferences, reviews and other work undertaken by practitioners.

Follow-through inspections assessed the extent to which services continued to improve the quality of their work to protect children. In follow-through inspections, inspectors revisited the council area to evaluate progress made in responding to the main points for action identified in the initial report.

HMIE recruited Associate Assessors to join the team of inspectors and to provide the perspective of current practitioners. Their skills and knowledge complemented those of the permanent or seconded inspectors. Each Associate Assessor was an experienced professional, with a relevant background and recent successful experience in child protection, including management experience in the range of services involved.

The framework

In consultation with other scrutiny bodies, a framework of quality indicators (QIs) was tested during the two pilot inspections and refined. This provided a set of 18 QIs which would be used in all inspections to evaluate the help children get when they need it (See Appendix A). HMIE later published the first framework for the self-evaluation of services to protect children, *How well are children and young people protected and their needs met?*[2] The framework related closely to other aspects of the child protection reform programme including the *Framework for Standards*[3] and the *Children's Charter*[4].

The inspection process was designed to gather evidence on each of the QIs. Inspectors gathered evidence from a range of sources including self-evaluation, data, stakeholder views and observations of practice. Based on this evidence, they evaluated practice in relation to each indicator.

Joint inspection and collective responsibility

Inspection of child protection services emphasised the importance of effective joint working and collective responsibility. Pre-inspection returns required a collective response from services involved in delivering child protection. The

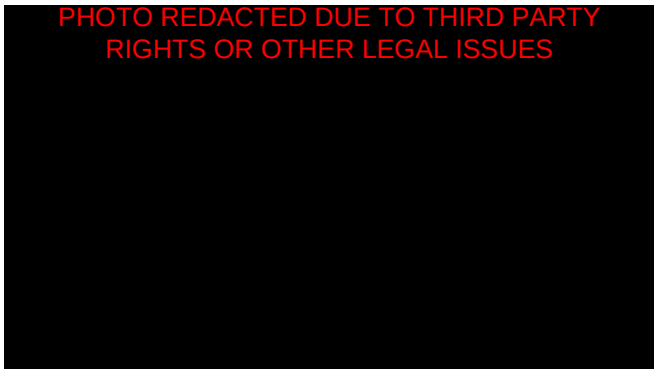
2 *Self-evaluation using quality indicators*, HMIE 2005, www.hmie.gov.uk

3 Framework for Standards for professionals for child protection, Scottish Executive 2004

4 *Protecting Children and Young People – The Charter,* Scottish Executive 2004

reports which followed the inspection focused on the experience of children of the collective range of services with which they had involvement. Individual services were not evaluated separately, although there were some recommendations contained in reports which were of particular relevance to specific services.

Discussion on inspection findings took place with senior representatives from each of the services involved. This reinforced the need for partners to work closely together in providing services to vulnerable children. It also reinforced collective accountability for the system of child protection within a local authority area, rather than attributing it to an individual service within that system.



Integrated children's services planning is a requirement of the Children (Scotland) Act 1995, but effective partnership working requires the application of 'hearts and minds' as well as statutes. In the 2002 audit and review of child care practice, *It's everyone's job to make sure I'm alright*[5], one of the findings was that services would attribute failings in the system of child protection to partner agencies rather than readily assume a collective responsibility for outcomes for children at risk of harm. Following the introduction of joint inspection it is no longer possible to assert that the responsibility for poor outcomes lies with another service.

The context for service delivery

The location and geography of local authority areas has a significant effect on the nature of the challenges faced in providing consistent quality of child protection services, including specialist services. Similarly, socio-economic factors affecting local populations contribute to the challenges of delivering good outcomes for children. Inspection findings took account of the context of inspection. Local authorities and their partners have a responsibility to deliver services which meet the needs of children and families within a local context. Chief Officers and senior staff within authorities have important responsibilities for ensuring that statutory requirements are met and that due regard is paid to national policy and guidelines. Inspections did not find any relationship between the nature of challenges faced and the success in meeting those challenges.

5 Report of the Child Protection Audit and Review, Scottish Executive, 2002

1

In 2007, during the first cycle of child protection inspections, there was a change in the Scottish Government. The Concordat between the Scottish Government and local authorities was agreed and a National Performance Framework (NPF) introduced. The Scottish Government has identified an increase in the overall proportion of local authority areas receiving positive child protection inspection reports as one of the 45 national indicators of success in achieving the national outcomes identified within the NPF. A positive child protection inspection report is defined as one where the evaluations of four reference QIs are satisfactory or better. The reference QIs are:

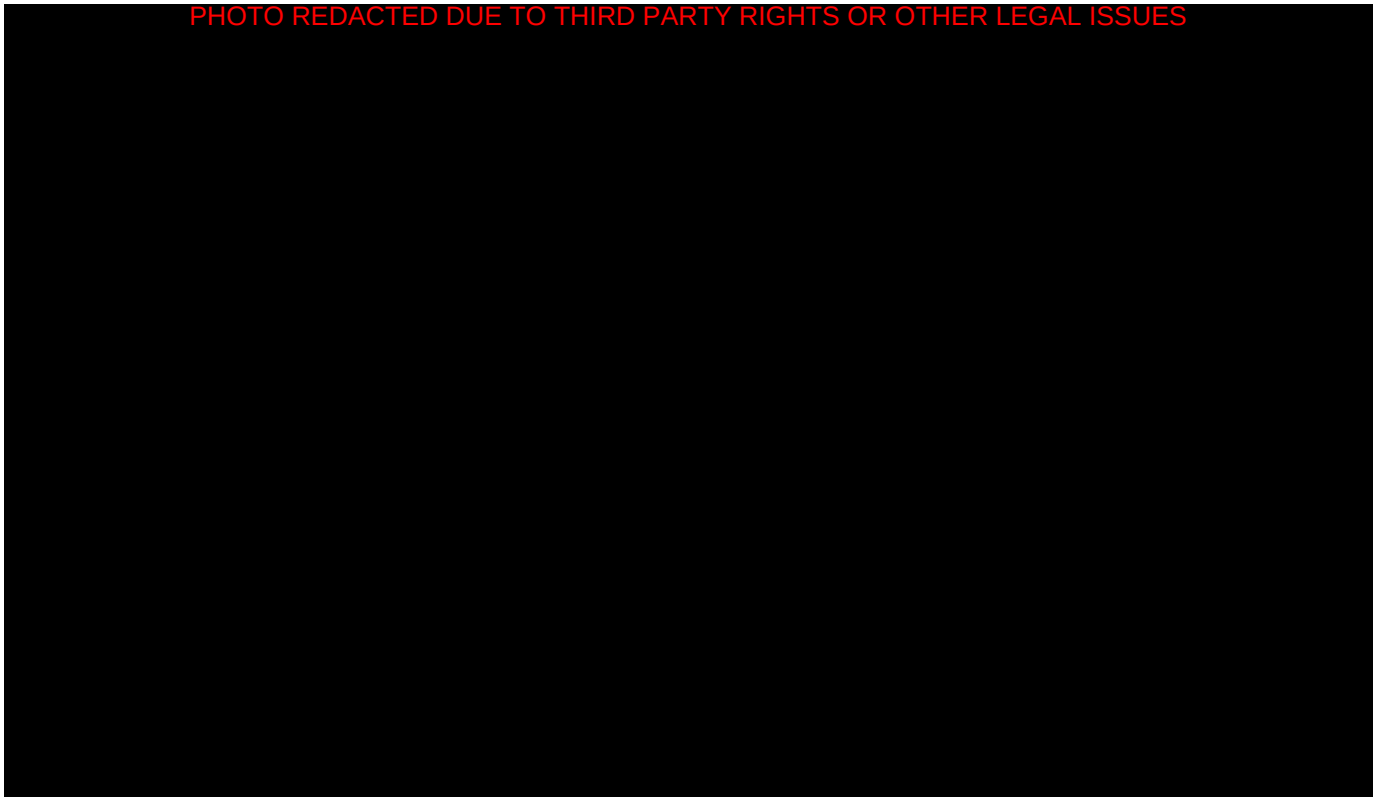
QI 1.1. Children and young people are listened to, understood and respected;

QI 1.2. Children and young people benefit from strategies to minimise harm;

QI 1.3. Children and young people are helped by the actions taken in immediate response to concerns; and

QI 1.4. Children's and young people's needs are met.

In the revised quality indicator framework these have been renumbered and are now 2.1–2.4.



Section Two: How well are the needs of children and families met?

In all areas police, education, social work, health and voluntary sector staff worked effectively together to deliver a range of programmes to children about keeping themselves safe and healthy. Children generally had a good understanding of this. Those we spoke to could identify trusted adults with whom they could share their worries or concerns. Most children were aware of the dangers associated with using the internet. They also knew how to contact relevant national child protection help lines, for example, ChildLine. In some areas police officers, working with other staff in schools, were making an effective contribution to raising children's awareness of keeping themselves safe.

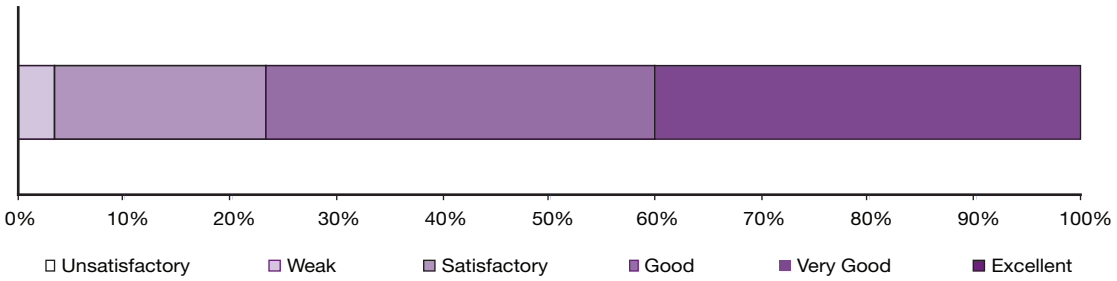
Vulnerable children and families benefited from a range of services delivered at an early stage to help stop difficulties arising, to reduce risks and to prevent their situation from deteriorating. This included the help and support provided by staff in child and family centres, early education and child care centres. In most areas staff across services, including health visitors and family support workers, worked well together to support vulnerable children and families. A variety of multi-agency meetings were sometimes used to coordinate the help and support children and families received and to monitor the impact of those services. This valuable support provided early enough was helping to keep children safe in most areas. However, in some areas, a strategic and coordinated approach to ensuring early help and support for vulnerable children and families is provided in a consistent and targeted way, was not sufficiently well developed. Some children and families living in rural areas did not have the same access to services as those living in larger towns or cities. In a few areas the help and support provided was delayed if the children were not on the Child Protection Register (CPR).

