

Joint inspection of services to protect children and young people in the Clackmannanshire Council area

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Introduction

The *Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006*, together with the associated regulations and Code of Practice, provide the legislative framework for the conduct of joint inspections of the provision of services to children. Inspections are conducted within a published framework of quality indicators, *How well are children and young people protected and their needs met?*¹

The inspection team included Associate Assessors who are members of staff from services and agencies providing services to children and young people in other Scottish local authority areas.

¹ *How well are children and young people protected and their needs met?* Self-evaluation using quality indicators, HM Inspectorate of Education 2005.

1. Background

The inspection of services to protect children² in the Clackmannanshire Council area took place between June and September 2007. It covered the range of services and staff working in the area who had a role in protecting children. These included services provided by health, the police, the local authority and the Scottish Children's Reporter Administration (SCRA), as well as those provided by voluntary and independent organisations.

As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services who work to protect children living in the area. Some of the children and families in the sample met and talked to inspectors about the services they had received.

Inspectors visited services that provided help to children and families, and met users of these services. They talked to staff with responsibilities for protecting children across all the key services. This included staff with leadership and operational management responsibilities as well as those working directly with children and families. Inspectors also sampled work that was being done in the area to protect children, by attending meetings and reviews.

As the findings in this report are based on a sample of children and families, inspectors cannot assure the quality of service received by every single child in the area who might need help.

Clackmannanshire covers an area of 159 square kilometres in the central belt of Scotland. It lies north of the river Forth and is the smallest mainland Scottish local authority area. The administrative centre is in Alloa.

The estimated population of Clackmannanshire is 48,630 of whom 10,747 are under 18 years. A high proportion of the area is among the most deprived in Scotland. The number of new people seeking help with drug misuse increased by almost a third in 2005 to 2006. In the same period, 8% of all children in Clackmannanshire were referred to the Children's Reporter on care and welfare grounds. This is the highest rate of referral in Scotland and double the average for comparator authorities³. The number of children who were the subject of a child protection case conference and the number of children who were listed on the Child Protection Register (CPR) are similar to national averages. In October 2006 the reported vacancy rate for children's social workers was 33%.

² Throughout this document 'children' refers to persons under the age of 18 years as defined in the *Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006*, Section 7(1).

³ Comparative Authorities include North Lanarkshire, West Lothian, Falkirk, South Lanarkshire and East Ayrshire.

2. Key strengths

Inspectors found the following key strengths in how well children were protected and their needs met in Clackmannanshire.

- The range of support provided by services to children and families.
- Identification of concerns by staff in health and education and efforts to obtain help for children and families.
- The promotion of children's rights and entitlements by the children's rights service.
- Approaches taken by some staff to involve children in the development of services.
- Safe recruitment practices.

3. How effective is the help children get when they need it?

Children knew who to go to for help and how to keep themselves safe. They were positive about their relationships with school staff. There was a good range of services providing support to vulnerable families. Children at risk of harm were recognised at an early stage by staff in health and education services. Those who were at immediate risk received effective help when they needed it. However, concerns did not always result in an early and appropriate response by all services. Some children did not receive the right help at the right time and were left for too long in circumstances which placed them at risk.

Being listened to and respected

Overall, the extent to which children were listened to and understood was adequate. Children had regular contact with staff in education, health and voluntary services. Staff communicated effectively with children. Children placed a high level of trust in teaching staff in schools. Health visitors and early education staff effectively monitored babies and young children for changes in their health, behaviour and wellbeing. These staff were knowledgeable about the children and families with whom they were working. Befrienders and Young Carers staff had developed consistent and trusting relationships with children and understood their needs. Some children and parents found it difficult to establish trusting relationships with social workers due to frequent staff changes and long periods without an allocated worker.