In most areas parenting programmes aimed at improving parents' skills and confidence in caring for their children were helping to keep children safe. A wide range of parenting programmes was available. These were sometimes provided to groups of parents or on a one-to-one basis. Some of the parenting programmes were delivered by staff from one particular service or by staff from more than one service working together. In many areas staff recognised the risks to unborn babies resulting from parental substance misuse and provided effective help and support to vulnerable pregnant women.

In almost all areas effective procedures had been established to trace and ensure the safety of children who were missing from the education system. Staff monitored and supported children who were educated at home. In some areas vulnerable children who were excluded from school were supported well to reduce the risks to them. In other areas the level of support provided to these children was more variable.

Support for vulnerable children and families and children's awareness of keeping themselves safe was a key strength nationally. Provision in most areas was good or better, with many evaluated as very good. Across Scotland, 23 out of 30 areas received an evaluation of good or better. Twelve areas were evaluated as very good. One area was evaluated as weak.

QI 1.2 Children benefit from strategies to minimise harm

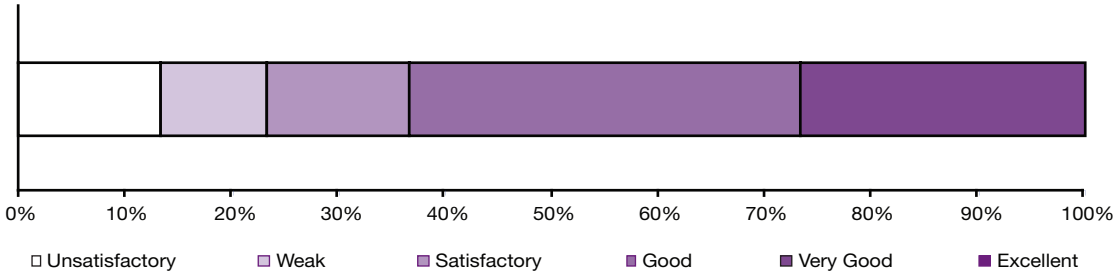


On the whole, staff across services were alert to the signs that children may be at risk of abuse or neglect. In most areas staff responded promptly and effectively when they had specific concerns about a child. Those concerns were usually shared with police and social work staff. Staff did not always recognise accumulating concerns around neglect or where there were patterns of concern or behaviour. In a few areas there were delays by education staff in reporting concerns about children. When concerns were raised about a child, information was gathered by staff and a decision was made about how those concerns would be investigated. Children and families were usually supported well during investigations by police and social work staff, and kept informed about what was happening.

When children were at significant risk of harm and it was no longer safe for them to remain at home, staff in most areas acted quickly to ensure their safety. The children were usually found a safe alternative place to stay with relatives, family friends or foster carers. An assessment of the suitability of relatives or friends to care for children was not always carried out before the children were placed with them. In a few areas staff did not act quickly enough and children were left in high-risk situations for too long. In most areas staff made effective use of appropriate legal measures, including child protection orders, when those were necessary to keep children safe.

In 19 out of 30 areas the action taken by staff in immediate response to concerns was evaluated as good or better. Eight areas were evaluated as very good. Seven areas were evaluated as weak or unsatisfactory.

QI 1.3 Children are helped by the actions taken in response to immediate concerns

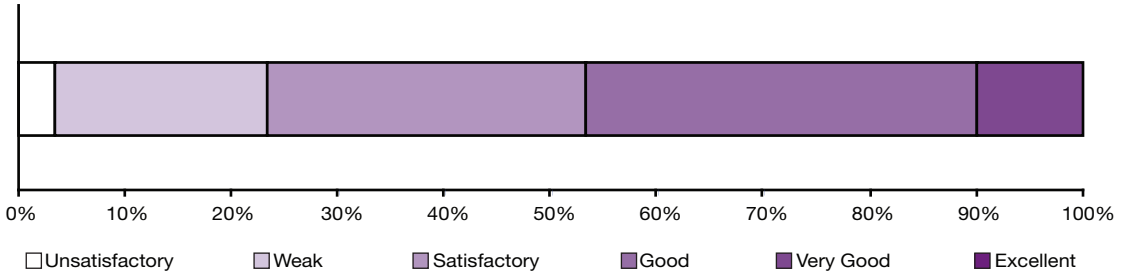


The short-term needs of children and families affected by abuse and neglect were usually met well. In most areas they benefited from the help and support provided by a range of services and their safety and welfare improved as a result. Services, including those provided by private and voluntary organisations, generally worked together well to meet the needs of children and families. In many areas the help and support was provided for as long as it was needed, but occasionally it was withdrawn too quickly, particularly when the child's name was removed from the CPR. In a significant number of areas there were delays in meeting the needs of vulnerable children who were not on the CPR and those experiencing neglect. Children who were unable to live at home or with relatives received effective help and support from foster carers and staff in residential units. In some areas a shortage of local foster carers meant that some children experienced several moves between carers, or had to live with foster carers outwith their local communities and further away from family and friends. In some areas children who moved to live with other family members were supported well, but in other areas they were not. The level of support provided to kinship carers varied. Staff from different services generally worked well together to meet the needs of vulnerable children with disabilities, complex health needs and additional support needs.

The specialist help and support provided to help children recover from their experiences of abuse and neglect, and to meet their longer-term needs was more variable. In most areas children benefited from the help and support provided by a range of specialist services, including services for children who had been abused, Child and Adolescent Mental Health Services (CAMHS) and services for children displaying sexually harmful behaviour. These services were sometimes delivered in partnership with the voluntary sector. However, there were often waiting lists for these specialist services and children did not always get the help and support they needed quickly enough. In a few areas, when staff were aware of these waiting lists, alternative support was provided until the more specialist support was available. In many areas a strategic and coordinated approach was needed to ensure that effective specialist help and support was provided consistently to meet the longer-term needs of children who had experienced abuse or neglect.

The evaluations of meeting children's needs reflected the variability of service provision. In 14 out of 30 areas meeting children's needs was evaluated as good or better. Three areas received evaluations of very good. There were no evaluations of excellent. Almost one-third of areas received a satisfactory evaluation. There were seven evaluations which were less than satisfactory.

QI 1.4 Children's needs are met



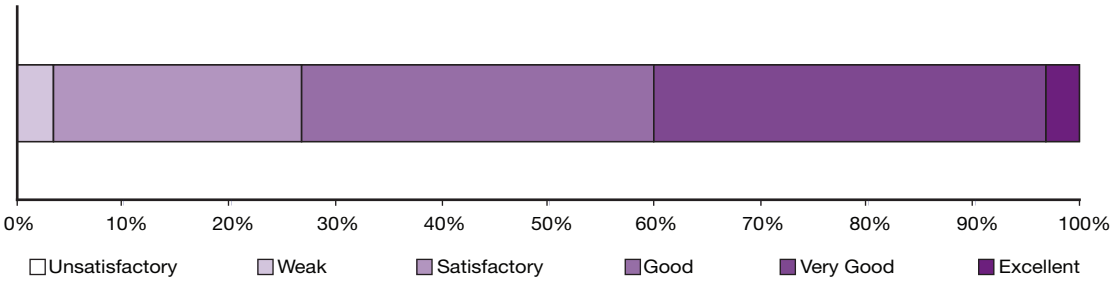
In most areas communication between staff and vulnerable children and their families was good. The views of children and families were listened to and taken account of when decisions about their future were being made. This was often achieved by staff using different approaches and demonstrating persistence with children and families who were challenging and unwelcoming of the staff involvement in their lives. In some areas staff used innovative approaches to maintain contact with them. These approaches included the use of mobile telephones, e-mails and text messaging. Health visitors and staff in child and family centres were particularly good at making careful observations of babies and younger children who were not able to communicate their views and feelings in the same way as older children. In most areas staff used a range of approaches effectively to overcome communication difficulties with children and families. These sometimes included the use of translation services when English was an additional language. In some areas children and families were helped to express their views and feelings by specialist staff, including children's rights officers and safeguarders. However, independent advocacy services were not always available or used effectively.

In almost all areas, through effective communication, staff in all services established positive and trusting relationships with vulnerable children and families. This was usually more effective when staff had regular contact with them and knew the children and families well. In a few areas, where the social work staff changed frequently or where visits were not made regularly, the relationships and trust between staff and children and their families were less effective.

2

In more than two-thirds of areas, 22 out of 30, the extent to which children, young people and their families were listened to, understood and respected by staff across services was evaluated as good or better. One area was evaluated as excellent. One area was evaluated as weak. This was a key strength nationally.

QI 1.1 Children are listened to, understood and respected



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Section Three: How good is the management and delivery of services?

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In many areas services provided helpful information for parents and children about key child protection processes which was written in a language they could easily understand. The practice of staff helping children and families to prepare for, and take part in, important decision-making meetings was well established in many areas.

In most areas parents were involved fully in decision-making meetings, including child protection case conferences, core groups and children's hearings. The chairs of these meeting often played an important role in ensuring that they were listened to and their views taken seriously. However, parents were not always shown reports about them, which had been prepared by staff, with sufficient time to read them thoroughly before the meeting took place. When this happened, it did not allow them to be prepared fully for the meeting. In some areas helpful approaches had been taken by staff to involve other family members in planning and decision-making for vulnerable children, for example, through family group conferences or other family meetings.

Children were routinely involved in children's hearings where panel members usually listened carefully to what they told them. Children's panel members in some areas took time to speak to children on their own to establish their views. However, the practice of involving children in other decision-making meetings was inconsistent. Older children who were capable of giving their views were not always invited to attend meetings to discuss their future. Children were not always encouraged or supported to attend meetings.

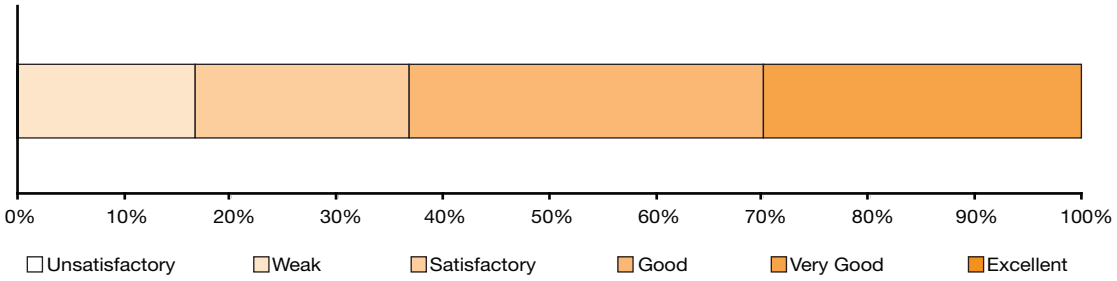
In some areas staff gathered and recorded children's views and represented these well at meetings. Where this was done well, staff often used *Having your say forms*, other specially designed forms or a computerised system. In other areas approaches to this were inconsistent within and across services.