Panel members took care during Children's Hearings to ensure children understood what was happening and encouraged them to be confident in speaking at these meetings. Very few children completed *Having Your Say* questionnaires before the hearing to let the panel know what they wanted to happen. The Children's Rights Officer served as an advocate for a small number of children, ensuring that their views and entitlements were understood and considered at formal meetings. Children and families often attended decision-making meetings with social workers who did not have a sufficient understanding and knowledge of their circumstances. Some children and families met a social worker for the first time immediately before a hearing. Some children who were subject to compulsory measures of care did not meet or speak with a social worker until a review hearing took place. Some children and their families felt that no-one knew their whole story.

Being helped to keep safe

There was a good range of services to help children keep safe. This included services for families experiencing the effects of domestic abuse, homelessness and substance misuse. Voluntary services provided good support and intervened at an early stage to help children and families experiencing difficulties. Family centres provided effective support and nurturing to families with vulnerable young children. Staff maintained a clear focus on children's needs, even when support was directed through parents. School Liaison Groups identified children in need of additional support and ensured that these children received the help they needed. Good practical support and help with parenting was provided for families through family centres, Brightstart and Barnardo's Matrix. The Independent Living Service (Pitstop) provided valuable practical support in the home. Parents found these services very helpful and children's lives had improved as a result. Good support was available from Women's Aid for women and children experiencing domestic abuse.

Schools provided a wide range of opportunities for children to learn about keeping themselves safe. Children received useful information and participated in workshops arranged by schools, the police and youth organisations. They were knowledgeable about the dangers of drug and alcohol misuse and showed a good awareness of personal safety. Children clearly remembered the messages about keeping themselves safe from the *Feel, Think, Do* programme delivered to all primary school children. Children identified trusted staff in school to whom they could talk about their worries. There were important gaps in their knowledge about their entitlements outlined in the Children's Charter. Headteachers and attendance and welfare officers supported children who were absent from school. Staff in the education service monitored and supported children whose parents had chosen to educate them at home. The procedure for responding to children missing from education was clearly understood by all staff.

Children and young people had a good awareness of how to obtain help and to whom they could go for help. They identified a range of ways to keep themselves safe in a variety of situations. However, some were not fully aware of how to keep safe on the internet. Not all children were aware of national helplines or what these services could offer. Community wardens and police had a visible presence in schools and the community. Most children believed they would get a response from school staff and police officers if they had a concern. Children felt unsafe in some places because of perceptions about local gangs.

Some examples of what children said about keeping themselves safe.

“Support workers are good – they are down to earth.”

“Mr X [guidance teacher] helps us with problems. He is kind and cares about your point of view.”

“I think Clackmannanshire is good. It helps me a lot because I feel safe and I know that I will be safe.”

“It's not good because you just get to trust them [social workers] with what you wanted to say and then they leave.”

Immediate response to concerns

Overall, the immediate response to concerns was weak. There was prompt action by all agencies to specific incidents of abuse. Children who were at immediate risk were made safe. However, action was not always taken in good time when there were less pressing concerns. Children who experienced neglect were identified by health and education staff. Attendance and welfare officers who visited school aged children in their own homes were particularly effective in raising concerns about neglect. These staff were alert to children who may be at risk and were careful in referring their concerns. The arrangements to ensure a multi-agency response for all children for whom there were concerns were not fully effective. Some children did not receive the help they needed early enough from social workers. Children remained in circumstances which placed their welfare at risk or until their situation deteriorated. There were no agreed arrangements for providing alternative care for

children who needed it at night and weekends. Midwives and staff working with adults affected by substance misuse were alert to the needs of unborn babies. However, the multi-agency protocol for responding to concerns for unborn babies did not lay down timescales for pre-birth planning. In a few cases planning was delayed until after the baby was born.

Meeting needs

Overall, the actions taken by staff to meet the needs of children at risk were weak. The immediate and short-term needs of children who were identified as being at risk were quickly met. However, some vulnerable children and their families did not receive the help they needed at the right time. The identification of longer term needs varied. The time taken to assess the needs of children was sometimes too long. Staff did not always make best use of all of the information available to identify children's needs. Children and families experienced uncertainty. Carers in the extended family received limited support to give children long-term stability.

There was a good range of services to meet children's needs. Some provided a high quality of service to children and families. Very good support was available to meet children's needs through the Primary and Secondary School Support Services. However, for children in need of protection, services did not always work well together in a coordinated way to ensure that their needs were met. The needs of some children escalated to crisis point before they received support. A few children who had been subject of a child protection investigation which identified a need for voluntary support did not receive this. Families were able to establish good and consistent relationships with most professionals. They were, however, unable to maintain consistent relationships with social workers. Some children and families found it difficult to get a helpful response from a person who knew their circumstances, especially when their social worker was on holiday or absent. Some accommodated children were not seen by a social worker for long periods.

Good support for children with complex emotional and psychological needs was available through Child and Adolescent Mental Health Services (CAMHS). These services were provided quickly and helped children to recover from the impact of abuse. Psychological Services had developed a range of support to reduce long-term effect of loss, trauma and abuse, for example, through the *Seasons for Growth* programme. The health needs of children looked after and accommodated by the local authority were well met through the Well Chosen Service.

4. How well do services promote public awareness of child protection?

Services had developed informative materials to publicise child protection. These were disseminated and available in a wide range of public places. There were services for members of the public to report their concerns about children at all times which were well used. A more coordinated approach to raising public awareness about child protection was planned.

Being aware of protecting children

Overall, the extent to which services had raised public awareness of child protection was good. NHS Forth Valley had issued guidance to all employees about the importance of protecting children. The Child Protection Committee (CPC) had established a working subgroup to promote public awareness of child protection. The CPC had developed an attractive and easily recognisable logo for all child protection publicity materials.

Eye-catching information posters and leaflets had been produced. These were prominently displayed, widely available and contained details of important contact points. Key agencies used newsletters and public magazines effectively to raise awareness among the public about child protection. Police officers actively promoted personal safety through schools and community groups. Central Scotland Police were planning a website designed for children and young people. Central Scotland Emergency Out of Hours Social Work Service (EDT) had developed its own publicity materials such as stickers, leaflets and posters. The CPC planned to develop and implement a coordinated approach to raising public awareness.

Members of the public frequently contacted police and social work services when they had concerns about children. Staff dealt with these calls promptly. Specialist family protection police officers and the social work duty service were available to receive concerns from members of the public during office hours. Outside office hours the police provided a point of contact for any concerns. Staff in the Central Scotland Police operations centre were clear about referring calls concerning the protection of children promptly to an appropriate officer. EDT ensured that a social worker experienced in child protection was available at all times outside office hours. There were no formal arrangements to ensure that members of the public who had raised a concern received feedback.

5. How good is the delivery of key processes?

Parents and some children who attended formal meetings were involved in decision-making. They did not always receive the support they needed to participate fully and to understand what was happening. There was inconsistency and important weaknesses in the sharing and recording of information. Services responded effectively to children who were at risk from specific incidents of abuse. However, the response to and assessment of risk for children who may be exposed to harm in the longer term were much weaker. There were systematic weaknesses in the processes to plan and monitor children's longer term needs. This left some vulnerable children exposed to the potential for continued harm.

Involving children and their families

Arrangements for involving children and their families were weak. Parents were routinely invited to child protection case conferences and core group meetings. Voluntary services including Barnardo's Matrix, Young Carers and NCH made very good efforts to involve children and parents in important decisions. Children's panel members informed and involved children and families in children's hearings. Some staff, including health visitors and social workers, discussed reports with parents before important decision-making meetings. Some social work managers explained the content of written reports and intended actions with parents in advance of meetings. Reviewing officers ensured that looked after and accommodated children, their parents and carers were involved effectively in review meetings. However, practice in sharing and explaining reports with parents and children was inconsistent. Written reports were often not available until the day of the meeting. Social work reports for planned hearings were often not available. Children and parents did not have sufficient time to read and understand reports or to consider the implications. Parents and children did not always receive a written account of plans and about what needed to be done to reduce risks and meet their children's needs. There was no guidance for staff to assist in decisions about when to involve children and parents in meetings. Overall, social workers did not take enough time to elicit children's views for child protection meetings. They did not always seek children's views in advance of these meetings and there was no agreed approach to guide staff in this work. The recording of parent's views in the minutes of meetings was inconsistent. Some children and families who had not had regular contact with a social worker felt let down. The Children's Rights Officer supported some children and parents to be actively involved in meetings and to clearly express their views. Staff from Who Cares? Scotland provided support and advocacy for children who were looked after and accommodated in residential child care services.