Advocacy services helped and supported some children to give their views at meetings. In some areas this service was aimed more at specific groups of children, for example, those children who were looked after or those with disabilities. Staff were not always clear about the role of advocacy. Advocacy services for children and parents involved in child protection processes were not always available or used well when this would have been helpful to them.

In almost all areas services had established effective processes for dealing with complaints from children and families. Leaflets about complaints procedures were widely available in most areas. These were more often aimed at parents. Information specifically aimed at children was provided in only a few areas. In some areas individual services monitored and analysed complaints made by children and families. A joint approach to using this information to help plan and deliver services better was less well developed and found only in a few areas.

Across Scotland, the involvement of children and families in key child protection processes was variable. It was evaluated as good or better in 19 out of 30 areas. There were no evaluations of excellent. In five areas this was evaluated as weak.

QI 3.1 Involving children and their families in key processes



In most areas staff were aware of the need to share information when there were concerns about children's safety. In most areas staff working with adults were aware of the need to share information to protect children. This included staff working in mental health, criminal justice and addiction services. They were usually clear that when a child was at risk of harm the sharing of information with other services overrides their duty of confidentiality to the adult.

Joint working arrangements had helped to promote information-sharing amongst staff. The development of protocols and procedures in many areas had given staff a clear understanding of when information should be shared and with whom. However, in a significant number of areas, some staff were uncertain about what information they should share with other services. In a few areas, information-sharing relied too heavily on establishing professional relationships. In some areas information held by staff, particularly staff in health services and occasionally those in schools, was not shared appropriately. In many areas information about vulnerable children was not shared effectively with school nurses.

Multi-agency meetings brought staff together to share information about vulnerable children for whom there were concerns. When meetings took place there was usually good information-sharing among key services who were represented. In some areas information was not shared well by General Practitioners (GPs) who often did not attend important decision-making meetings about their patients. Chronologies of significant events were being used increasingly by staff, which supported effective information-sharing and the assessment of risks and needs within and across services. However, in many areas the quality of chronologies varied. They did not always list all the significant events in a child's life. Jointly prepared chronologies were rarely produced.

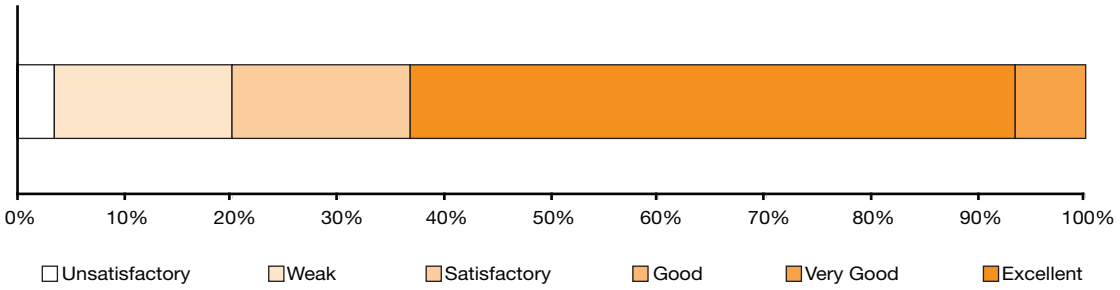
In almost all areas the quality and content of records services held about children varied considerably. In some health records were comprehensive and accurate. However, in many areas there was a lack of information in many of the school nurse and health visitor records. They were often incomplete, lacked organisation and did not always accurately record child protection concerns. In some areas social work records were well-structured and the information they contained was comprehensive, accurate and complete. However, in many areas social work records had gaps in the recording of contacts with children and families. These records were not well-organised and key information was not always recorded. In a few areas school files were comprehensive, well-structured and contained relevant information. In a few areas recording in pre-school files was of a high standard. However, in most areas education files were not structured well and child protection information was not recorded appropriately. In some areas police records contained relevant information, which were managed well. In other areas records were not consistent or easy to access.

In almost all areas staff were aware of the need to inform children and families when and with whom information about them would be shared. In most areas staff did not seek the written consent of children and families to share information. Obtaining their consent was usually done verbally and that was not always recorded. In a few areas staff did not consistently tell families what information would be shared across services. Practice was variable.

In all areas police, criminal justice social workers and housing staff routinely shared information on risks posed to children by sex offenders well. In some areas police officers with a responsibility for managing and monitoring sex offenders attended relevant child protection case conferences to share information they held, which was relevant to the safety and welfare of children. Meetings held under Multi-Agency Public Protection Arrangements (MAPPA) attended by police, social work and housing staff, were used effectively to share information when sex offenders posed a risk to children. Information about children for whom there were concerns was shared appropriately at these meetings. In almost all areas police officers diligently recorded information about adults who might pose a risk to children so that this was highlighted when checks by Disclosure Scotland were made.

Information-sharing and recording was evaluated as good or better in 19 out of 30 areas. Two areas were evaluated as very good. There was no evaluation of excellent. Five areas were evaluated as weak and one area was unsatisfactory.

QI 3.2 Information sharing and recording



Across services, almost all staff recognised their responsibilities to protect children and were alert to the signs that children may have been abused or neglected and in need of help. In most areas, where there was a child protection concern, staff made an initial assessment of the situation and generally acted promptly by sharing their concerns. In a few areas there were variations in thresholds between social work teams or between social workers and other staff, which contributed to an ineffective response. Individually and together, police and social work staff were usually effective at assessing risks and needs of children at an early stage. However, in many areas health staff were not involved well by police and social workers in making an early assessment. The decisions by police officers and social workers were often taken without access to all relevant information held by health professionals. The involvement of health staff in initial planning to investigate child protection concerns was inconsistent.

In most areas suitably trained doctors were available to carry out medical examinations and, in most areas, these were carried out without delay. In the few areas where there were delays in carrying out medical examinations of children, this was associated with a lack of clear guidance to staff or, was due to staff failing to follow established guidance or procedures. However, paediatricians were not always consulted appropriately when a medical examination of the child was a consideration. In these circumstances the wider health needs of children were not always considered or met well. In some areas children were examined by doctors without the required experience or training. In a few areas children were not always examined in appropriate facilities.

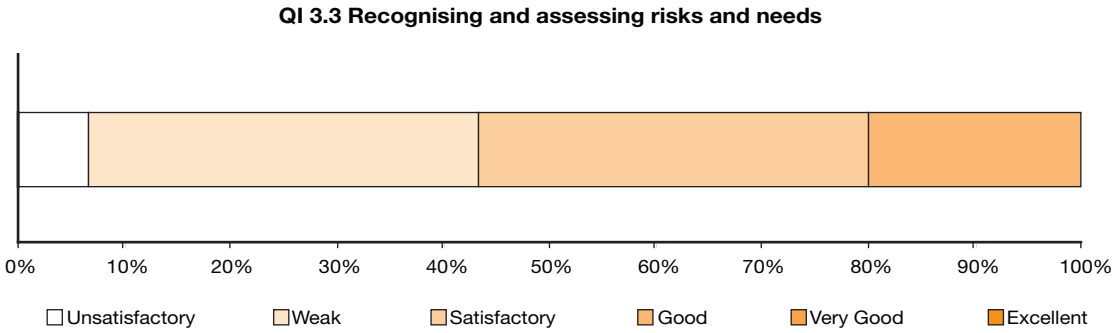
In most areas staff were alert to the risks to unborn babies and took action to ensure risks and needs were assessed effectively. In some areas there were delays in carrying out multi-agency assessments of risks and needs for unborn babies.

Joint investigative interviews of children conducted by police and social work staff were usually planned and carried out effectively by suitably trained staff. However, in some areas suitably trained staff were not always available or used to undertake these joint investigative interviews. In some areas there were delays between the child protection investigation and the initial child protection case conference, which sometimes reduced the effectiveness of a multi-agency assessment of risks and needs.

The quality of assessments of risks and needs, within and across services, was highly variable. In many areas the assessment of risks and needs of vulnerable children and families was hindered by a lack of shared assessment tools for staff. When assessment tools were available staff did not always understand how to use them well. In some areas chronologies of significant events in a child's life were not always used effectively to identify patterns of risk and need. In some areas the needs of children living in long-term situations of neglect were not always assessed well enough.

In almost all areas staff in both children's and adults' services recognised the adverse impact on children of living with parental substance misuse. Staff usually reported concerns about children. However, there were only a few areas in which staff worked consistently and well together to ensure that the assessment of risks and needs of these children were carried out systematically. In many areas a more strategic approach to joint working was required to meet these children's needs more effectively.

The assessment of risks and needs of vulnerable children and families was evaluated as weak or unsatisfactory in 13 out of 30, almost one half, of the areas. Six areas were evaluated as good. No areas were evaluated higher than good. This is a key area for development nationally.



In most areas staff from across services met regularly to plan for children who needed protection and held initial child protection case conferences promptly. These case conferences were mostly well-attended by relevant staff. However, these meetings were not attended well by GPs. In a few areas adult workers and school nurses did not attend the meetings. In some areas review child protection case conferences, where important decisions about de-registration were taken, were less well attended.

In most areas all children whose names were placed on the CPR had an allocated social worker and a child protection plan in place. Planning to meet children's needs was less effective in the few areas where children on the CPR were not always allocated a social worker.

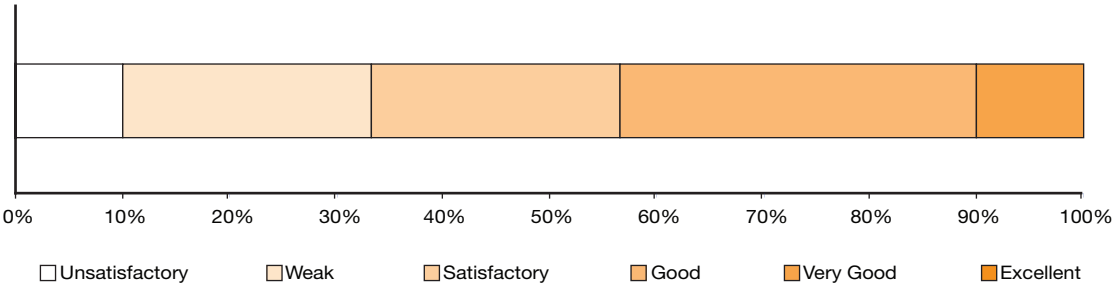
Staff identified the needs of vulnerable children and agreed appropriate actions to meet those needs. The plans that were produced were not always linked clearly to an assessment of risks and needs. In many areas the quality of child protection plans was variable. The most effective plans set clear objectives, identified the staff responsible for taking action and the timescale in which this was to be done. In other areas actions were not clearly enough defined and roles and responsibilities and timescales for completing them were not always stated. It was not always clear what changes were required or expected to reduce the risk to children. In some areas staff did not consistently consider what alternative actions may be necessary to help children if levels of risk were not reducing or their circumstances changed. In many areas there were delays in progressing plans for a small number of children who needed to be placed permanently with new families. There were delays in planning for longer-term needs of vulnerable children. Staff from different services met to review the circumstances of children who were looked after by the local authority and to plan to meet their needs. In a few areas social work reports were not always submitted in good time to the Children's Reporter. Late reports from social workers contributed to delays in holding some important decision-making meetings.

In almost all areas core groups had been established to enable staff to meet regularly to monitor the effectiveness of child protection plans and to take account of changing circumstances. In some areas core groups were not always held regularly. As a result the planning for vulnerable children was less effective.

In most areas child protection case conferences were chaired by staff who did not have direct responsibility for those who were providing services to the children and families. This helped the chairs to bring a degree of objectivity to the meetings and the important decisions that they were making. In some areas the role of the chairs of these meetings had been usefully developed to make them responsible for monitoring the progress of child protection plans and challenging any delays in action being taken by staff or changes to the plan which had not been agreed. In other areas the chairs had not been given this level of authority.

The effectiveness of planning to meet the needs of vulnerable children was evaluated as good or better in 13 out of 30, less than one-half of the areas. It was evaluated as weak or unsatisfactory in 10 out of 30, one-third of areas. Three areas were evaluated as very good and there was no evaluation of excellent. Planning to meet children's needs is a key area for development nationally.

QI 3.4 Effectiveness of planning to meet needs

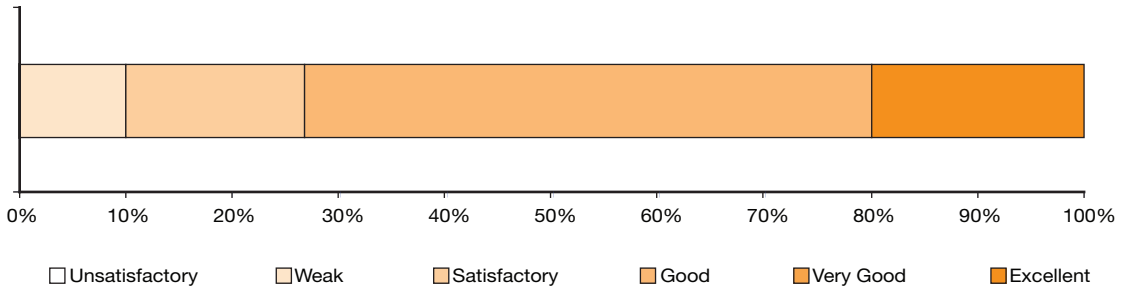


In almost all areas services had produced a range of clear policies and procedures, including helpful inter-agency procedures, to guide staff and support effective practice in protecting children. In most areas policies and procedures had been widely disseminated and were easily accessible to staff. This was often achieved using intranet facilities. Staff were usually able to demonstrate a high level of awareness of policies and procedures and used them well. In a few areas staff did not have an appropriate level of awareness of relevant policies and procedures. In a few others staff did not benefit from clear, unambiguous guidance. Procedures were not always adequate or there were significant gaps.

In many areas there was no systematic approach across all services to evaluating child protection policies and procedures and assessing their impact on staff practice. Staff in many areas had established a process for regularly reviewing and updating their child protection policies and procedures. However, in some areas this had not been carried out at all and in others a review had been started, but was subject to lengthy delays in concluding it.

The range of child protection policies and procedures linked to vision, values and aims was evaluated as good or better in almost three-quarters, 22 out of 30, of areas. There were six evaluations of very good. Three areas received an evaluation of weak. This was a key strength nationally.

QI 4.1 Policies and procedures

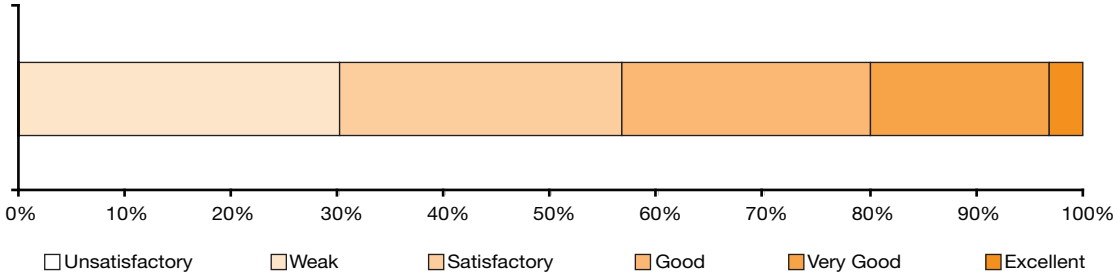


In most areas the Integrated Children's Services Plan (ICSP) established a clear vision and improvement priorities for children's services, including child protection. A collective approach had been taken in most areas to developing the ICSP, but in a few areas there had been insufficient consultation with some services. Following the introduction of Single Outcome Agreements (SOAs) as a part of the Scottish Government's National Performance Framework, areas inspected more recently, had either reviewed or were reviewing their planning arrangements to ensure that child protection planning linked more effectively to children's services planning and wider community planning arrangements. In many areas there was insufficient awareness amongst staff about the ICSP and how it influenced and directed their work with vulnerable children and families. In those areas where a wider ownership amongst staff had been achieved, inspection reports were mostly positive overall.

Effective monitoring of progress in implementing the ICSP and the impact on improving outcomes for vulnerable children had yet to be developed in many areas. Most services collected management information, but only some were using it systematically and successfully to help direct service improvements. Joint and systematic analysis of management information to inform service planning by CPCs was at an early stage of development in most areas.

Operational planning was good or better in 13 out of 30, less than half, of the areas. Almost one-third, 9 out of 30, were weak. This is a key area for development nationally.

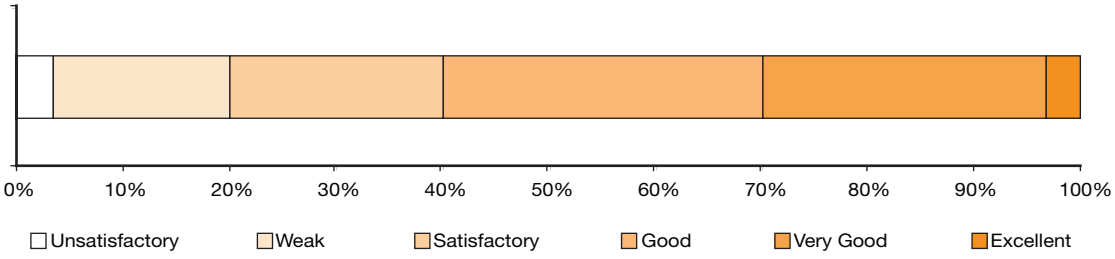
QI 4.2 Operational planning



In many areas wider services for children were providing ways for services to involve children and young people in influencing policy and service development more generally. These included pupil councils in schools, dialogue youth groups and youth health forums. In some areas children and young people had been involved meaningfully in the development of the ICSP. In a few areas there was regular consultation with young people by individual services. Children and young people were sometimes consulted on specific issues or when a new service was being developed. These included the development of sexual health services and services for the homeless and young carers. In a few areas services were beginning to use a range of methods to seek the views of vulnerable children and families involved in child protection processes, including the use of questionnaires and surveys. Across the country most services were still at an early stage of developing approaches to involving vulnerable children and families effectively in planning and developing child protection services.

The participation of children and families in policy and service development was evaluated good or better in 18 out of 30 areas. Eight areas were evaluated as very good and one area evaluated as excellent. Six areas were evaluated as weak or unsatisfactory.

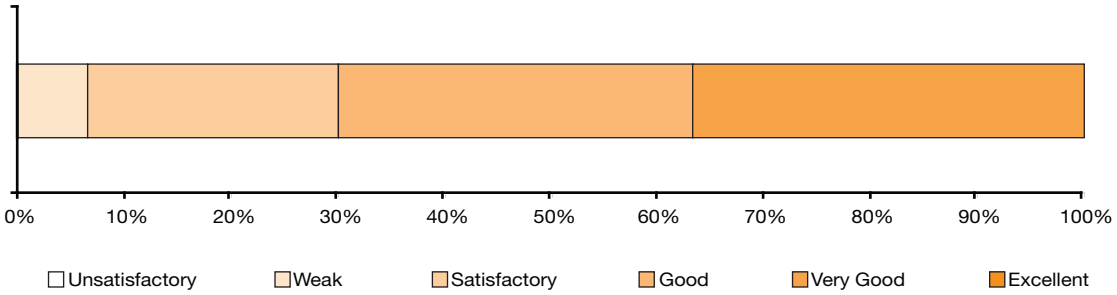
QI 4.3 Participation of children, families and other relevant people in policy development



In most areas individual services had a good understanding of the staffing levels needed and the skills staff required to provide an effective service for vulnerable children and families. Effective strategies had been developed in most areas to recruit and retain sufficient staff. In some areas particular schemes to recruit suitable staff for council-sponsored social work training had been particularly successful. Workforce planning was usually undertaken by individual services and did not often involve taking a joint approach. In some areas health and social work services had experienced difficulties in maintaining staffing levels. In a few areas services were struggling to meet increasing demands and the needs of the most vulnerable children and families. In those areas where staffing levels were adversely affected the needs of vulnerable children and families were not always met well. Across the country safe recruitment procedures, including the vetting of staff who would have contact with children, had generally been established. In a few areas some services had begun to carry out retrospective vetting checks of staff. In almost all areas services had established effective procedures for investigating allegations of abuse by staff, foster carers and volunteers, which link to disciplinary procedures.

The recruitment and retention of staff was evaluated as good or better in 21 out of 30, just over two-thirds, of areas. Eleven areas were evaluated as very good. Two areas were evaluated as weak.

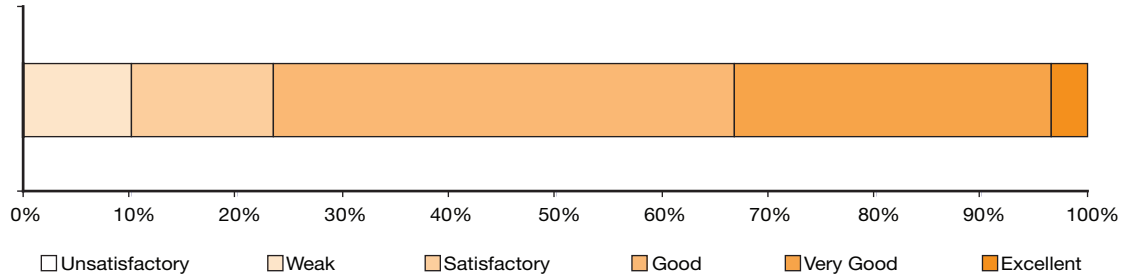
QI 4.4 Recruitment and retention of staff



In most areas the training and support provided by managers across services had helped to ensure staff were competent and confident in carrying out their work to protect children and keep them safe. Most areas had identified staff training needs and planned and delivered training to meet those needs. This had either been done through training provided by individual services or through inter-agency training. The training provided usually took account of national and local priorities. In some areas induction training for new staff had helped to ensure that they were clear about their responsibilities to protect children. Staff in some areas were not always able to access the training they needed. In the very few areas where there were significant gaps in the provision of training, this was associated with poorer outcomes for vulnerable children and families. Across the country services were generally at an early stage in routinely evaluating the impact of training in improving staff confidence and competence. In some areas more needed to be done to ensure that all staff are supported well and have their work in keeping children safe supervised and reviewed appropriately.