All services had policies and procedures for dealing with complaints from children and parents. Information on how to make a complaint was available across services. Information leaflets for services provided by the local authority included a section on making comments and complaints. These leaflets were not child-friendly and children and parents were not always aware of how to make a complaint. A few expressions of dissatisfaction were noted in children's records. However, the ways in which these had been resolved were not always clearly recorded. Formal complaints were investigated well in line with published procedures.

Sharing and recording information

Overall, the sharing and recording of information was weak. Staff in all services were aware of the importance of sharing and recording information. Most staff demonstrated good awareness of child protection taking precedence over confidentiality. There was a draft protocol for the sharing of information across Forth Valley partners which had yet to be implemented. Multi-agency meetings were not always used to bring relevant staff together to share information at an early stage when there were concerns about children. Decisions about actions in response to concerns were not always recorded in social work files. Feedback from social workers to staff in other services who reported concerns about children was inconsistent.

Particular features of information-sharing included the following points:

- Good information-sharing among agencies within the Multi-Agency Public Protection Arrangements (MAPPA).
- Up to date chronologies of significant events in some health visitor and family centre records.
- Delays in multi-agency planning meetings and case conferences resulted in a failure to share information promptly when there were concerns about children.
- Examples of poor record keeping in all services.
- Health advice was available on a 24-hour basis to assist the planning of child protection investigations. However, police officers and social workers did not routinely seek this information when they carried out joint investigations.
- Staff found the social work information system difficult to use. It did not readily highlight children who were on the CPR which this was particularly important for staff operating outside office hours.
- The arrangements for child protection case conferences did not include a procedure for sensitive and restricted information to be shared.
- The electronic alert system allowed staff to track attendance of children at accident and emergency services.

Recording in children's files varied. Overall, health visitor, family centre, education and police records were comprehensive and easy to read. There was inaccurate recording of personal details across services. Social work and Children's Reporter's records were not always easy to follow. Police records did not always record decisions or outcomes of risk assessments. There were examples of important information being held in the records of a service which had not been shared or communicated to other services. Minutes of child protection core group meetings were not always recorded or distributed to participants.

Overall, staff were aware of the circumstances in which they need to obtain consent from children and families to share information. Family centre staff and health visitors used a clear procedure to explain and obtain consent to share information. Staff working with adults such as addiction, mental health and criminal justice workers were clear about their responsibilities for sharing information for the protection of children. However, across other services, there were insufficient formal procedures to help staff routinely to obtain and record consent. This was sometimes undertaken informally and some parents were unsure what information was held about them.

The sharing and recording of information on sex offenders was good. The links between police, housing and criminal justice ensured that there were processes to protect children from adults who posed a risk to their safety. Police officers had a good knowledge of arrangements for sharing information and were aware of the need to manage information on sex offenders effectively. There was regular sharing of information on child protection and domestic abuse among co-located police officers. Officers were aware of the need to record intelligence about allegations against individuals at the outset of investigations. This ensured that information about individuals who may have committed offences, but had not yet been convicted, were known to Disclosure Scotland.

Recognising and assessing risks and needs

The recognition and assessment of risks and needs was weak. Overall, staff, including those who did not work directly with children, were confident in recognising signs that a child may be at risk. Health visitors used the family health record to monitor risks and assess needs on an ongoing basis. Some staff were alert to and recognised the impact of domestic abuse upon children. Some staff in education showed limited understanding of the impact of parental substance misuse or mental health on children and were not always confident in contributing to assessments of risk. Police and social workers carried out assessments of children who were at immediate risk and responded promptly to ensure their safety. Some social workers and health visitors made good assessments of risks and needs. Health staff prepared useful and helpful chronologies of significant events. However, poor communication, inaccurate recording and a lack of chronologies in services other than health hindered the identification of patterns of risk over time. Staff did not clearly identify an accumulation of concerns or adequately assess the risks associated with neglect or emotional abuse.