In around three-quarters of areas, 23 out of 30, the development of staff was evaluated as good or better. Nine areas were evaluated as very good and one area was excellent. The development of staff was a key strength nationally.

QI 4.5 Development of staff

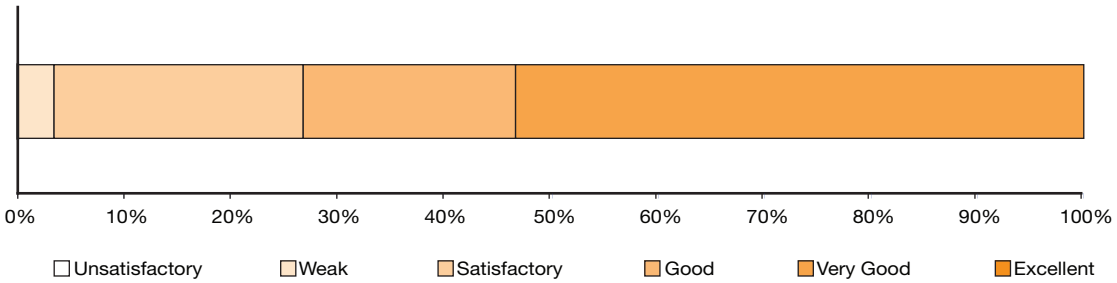


In most areas CPCs had used a wide range of materials to promote their work and increase public awareness of child protection. This included the use of leaflets and posters providing details of how and where to report child protection concerns. These were often displayed in public areas of buildings, including schools, health centres, social work offices and police stations. In many areas effective use had been made of websites to provide information on child protection. Some areas had made very effective use of local radio and newspapers and other media, including text messaging, to promote child protection in their area. Key child protection messages provided electronically in public areas such as shopping centres or to specific community groups promoted public awareness of child protection.

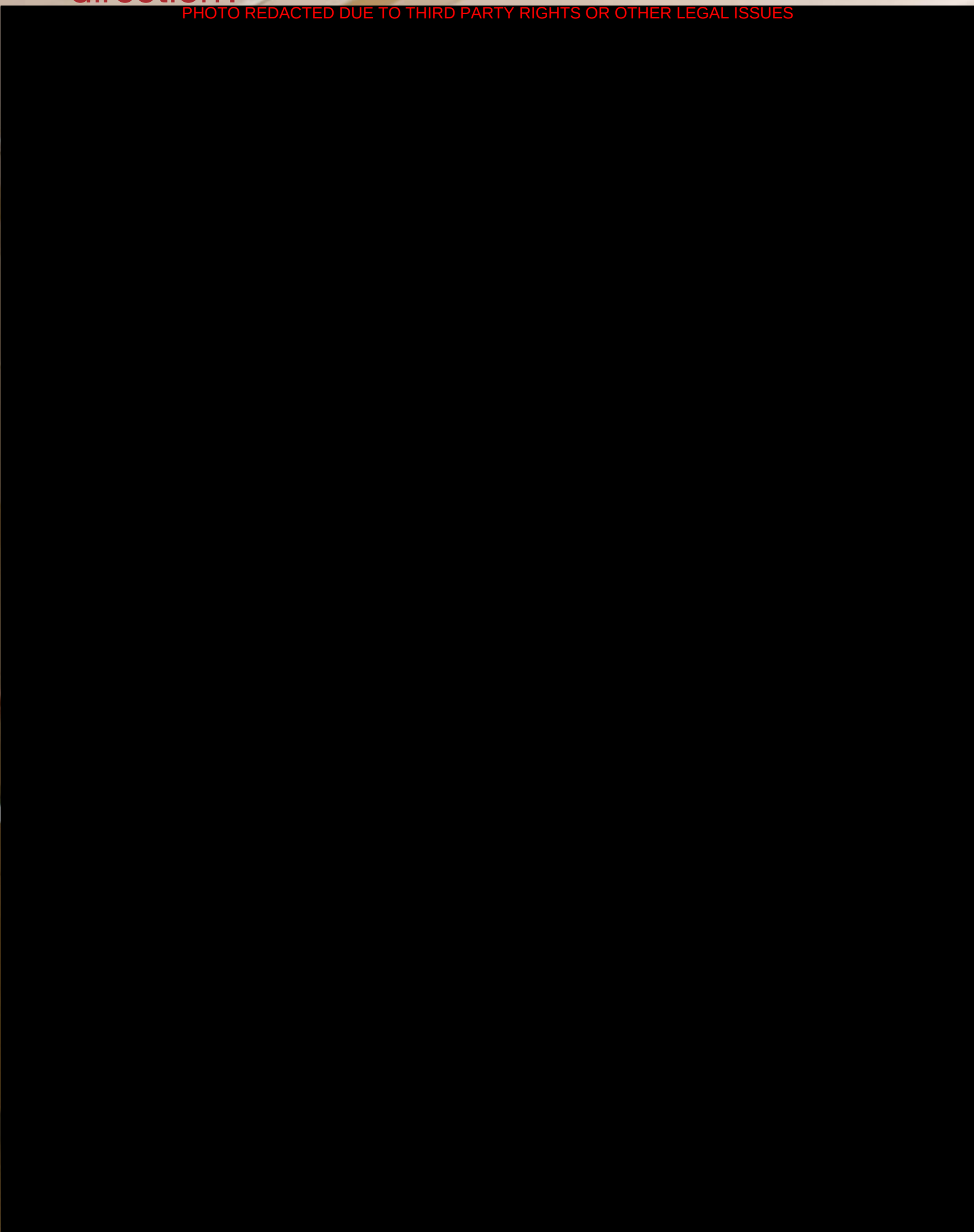
Overall, concerns raised by members of the public, including those made anonymously, were taken seriously in most areas and usually resulted in prompt and appropriate action. Services were usually able to be contacted at any time using out of hours services, although there was sometimes a delay in the response by these services in some areas. Feedback to members of the public who made referrals about children was not provided consistently in many areas.

The promotion of public awareness of child protection was evaluated as good or better in 22 out of 30, almost three-quarters, of areas. There were 16 evaluations of very good. There was one evaluation of weak. This was a key strength nationally.

QI 2.1 Public awareness of the safety and protection of children



Section Four: How good is leadership and direction?



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In almost all areas services had, individually and collectively, established a clear vision, values and aims for child protection. Overall, senior managers and staff had a clear understanding of their individual and collective responsibilities for keeping children safe. However, in a few areas they had focused on the development of their individual aims and objectives and a shared vision, values and aims across services had not been developed and communicated to staff sufficiently well.

In almost all local authorities elected members were clear about their responsibilities for child protection, and the safety and welfare of children was a key priority for them. In many of those areas the elected members provided a high level of support to managers and staff ensuring that resources were made available to meet the needs of the most vulnerable children and families in their communities. This was often being done in the face of challenging financial constraints.

In most local authorities the Chief Executive and senior managers ensured that their vision for child protection was shared with staff across council services and that child protection was regarded as a corporate responsibility. In the local authorities where this had not been achieved successfully, this was usually associated with poorer outcomes for vulnerable children and families.

In all Health Board areas Chief Executives and their senior staff had been pivotal in establishing a shared vision, values and aims for staff across community and specialist health services. Members of Child Protection Action Groups and managers and staff in key posts, including lead paediatricians, child health commissioners, nurse consultants and child protection advisors promoted child safety, health and wellbeing among a wide range of multidisciplinary staff. This helped to ensure that the needs of vulnerable children and their families were given a high priority. Overall, the communication of a clear vision, values and aims to health staff had been successful in almost all areas. In a few areas more work need to be done to ensure that all staff were clear about individual and collective responsibilities for child protection.

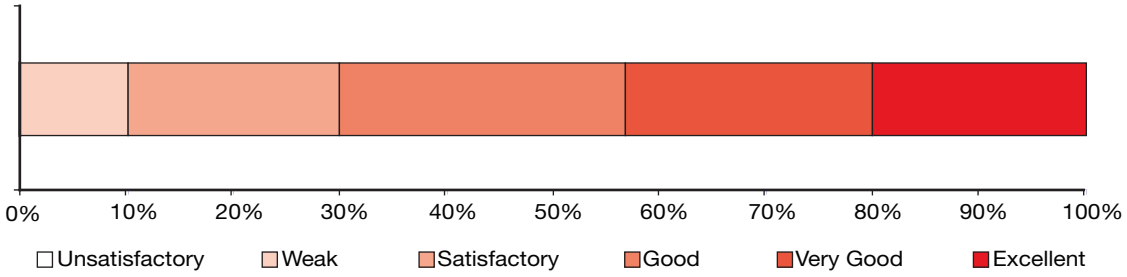
Across the country, Chief Constables had taken very effective action to ensure that child protection was a key strategic priority for their staff. In doing so they often considered child protection in the wider context of public protection along with the management and monitoring of sex offenders. In all areas the Chief Constable's vision, values and aims had been driven by the Divisional or Area Commander and incorporated in local policing plans. These plans prominently identified child protection as a priority area of their work. This vision, values and aims had been communicated effectively to police and support staff using a

variety of methods, including daily meetings and briefings with managers and staff.

In most areas the ICSP had set out a shared vision for the safety, protection and wellbeing of children which had been communicated effectively to staff. These plans were often linked well to the Community Planning structures and frameworks and increasingly to SOAs. In some areas staff did not understand the relevance of the ICSP to their child protection work. In a few areas plans were still being developed.

In most areas, 21 out of 30, vision, values and aims was evaluated as good or better. In six areas the evaluation was excellent and was often associated with very good outcomes for vulnerable children and families. This was a key strength nationally.

QI 5.1 Vision, values and aims



In almost all areas Chief Officers, senior managers and elected members with a specific remit for child protection were clear about their individual and collective responsibilities to protect children and keep them safe. Overall, Chief Officers were strongly committed to child protection. In almost all areas Chief Officers, including the Chief Executive of the Council, the Chief Executive of the Health Board, the Chief Constable and the Authority Reporter from the SCRA, formed a Chief Officers' Group (COG) which was well-established. They were usually providing effective leadership and direction to senior managers across the various services who were members of the CPC. In some areas the COG covered more than one local authority area and sometimes their remit was extended to include a wider public protection agenda, including the protection of vulnerable adults and the management and monitoring of sex offenders. In a few areas the COG had only recently been established and in some areas their role and remit and their relationship to the CPC was unclear. In a few areas the role and remit of the COG was reviewed and their relationship to CPCs clarified and strengthened.

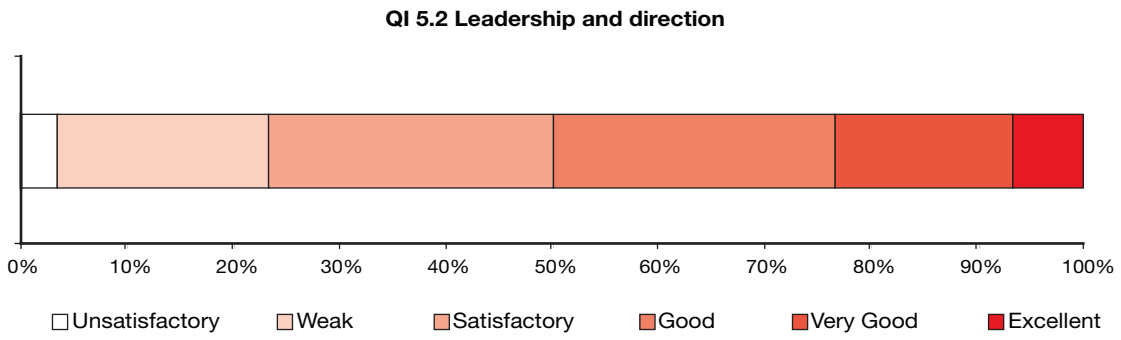
4

A CPC, comprising senior managers from across services with a responsibility for protecting children, has been set up in all areas. One of them covered three local authority areas. The level of representation on CPCs varied, but most included appropriate representation from the private and voluntary organisations. In many areas, CPCs had been provided with additional support through the appointment of independent chairs, lead officers, training coordinators and administrative support. Many CPCs were firmly established and provided strong and effective joint leadership and direction to staff. Others have been established more recently and were at a relatively early stage of development and a few were not yet fully effective in providing the necessary leadership and direction.

In a few areas no collective approach had been taken by services to address weaknesses in a particular service. In many areas the CPCs did not have a sufficiently clear view of the effectiveness of child protection services for which they were responsible. They did not always have good enough management and performance information about key child protection processes and outcomes for vulnerable children and families. As a result, they were not fully aware of their own strengths and areas for development.

Joint funding and effective approaches to sharing resources had been established in many areas. This work was often coordinated by the CPCs and included the provision of shared posts or agreement to jointly fund specific projects or initiatives. In some areas staff from different services who were colocated were strengthening approaches to child protection. In many areas the CPC had taken effective steps to develop child protection policies and procedures and develop and coordinate staff training. In a few areas, progress in these areas had been slower and sometimes this was due to lack of joint funding. A few CPCs had delayed producing an up to date business plan. Overall, most CPCs were adhering to the national guidance which had been issued to them.

In 15 out of 30 areas leadership and direction was good or better. In ten of those areas where leadership and direction was good or better all of the reference quality indicators were evaluated as good or very good. In the remaining five areas, three out of four of the reference quality indicators were evaluated as good or very good. In the seven areas where leadership and direction was weak or unsatisfactory, two or more of the reference quality indicators were also weak or unsatisfactory.



Across the country, Chief Officers were committed to collaborative working arrangements within and across services and promoted partnership working amongst staff. In most areas Chief Officers demonstrated their commitment to partnership working and to CPCs through the establishment of a variety of strategic planning and oversight groups in which they played a key role. This had helped strengthen accountability and governance arrangements for child protection. In almost all areas a culture of partnership working had been firmly established.

In many areas Chief Officers and senior managers in the local authority, police, health and SCRA were working together effectively to plan and develop integrated children services, including child protection. In a few areas this approach was still at a relatively early stage of development.

In almost all areas there was effective partnership working with private and voluntary organisations. The voluntary sector providers were usually represented on a variety of strategic planning groups, including CPCs.

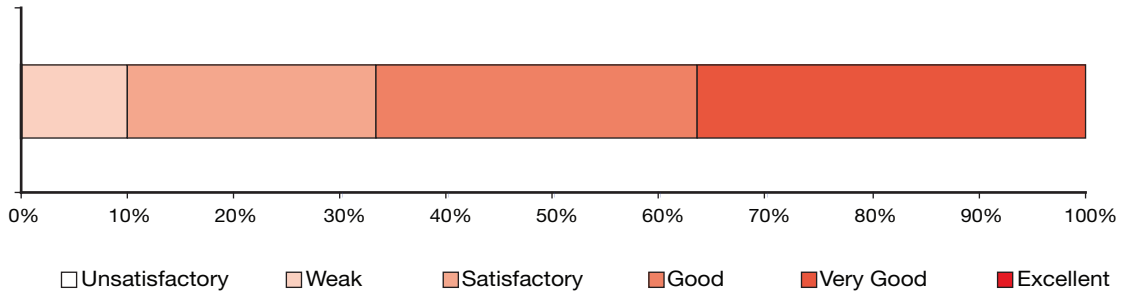
In many areas staff worked well together to deliver a range of services to help and support vulnerable children and families. This included services to children and families affected by domestic abuse or parental substance misuse. In some areas the colocation of managers and staff from different services supported effective joint working. In a number of areas the Community Health and Care Partnerships were also supporting joint working arrangements between staff from different services.

In many areas there were effective joint working arrangements in schools, which provided help and support to vulnerable children and their families. This work was usually coordinated through meetings of multidisciplinary staff held in schools. In a few areas school-based police officers were providing very effective help and support to children, including those who were more vulnerable.

4

The leadership of people and partnerships was good or better in, 20 out of 30, two-thirds of areas. Three areas were evaluated as weak where the outcomes for vulnerable children and families were also weak in significant aspects.

QI 5.3 Leadership of people and partnerships



Section Five: How are services improving?

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Overall, the quality of leadership of change and improvement was variable. There was a high level of commitment to improving services to protect children across services. Chief Officers and CPCs recognised the importance of joint self-evaluation. Most senior managers recognised and actively promoted the need for a systematic approach to self-evaluation. Increasingly staff were beginning to understand the need for self-evaluation to inform improvement. However, in a few areas Chief Officers and the CPC did not promote self-evaluation, were not aware of the overall effectiveness of their services and not able to assure themselves fully that children were protected.

A number of multi-agency audits, individual case reviews and self-evaluation exercises had taken place across services. These identified good practice and innovative practice as well as areas for development. Some individual services had reviewed their practice and made improvements. Most services were actively involved in self-evaluation and implementing improvement actions. However, this was not yet coordinated well enough to ensure improvements were consistently achieved and sustained. A wide range of single service evaluations of practice had taken place. Self-evaluation did not sufficiently focus on outcomes for children and did not always lead to improvements in practice. Staff were often unclear of any learning which came from self-evaluation. Although there was a very high level of commitment to self-evaluation it was not embedded within all services.

In half of the areas the CPC had coordinated multi-agency self-evaluation although some were at early stages of development. The multi-agency self-evaluations identified strengths and weaknesses, but were not robust enough to evaluate the impact services had in improving the lives of vulnerable children. In a few areas very effective self-evaluation involving staff at all levels resulted in very clearly written action plans with identified timescales and resources. This allowed progress to be measured and reported on effectively. Service users were rarely involved in joint self-evaluation.

The majority of areas had reviewed practice through multi-agency case file audits. Some of this work was at an early stage of development. In a very few areas case files were regularly reviewed on an inter-agency basis, with lessons learnt and current good practice communicated quickly to staff. Quality assurance was not always robust enough when monitoring the effectiveness of core groups, risk assessment and planning.

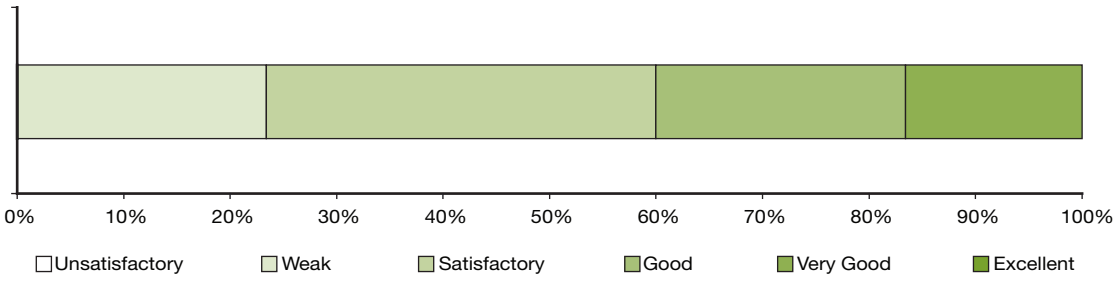
In most areas a procedure to review significant cases had been agreed and implemented. Some areas compared their own child protection systems and processes with findings from local and national reviews. Managers across services were generally well informed about lessons from child protection

inspections and enquiries. Action plans were identified and these were monitored by CPCs. However, in some areas, weaknesses identified at reviews often continued following the review. There was no systematic process to cascade lessons learnt and share good practice across services. Learning from reviews was not always communicated effectively to staff. In some areas local good practice seminars were held to share good practice. Multi-agency practitioner forums very effectively helped staff review practice and build capacity for improvement in a few areas. Practitioner forums were not available to many staff.

Implementation of improvement plans was generally monitored and reviewed by the CPC. The CPC monitored trends and activity, such as, reports submitted to, and attendance at, child protection case conferences. Most CPCs had established a practice development or quality assurance sub-group, which had developed an improvement plan, and some had carried out a broad range of audits. In many areas performance was monitored by the CPC using management information. Many areas identified the need to improve the quality of management information gathered. In a few areas robust performance monitoring arrangements were in place across services. However, in many areas management information was not consistently used to determine a clear view of impact of services on vulnerable children.

Overall, the quality of leadership of change and improvement was variable. Five areas were evaluated as very good and seven areas evaluated as weak. The remaining 18 areas were satisfactory or good. In those areas that were evaluated as very good, the outcomes for vulnerable children and families were also very good overall.

QI 5.4 Leadership of change and improvement



Improvements following inspection

Nine reports of follow-through inspections of services to protect children were published between August 2007 and June 2009. They reported on the progress made in responding to 47 main points for action. Satisfactory or better progress was made in almost all of the areas identified for improvement and good or very good progress had been made in most of them.

Reports commonly featured areas for improvement relating to information-sharing and recording, assessment of risks and needs, involving children and families in policy and service development and leadership of change and improvement.