There was a lack of clarity about who should convene a child protection case conference when there were concerns that children may be at risk of abuse. Occasionally, when a decision was made to hold a case conference it did not take place. Overall, relevant staff attended case conferences and contributed effectively to the assessment of risks and needs. However, in some cases, staff received invitations too late to allow them to attend. In other cases, not all of the relevant information was used to determine levels of risk. Effective assessments of risk and helpful plans to protect children were made at some case conferences. Staff did not always focus sufficiently on the progress made in relation to initial assessments of risks, nor did they fully consider the implications of new information. Social workers coordinated assessments using a multi-agency risk assessment model. However, this tool was not always understood by them, their managers or staff in other services. Although there were a few examples of effective multi-agency assessments of risks and needs, comprehensive assessments were not regularly carried out for all of the children who needed it. Staff did not always give sufficient attention to the needs of individual children within a family.

Joint investigative interviews were carried out effectively by trained and experienced staff. Staff in police and social work worked well together to plan joint investigations when there were concerns about a child. However, in a few urgent situations the preparation was not thorough and carried out quickly. Health staff were not routinely involved in providing information and advice to assist in the joint planning of an investigation. Paediatricians and forensic medical examiners had recently improved their approaches to ensure that children received an appropriate medical examination. However, police officers, sometimes in consultation with social workers, made decisions on the necessity of medical examinations.

As a result, the health needs of some children were overlooked during child protection investigations. There were a few examples where symptoms of long-term neglect were missed.

Criminal justice social workers and addictions staff were alert to the risks to children whose parents misused drugs and alcohol. They informed childcare social workers about any concerns. Police appropriately reported concerns about children affected by substance misuse to the social work service and the Children's Reporter. A proposed multi-agency framework for assessing risks and needs of children affected by substance misuse had not yet been implemented. A multi-agency procedure to ensure consistency among services supporting children in families affected by substance misuse was not yet in place.

Planning to meet needs

Overall, the effectiveness of planning to meet children's needs was unsatisfactory. Few reports were submitted on time for planning and decision-making meetings. Planning meetings were frequently postponed or rescheduled a number of times, causing serious delays for children. Some reviews for children who were looked after and accommodated by the local authority had not taken place within the required timescales. Plans to meet children's needs were informed by assessments which lacked analysis. Recommendations provided by social workers to Children's Reporters, hearings, child protection meetings, and looked after children's review meetings were sometimes insufficient to adequately meet children's needs.

Child protection plans did not always clearly define the actions to be taken to reduce the risks to each child, the responsible person for those actions, or the timescales by which they should be achieved. There was no standard format for child protection plans and some showed a lack of understanding of the law and guidance on planning for children. In some cases previously agreed actions such as risk assessments, had not been carried out within agreed timescales. Some case conferences were ineffective because essential written information was not available before or during these meetings. A few children had their names removed from the CPR without a case conference to assess whether there had been an improvement in their circumstances.

School reviews and school liaison groups were well attended, took account of changing circumstances and planned effectively to meet the needs of vulnerable pupils. Staff in family centres and voluntary organisations regularly reviewed children's progress and involved families and relevant staff in these processes. Insufficient attention had been paid to planning for children in need of longer-term care and support. However, most children who were looked after and accommodated now had an allocated social worker to carry this out. A number of children who were subject to a home supervision order did not have an allocated social worker, nor did they have a plan in place to meet their needs.

Managers and staff were not clear about the purpose of core group meetings for children whose names were on the CPR, how often they should meet and who should attend. A small number of core groups were working well to monitor and reduce risk to children. However, there was no active or effective core group for many of the children whose names were placed on the CPR. When decisions were made to hold core group meetings they did not always take place as planned. Core group meetings did not always take place regularly to share information, monitor progress and continually assess the risks for children in changing circumstances.