In all areas where information-sharing and recording were identified as an area for development, follow-through inspections found that good or very good progress had been made in making improvements. These improvements were linked to systems and processes and developing a strong culture of sharing information in the best interests of children within and across services at all levels.

Overall, progress in improving the assessment of risks and needs was variable. On most occasions where this had been identified as an area for development, improvement had been supported through the introduction of revised frameworks and tools to guide staff in the identification of the risks and needs of children in the immediate, short and long term. Where this had been accompanied by relevant staff training, staff were more confident in carrying out assessments. These improvements had resulted in an increased consistency in, and quality of, assessments. In those areas where progress was evaluated as satisfactory or weak, more needed to be done to ensure consistency in gathering health information to inform initial assessments of risks and to ensure the routine involvement of paediatricians when planning and carrying out medical examinations.

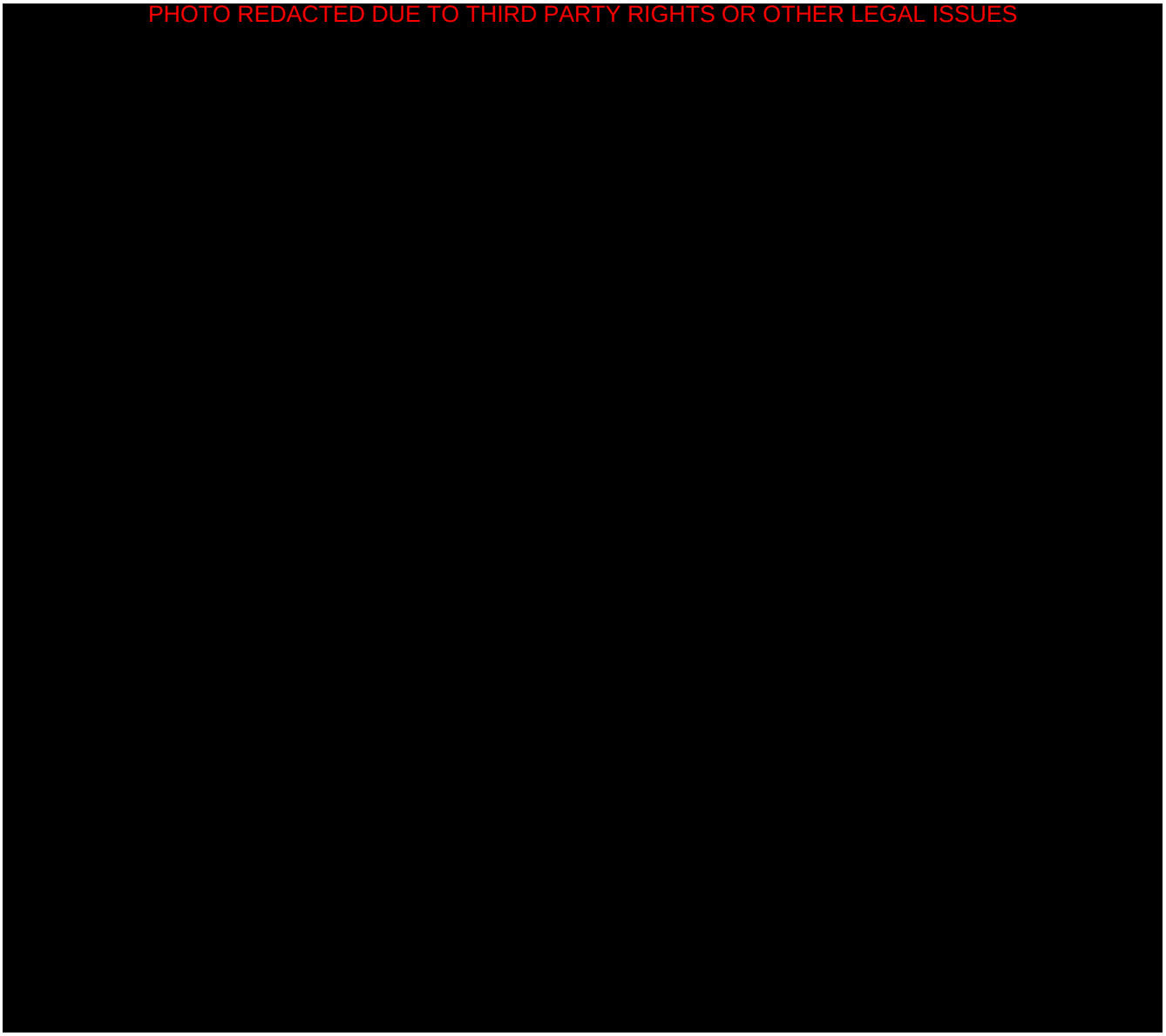
Progress in improving the involvement of children and families in policy and service development, where this had been identified as an area for development, ranged from satisfactory to very good. Improvements had taken place as a result of strategic approaches to the successful consultation with and participation of children and families across services. There were improvements in the ways in which children and families in need of care and protection had been involved in the review and development of ICSPs. Some areas had employed dedicated staff to consult with and improve the participation of children and young people and some had appointed elected members as children's champions.

Progress in improving leadership of change and improvement, where this had been identified as an area for development, ranged from satisfactory to very good. Improvements in the leadership of change and improvement were associated with well-established groups of Chief Officers who shared accountability for scrutinising and monitoring performance. It was also associated with a joint approach by Chief Officers and CPCs to evaluating performance and a shared approach to establishing priorities for improvement.

Follow-through inspections identified that successful approaches to leading continuous improvement across services to protect children were associated with:

- strong collective leadership by Chief Officers and CPCs;
- promotion of partnerships and joint working at all levels;
- improved joint accountability and scrutiny arrangements;
- systematic approaches to self-evaluation and quality assurance which focused on the experiences and outcomes for children and families;
- placing a high priority on consulting with children and families with first-hand experience of services to protect children; and
- effective communication of priorities for improvement to all relevant managers and staff.

5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Section Six: Looking forward

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As this report shows, services across Scotland have substantial strengths in protecting children, but there are areas of weakness which need to be addressed to improve provision to protect children and meet their needs. Most Chief Officers are clear about their accountability for child protection. Across the country there is a wide range of support services to help children and families at an early stage. Staff have access to a range of policies and procedures linked to vision, values and aims which help them in their child protection work. Effective training provision in most areas has increased staff confidence and competence. The workforce is increasingly alert to signs that children may need help and generally act promptly and appropriately when concerns arise. Staff communicate effectively with children and families and establish trusting relationships. Services have taken positive and effective steps to promote public awareness of child protection. These strengths provide a useful platform on which to build to provide greater consistency across the country in meeting the needs of children who may be at risk of abuse and neglect.

The report has identified a range of challenges which now need to be addressed in order to ensure the day-to-day experiences of all vulnerable children improve and help them build a more positive future.

Assessment of risks and needs

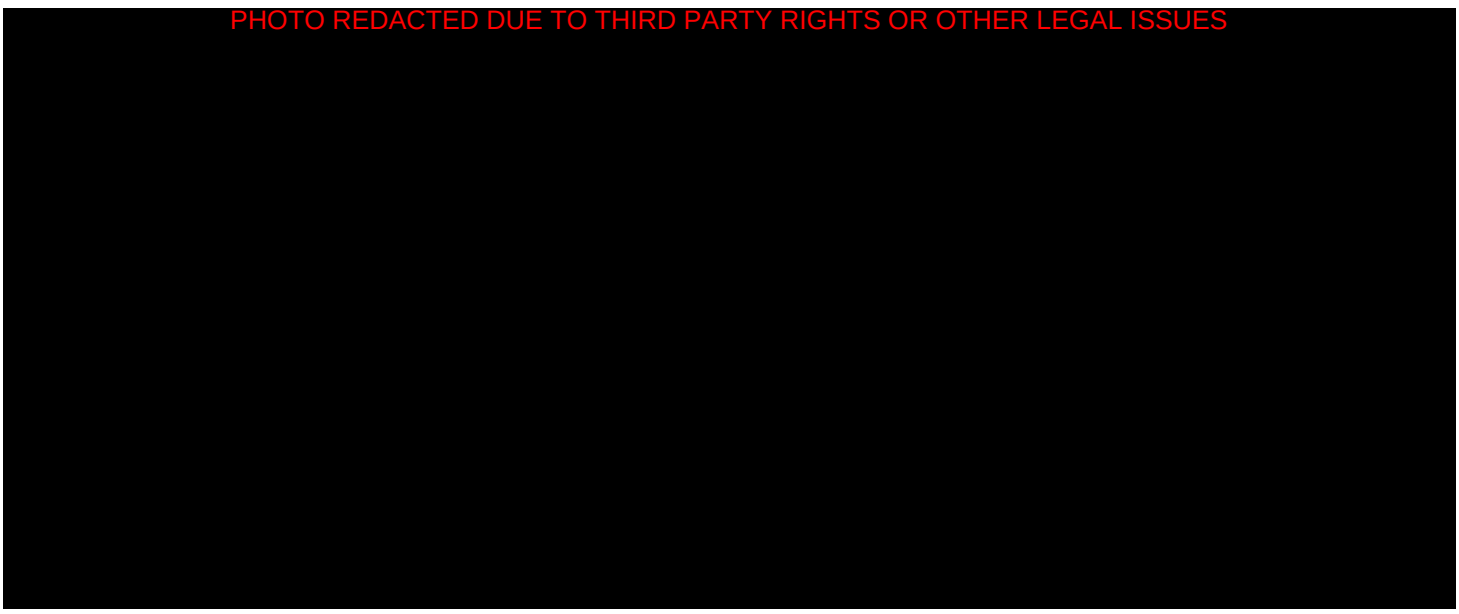
Staff across services recognise when children need help and in most cases, act effectively to respond to immediate concerns. However, there are important weaknesses in the quality and rigour of assessment of risks and needs. Assessment is an ongoing process not a one-off event and should address children's longer-term needs as well as their immediate safety. Effective assessments need to be informed by all relevant information. Priorities include:

- involving health staff, including medical staff, at an early stage when investigating concerns, so that children's needs are considered fully;
- always making available suitably trained paediatricians and forensic medical examiners to carry out medical examinations and full health assessments of children in a child-friendly environment;
- improving the quality of assessment by staff across services, making better use of existing assessment tools and ensuring children's longer-term needs are considered appropriately; and
- identifying and focusing on the particular needs of children affected by parental substance misuse and domestic abuse and children who may experience neglect, ensuring that assessments take account of accumulating or repeated lower-level concerns.