6. How good is operational management in protecting children and meeting their needs?

Helpful inter-agency guidance on child protection had been produced for all staff. However, there were inconsistencies in the ways in which staff implemented this guidance. Integrated plans had been developed to direct the work of all children's services. These were not sufficiently understood by all relevant staff. Overall, operational management had not effectively monitored or reviewed the impact of inter-agency working in child protection. Managers across services had not worked together to minimise the impact of severe and long-term staffing shortages in social work.

Aspect	Comments
Policies and procedures	Overall, policies and procedures were adequate. Inter-agency child protection guidelines were easy to read and widely available to staff. Individual services had reviewed their own procedures to complement these guidelines. Some of these were still in draft form and had yet to be disseminated to staff. There were some good examples where revised guidelines had led to improved practice. Overall, staff were aware of guidance and procedures, however the range of policies, procedures and protocols were not used widely enough by staff to provide a consistency of approach. There was no clear framework for risk assessment or a sufficiently systematic approach to reviewing and evaluating policies and procedures.
Operational planning	Operational planning was weak overall. The Integrated Children's Service Plan (ICSP) for 2005-2008 set out areas for improvement to keep children safe. The Children's Services Planning Group monitored progress on a large number of objectives, however, monitoring did not focus sufficiently on outcomes for children. There was a lack of awareness among staff about the ICSP and how this influenced their work. Management information regarding child protection work was not collated jointly or systematically reviewed by the CPC. There was no agreed inter-agency approach to measure and manage the impact of very low staffing levels in social work.
Participation of children, their families and other relevant people in policy development	The participation of children, their families and other relevant people in policy development was good. A child-friendly version of the ICSP had been prepared and children encouraged to make comments and suggestions. The Youth Council and the Youth Forum provided opportunities for children to participate in policy development. Some individual services, including the voluntary sector, consulted effectively with children and families. The Council had involved children in the planning of new schools. Central Scotland Police had engaged with young people to inform a force-wide youth strategy. NHS Forth Valley had commissioned consultation with families on child protection processes.

Aspect	Comments
Recruitment and retention of staff	<p>The recruitment and retention of staff was adequate. Overall, services had safe recruitment practices which took full account of current legislation and the need to carry out disclosure checks. The NHS Forth Valley safe recruitment practice complied with national guidance. However, the written procedures had not yet been updated in line with current guidance. The local authority had recently identified the recruitment and retention of social workers as a key priority. Senior managers in social work had recently made successful efforts to recruit childcare social workers. There had also been some recent improvements in the retention of this group of staff. Allegations of abuse against staff were dealt with appropriately through the child protection procedures. Joint workforce planning across services had not yet been initiated.</p>
Development of staff	<p>The development of staff was adequate. There was a detailed inter-agency child protection training strategy and this training was well received by staff. This complemented a good range of single agency training across services. Child protection training had been provided for all relevant groups of staff and was mandatory for some workers. Managers in social work had identified the development needs of new and inexperienced staff and had begun a programme to meet these. Health staff knew who to contact for support and guidance however, there were no formal arrangements to ensure the review of their child protection work. Social workers had access to formal support but there was a lack of continuity of supervisor and outcomes were not clearly recorded.</p>

7. How good is individual and collective leadership?

A vision for the protection of children had been developed across the key agencies. Protecting children had been given a high priority within services. There was strong individual leadership and direction in some services but longstanding weaknesses in others which were still having an impact. The Forth Valley Child Protection Strategy Group (FVCPSG) had not given sufficient direction to the Clackmannanshire Child Protection Committee (CPC). The CPC had identified areas for improvement. However, it did not make good use of information in planning. An early start had been made towards inter-agency self-evaluation but this was not yet firmly established.

Vision, values and aims

Overall, the vision, values and aims to protect children were adequate. The local authority, NHS Forth Valley and Central Police had established clear aims for the protection of children. Chief Officers consistently expressed a strong message of corporate responsibility for protecting children within their own service. However, the FVCPSG had not developed a strong collective vision for staff or sufficient strategic direction for the CPC. Staff at an operational level were not clear about who was accountable for leading this work.

- There was cross-party political support for child protection and elected members were clear about the Council's vision of achieving the best outcomes for all children. Together they had recently acknowledged that the Social Work Service for children and families needed significant improvements. The Chief Executive and senior officers of the council were all clear about the priority afforded to the protection of children.
- The Chief Executive of NHS Forth Valley had a clear vision for the protection of children and had ensured that this vision was shared by all staff. She had established a Child Protection Action Group and staff were very clear about their contribution to keeping children safe. NHS 24 and the Ambulance Service ensured that staff were aware of their responsibilities for the protection of children.
- The Chief Constable of Central Police assisted by the Assistant Chief Constable had ensured that child protection was included in the priorities for the force and that this was communicated and understood by all staff. This had resulted in a higher profile for child protection and domestic abuse within the Force.

The ICSP set out a shared local vision for children in Clackmannanshire. The plan was published in an accessible format for children and available in a range of minority languages. However, the ICSP focused on processes. Insufficient attention was paid to the measurement of impact and upon improving outcomes for children and families. The links between the ICSP and the Community Plan had not ensured that the needs of children were effectively prioritised within community planning arrangements.

Leadership and direction

Members of the FVCPSG were clear about their own accountability for child protection across Forth Valley. It had accomplished joint inter-agency guidelines for child protection and a joint approach to inter-agency training, including the joint funding of a training officer. However, there was no joint training budget to support this. The FVCPSG was planning to put in place arrangements to gather robust information about child protection across Forth Valley. However, it did not hold a strategic overview of services to protect children across all agencies. Collective leadership and direction was weak.

The CPC was developing systems to improve their understanding of the impact of child protection work across the local authority area. The appointment of a lead officer had improved coordination and implementation of agreed actions. However, the CPC's action plan was not sufficiently informed by robust management information. Some key managers were unaware of the priorities and work of the CPC. Members of the CPC had not taken a collective approach to minimise the impact of shortages of childcare social workers.

Elected members had ensured that services to protect children were prioritised within the council. There had been recent improvements in working collaboratively to develop and provide effective services within the Council. The management structure for the childcare social work service had been strengthened and a strategy implemented to address recruitment and retention difficulties. However, these changes had not yet led to improvements in the experiences and outcomes for children in need of protection. The allocation of resources within NHS Forth Valley had been prioritised to improve services for the protection of children. Central Scotland Police had increased staffing within the Family Unit.

Leadership of people and partnerships

Leadership of people and partnerships was weak. Overall, senior managers provided effective leadership and supported staff well within their own organisations. Chief Officers were committed to the FVCPSG and there were good relationships between partner agencies. The FVCPSG had not taken an effective lead on gathering and analysing information across services. More needed to be done to develop interagency protocols in a number of areas to ensure an improved and consistent approach to practice.

Staff within health and police services had strong internal working relationships and demonstrated effective teamwork. The difficulties in recruitment and retention of childcare social workers, low morale and previous poor management within the childcare service had made it difficult to establish effective joint working. The recent introduction of Area Management Boards (AMB) provided a way to enhance joint working within local neighbourhoods. Devolved budgets to the AMB had been identified enabling resources to be targeted to meet children's needs locally. However it was unclear how AMBs would contribute to the overall strategy for the protection of children.

The Children's Services Planning Group led the integrated planning and delivery of services to children and families, however this group did not have a wide range of representatives. Voluntary services working with children were not included in all relevant strategic partnerships. The potential contribution of the voluntary sector and children and their families was recognised as an area for further development by the FVCPSG. In her former role, the new Head of Social Work had established strong partnerships with

Clackmannanshire Community Health Partnership (CHP). This was now beginning to effect better joint working in relation to children's services.

Leadership of change and improvement

Overall, the leadership of change and improvement was adequate. Chief Officers and senior managers recognised the need to establish a more systematic approach to quality assurance and self-evaluation as a means of improving services to protect children. Arrangements for developing joint self-evaluation were at an early stage. The CPC had established a continuous improvement subgroup which had made a start at jointly evaluating practice. Management information was not used consistently by the local authority, elected members, the CPC or the FVCPSG to determine a clear view of the overall effectiveness of the impact of services to children and what action may be required to address weaknesses.