Planning to keep individual children safe and improve their circumstances

Across the country, staff meet regularly to plan together for children who may be in need of protection. Most children at risk have an allocated social worker and a child protection plan, but too often plans are vague and do not specify what needs to change in order to reduce risks. More rigorous planning is required to ensure support continues after children's names are removed from the CPR, so that improvements continue. Priorities include:

- ensuring all services demonstrate their commitment to joint planning by participating in initial and review case conferences where important decisions are made about children;
- improving the quality of child protection plans, ensuring they are always outcome-focused, measurable and detail each person's responsibilities clearly;
- meeting children's longer-term needs as well as their immediate safety through child protection plans;
- monitoring progress carefully and activating contingency plans promptly when progress is not made or circumstances deteriorate;
- ensuring chairs of meetings have sufficient authority to challenge any lack of progress and ensure action is taken and resources made available to meet children's needs;
- using core groups effectively to implement agreed plans and deliver real improvements in children's day-to-day experiences; and
- coordinating and monitoring support effectively when children's names have been removed from the CPR.



Meeting longer-term needs

Overall, the short-term needs of vulnerable children are usually met well. However, some children who have suffered abuse and neglect do not get the additional help they need to recover from their experiences and build more positive futures. Priorities include:

- improving the availability of specialist resources to help children recover from long-term abuse and neglect and making services available to all children who need them; and
- increasing the stability of care arrangements for children who are unable to live at home, providing, where appropriate, increased support to extended family members to enable them to assume caring responsibilities for children on a full-time or part-time basis.

Information-sharing and recording

Most staff have guidance and support to help them decide how and when to share information to protect children. In many areas, effective information-sharing is supported by positive working relationships between staff across services. However, some staff are not included when they may have important information to share about a child's circumstances that would help meet children's needs better. Priorities include:

- ensuring GPs and school nurses are fully involved in information-sharing about vulnerable children and families;
- helping children and families understand information-sharing practices which protect children;
- compiling and maintaining chronologies of significant events in a child's life, to which all services contribute;
- ensuring chronologies are used as a key tool in helping to identify patterns and trends which assist the assessment of needs and risks and support informed decisions about children's lives;
- tackling poor recording, particularly in social work, health and education services; and
- giving greater attention to achieving more consistent recording of staff contacts with vulnerable children.

Seeking the views of children and families

Most services involve parents in meetings where important decisions are made about their children, such as case conferences, reviews and core groups. Practice in seeking children's views and involving them in decision-making is at an early stage of development across the country. Service planning now needs to take greater account of the views of children and families about the effectiveness of the help they have received. Priorities include:

- promoting a culture where children's views are always sought and considered when decisions are made about them;
- including children in meetings wherever possible and using effective methods of obtaining their views, appropriate to their age and circumstances;
- developing independent advocacy services for children involved in child protection processes, helping staff and families understand when it is appropriate to use them and how they might benefit children; and
- gathering and analysing the views of children and families about the effectiveness of the help they have received and using these to improve services.

Quality assurance and self-evaluation for improvement

Most services have carried out some structured evaluation of their work to protect children, but in many areas, joint self-evaluation is still in the early stages of development. Quality assurance and open and rigorous self-evaluation now need to become more firmly embedded in practice. They require a clearer focus on impact on, and outcomes for, vulnerable children and families. Priorities include:

- establishing robust systems to monitor the quality of key child protection processes, such as core groups, risk assessment and child protection plans;
- involving all key stakeholders, including children and families, in self-evaluation and review;
- monitoring and implementing improvement plans effectively to ensure they lead to positive changes;
- communicating learning effectively to staff, including learning from self-evaluation and from significant and serious case reviews; and
- building capacity among the workforce by supporting the development of practitioner forums and other methods of sharing good practice.

Leadership and direction

Chief Officers and senior managers are clear about their individual and collective responsibilities for child protection. Where there is effective leadership and direction, outcomes for vulnerable children and families are improved. Chief Officers should continue to demonstrate their commitment to child protection and partnership working, and be accountable for the effectiveness of the services their staff provide. Priorities include:

- developing robust management and performance information across services so that Chief Officers and CPCs can assure themselves that the needs of children at risk are being met and that services are improving outcomes for vulnerable children in the short and longer term;
- strengthening joint working between Chief Officers and senior managers to improve services; and
- enabling CPCs to work effectively, ensuring they have the resources they need to support improvements.

Next steps

In February 2009, Ministers requested that HMIE lead and coordinate a further, more proportionate programme of child protection inspections from April 2009. This programme will conclude in 2012.

Acknowledging both the Crerar recommendations and the Government response, the revised model of child protection inspections places self-evaluation at the centre of the inspection process. In 2009, HMIE published a revised self-evaluation guide, *How well do we protect children and meet their needs?*[6] to assist services undertaking self-evaluation for improvement. The revised inspection model is more proportionate, intelligence-led and flexible and has a sharper focus on outcomes for vulnerable children and families. Each CPC has a link inspector from HMIE who will assist in building capacity for self-evaluation and supporting improvement within and across services focusing on improving outcomes for vulnerable children.

6 *Self-evaluation using quality indicators,* HMIE May 2009, www.hmie.gov.uk

APPENDIX A

Child protection

Table 10 Quality indicator evaluations for child protection inspections of 30 local authority areas[1], Scotland

Quality Indicator[2]	Number							Percentage					
	E	VG	G	S	W	U	Total	E	VG	G	S	W	U
NPF reference quality indicators													
1.1 Children are listened to, understood and respected	1	11	10	7	1	0	30	*3*	*37*	*33*	*23*	*3*	*0*
1.2 Children benefit from strategies to minimise harm	0	12	11	6	1	0	30	*0*	*40*	*37*	*20*	*3*	*0*
1.3 Children are helped by the actions taken in response to immediate concerns	0	8	11	4	3	4	30	*0*	*27*	*37*	*13*	*10*	*13*
1.4 Children's needs are met	0	3	11	9	6	1	30	*0*	*10*	*37*	*30*	*20*	*3*
Additional quality indicators													
2.1 Public awareness of the safety and protection of children	0	16	6	7	1	0	30	*0*	*53*	*20*	*23*	*3*	*0*
3.1 Involving children and their families in key processes	0	8	11	6	5	0	30	*0*	*27*	*37*	*20*	*17*	*0*
3.2 Information-sharing and recording	0	2	17	5	5	1	30	*0*	*7*	*57*	*17*	*17*	*3*
3.3 Recognising and assessing risks and needs	0	0	6	11	11	2	30	*0*	*0*	*20*	*37*	*37*	*7*
3.4 Effectiveness of planning to meet needs	0	3	10	7	7	3	30	*0*	*10*	*33*	*23*	*23*	*10*
4.1 Policies and procedures	0	6	16	5	3	0	30	*0*	*20*	*53*	*17*	*10*	*0*
4.2 Operational planning	1	5	7	8	9	0	30	*3*	*17*	*23*	*27*	*30*	*0*
4.3 Participation of children, families and other relevant people in policy development	1	8	9	6	5	1	30	*3*	*27*	*30*	*20*	*17*	*3*
4.4 Recruitment and retention of staff	0	11	10	7	2	0	30	*0*	*37*	*33*	*23*	*7*	*0*
4.5 Development of staff	1	9	13	4	3	0	30	*3*	*30*	*43*	*13*	*10*	*0*
5.1 Vision values and aims	6	7	8	6	3	0	30	*20*	*23*	*27*	*20*	*10*	*0*
5.2 Leadership and direction	2	5	8	8	6	1	30	*7*	*17*	*27*	*27*	*20*	*3*
5.3 Leadership of people and partnerships	0	11	9	7	3	0	30	*0*	*37*	*30*	*23*	*10*	*0*
5.4 Leadership of change and improvement	0	5	7	11	7	0	30	*0*	*17*	*23*	*37*	*23*	*0*

1. All 32 local authority areas have been inspected. Data do not include East Dunbartonshire and Highland as they were pilot inspections. Inspections refer to the first local authority area child protection inspection, not to the evaluations from any subsequent follow-through inspections.

2. The categories are

E - Excellent
VG - Very good
G - Good
S - Satisfactory
W - Weak
U - Unsatisfactory

Note: The four reference quality indicators upon which the National Indicator is based are 1.1, 1.2, 1.3 and 1.4. The other quality indicators are also evaluated as part of the inspection process but are not used to calculate the National Indicator.

APPENDIX B

Definition of evaluative terms used in inspection

Level 6	***excellent***	outstanding or sector leading
Level 5	***very good***	major strengths
Level 4	***good***	important strengths with areas for improvement
Level 3	***satisfactory***	strengths just outweigh weaknesses
Level 2	***weak***	important weaknesses
Level 1	***unsatisfactory***	major weaknesses

An evaluation of ***excellent*** will apply to performance which is a model of its type. The outcomes for children, young people and their families along with their experience of services will be of a very high quality. An evaluation of *excellent* will represent an outstanding standard of performance, which will exemplify very best practice and will be worth disseminating beyond the service or area. It will imply these very high levels of performance are sustainable and will be maintained.

An evaluation of ***very good*** will apply to performance characterised by major strengths. There will be very few areas for improvement and any that do exist will not significantly diminish the experience of children, young people and their families. While an evaluation of *very good* will represent a high standard of performance, it is a standard that should be achievable by all. It will imply that it is fully appropriate to continue the delivery of service without significant adjustment. However, there will be an expectation that professionals will take opportunities to improve and strive to raise performance to excellent.

An evaluation of ***good*** will apply to performance characterised by important strengths, which taken together clearly outweigh any areas for improvement. An evaluation of *good* will represent a standard of performance in which the strengths have a significant positive impact. However, the quality of outcomes and experiences of children, young people and their families will be diminished in some way by aspects where improvement is required. It will imply that the services should seek to improve further the areas of important strength, but take action to address the areas for improvement.

An evaluation of ***satisfactory*** will apply to performance characterised by strengths, which just outweigh weaknesses. An evaluation of *satisfactory* will indicate that children, young people and their families have access to a basic level of service. It represents a standard where the strengths have a positive impact on the experiences of children, young people and their families. However, while the weaknesses will not be important enough to have a substantially

adverse impact, they will constrain the overall quality of outcomes and experiences. It will imply that professionals should take action to address areas of weakness while building on its strengths.

An evaluation of ***weak*** will apply to performance, which has some strengths, but where there will be important weaknesses. In general, an evaluation of *weak* may be arrived at in a number of circumstances. While there may be some strengths, the important weaknesses, either individually or collectively, are sufficient to diminish the experiences of children, young people and their families in substantial ways. It may imply that some children and young people may be left at risk or their needs not met unless action is taken. It will imply the need for structured and planned action on the part of the agencies involved.

An evaluation of ***unsatisfactory*** will apply when there are major weaknesses in performance in critical aspects requiring immediate remedial action. The outcomes and experiences of children, young people and their families will be at risk in significant respects. In almost all cases, professionals responsible for provision evaluated as *unsatisfactory* will require support from senior managers in planning and carrying out the necessary actions to effect improvement. This may involve working alongside other staff or agencies. Urgent action will be required to ensure that children and young people are protected and their needs met.

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