Elected members and the Chief Executive of the Council had recognised the need to improve the leadership and management of child protection and had taken a number of steps to improve this. This included the strengthening of the management structure within the childcare social work service and the introduction of a new approach for the assessment of staff who undertook child protection work. Communication with childcare social work staff had improved through a series of regular of whole-staff development days. However, the local authority had not engaged fully with its partners in a collective approach to consider the impact on other services and the lives of children of social work staffing shortages and poor performance.

The police had carried out a comprehensive single service self-evaluation of child protection across the Central Police Force area. NHS Forth Valley produced a quarterly report on child protection activity within the Health Board area which was presented to NHS Forth Valley Child Protection Action Group. The local authority produced an annual childcare services report which identified action points for the following year. There was a lack of awareness at a senior level of the information held by partner agencies. This information was not used collectively to highlight areas for joint improvement.

8. How well are children and young people protected and their needs met?

Summary

Inspectors were not confident that all children at risk of harm, abuse or neglect, and in need of protection, were being identified early enough to receive the help and support they needed. Some children had received help from a range of services and their situation had improved. The local authority had taken very recent steps to revise structures and address serious staff shortages in the childcare social work service. However, much more needed to be done to ensure that the most vulnerable children were protected and had their needs met. Clear and agreed frameworks for the assessment of risks and needs were required to improve the protection of children. Urgent work was required to provide guidance to staff and to improve practices in planning to meet needs.

The CPC and individual services, guided by the FVCPSG had structures in place to identify and implement improvements in the protection of children in Clackmannanshire. In doing so Chief Officers and the CPC should take account of the need to:

- involve children and families more fully in decisions about their lives;
- improve the processes for the assessment of risk and needs;
- fully involve health and medical staff at an early stage when there are child protection concerns and improve the arrangements for medical examinations;
- improve the quality of social workers' reports and ensure that they are provided on time;
- improve joint planning to meet children's needs and ensure regular planning meetings take place for all children in need of protection;
- improve joint performance monitoring of key child protection processes and outcomes for children and families; and
- sustain sufficient levels of social workers within the childcare social work service.

9. What happens next?

The Chief Officers have been asked to prepare an action plan indicating how they will address the main recommendations of this report, and share that plan with stakeholders. Within four months, Chief Officers should submit to HM inspectors a report on the extent to which they have made progress in implementing the action plan. Within one year of the publication of this report HM inspectors will re-visit the authority area to assess and report on progress made in meeting the recommendations.

Jacquie Pepper
Inspector
February 2008

Appendix 1 Quality Indicators

The following quality indicators have been used in the inspection process to evaluate the overall effectiveness of services to protect children and meet their needs.

How effective is the help children get when they need it?	
Children are listened to, understood and respected	Adequate
Children benefit from strategies to minimise harm	Good
Children are helped by the actions taken in response to immediate concerns	Weak
Children's needs are met	Weak
How well do services promote public awareness of child protection?	
Public awareness of the safety and protection of children	Good
How good is the delivery of key processes?	
Involving children and their families in key processes	Weak
Information-sharing and recording	Weak
Recognising and assessing risks and needs	Weak
Effectiveness of planning to meet needs	Unsatisfactory
How good is operational management in protecting children and meeting their needs?	
Policies and procedures	Adequate
Operational planning	Weak
Participation of children, families and other relevant people in policy development	Good
Recruitment and retention of staff	Adequate
Development of staff	Adequate
How good is individual and collective leadership?	
Vision, values and aims	Adequate
Leadership and direction	Weak
Leadership of people and partnerships	Weak
Leadership of change and improvement	Adequate

This report uses the following word scale to make clear the evaluations made by inspectors:

Excellent	Outstanding, sector leading
Very Good	Major strengths
Good	Important strengths with areas for improvement
Adequate	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

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