

**Joint Interim Follow-Through inspection of services  
to protect children and young people in the  
City of Edinburgh Council area**

**September 2008**

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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?*'.<sup>1</sup>

Inspection teams include Associate Assessors who are members of staff from services and agencies providing services to children and young people in other Scottish local authority areas.

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

## **1. The inspection**

HM Inspectorate of Education (HMIE) published a report on the joint inspection of services to protect children and young people in the City of Edinburgh Council area in September 2007. Working together, services within the City of Edinburgh Council area prepared an action plan indicating how they would address the main points for action identified in the original HMIE inspection report.

Inspectors revisited the City of Edinburgh Council area in June 2008 to assess the extent to which services were continuing to improve the quality of their work to protect children and young people, and to evaluate progress made in responding to the main points for action in the initial report.

## **2. Continuous improvement**

A collective approach had been taken by Chief Officers and senior managers to improve structures and services.

Within the local authority there had been a number of significant changes since the initial inspection. A new Director of Children and Families and a new Chief Social Work Officer (CSWO) had been appointed. The Children and Families departmental structure and roles and responsibilities of senior managers had been reviewed. The number of heads of service had been reduced. From May 2008 one had been appointed as a new Head of Service for Children and Young People with overall responsibility for children and families social work and child protection. The Head of Service for Children and Young People was supported by a new service manager with direct responsibility for the social work practice teams and the chairs of child protection case conferences. This was intended to provide clearer lines of accountability and professional leadership in children and families social work. The role of the CSWO had been strengthened. The CSWO was now part of the Senior Management Team and had been given additional responsibility for quality assurance of children and families social work.

The Child Protection Committee (CPC) had appointed an Assistant Chief Constable of Lothian and Borders Police as its new chair. At a meeting of the CPC held during this interim follow-through inspection an Executive Group of the CPC was set up to streamline decision-making. A new police commander for the City of Edinburgh had recently been appointed.

### **3. Progress towards meeting the main points for action**

The initial inspection report published in September 2007 identified six main points for action.

#### **3.1 Provide, without delay, safe alternative care arrangements for all children identified as living in situations which are unsafe.**

An encouraging start had been made to improving safe alternative care arrangements.

There was clearer identification of children living in unsafe situations by managers and staff. The decisions of children's hearings to remove children under the age of 12 years to a safe place were almost always implemented within a few days. Some older children had to wait longer in unsuitable situations. When a safe alternative care placement could not be found immediately alternative support was provided until a suitable place was available. Senior managers had begun to monitor waiting times for individual children and emerging trends in placement. When it was no longer safe for children to remain with their parents staff were encouraged to consider other options for them. These included placing them with other family members or friends or by providing additional support. Procedures to guide staff about this had been issued very recently. Practice in seeking emergency police checks when children were placed with family or friends was inconsistent. Guidance to staff had been issued recently to address this. The council provided financial help for some of these carers. A respite and outreach service for older children was close to becoming fully operational.

Through increased use of independent providers, 50 additional foster care places had been purchased by the Council. Efforts had been made to recruit additional foster carers. A communications officer had been appointed to coordinate these arrangements. The potential benefits of this recruitment initiative had not yet been achieved. An emergency foster carer scheme had been established recently. This provided out-of-hours staff access to carers for children at risk. The scheme had two carers who sometimes had more children than they were permitted to have. The number of adoption assessments made by social work staff was increasing with the aim of placing more children with adoptive parents and freeing up foster carers.

#### **3.2 Improve assessment of risk and needs to ensure that consistent and timely assessments are carried out when there are concerns about children.**

Limited progress had been made in improving the assessment of risks and needs. A number of important procedures had been implemented to ensure greater consistency in the assessment of risks and needs. These included the Lothian Concern Model which had become established practice among health visitors. Agreements had been put in place to guide health and social work staff in managing the transfer of responsibility when children and families move from one area of Edinburgh to another. The health service had devised and introduced guidance on the management of cases when health visitors were unexpectedly absent from work. Practice standards for social workers had started to ensure a consistency of approach to some areas of work, for example, in the assessment of kinship carers.

A revised and improved framework for assessment to be used by children and families social workers was near to completion. There were signs that initial assessments of risk completed by social workers prior to child protection case conferences were improving. Levels of risk

were analysed more clearly. There had been some recent progress in the provision of timely assessment reports to the Children's Reporter. The practice of timely risk assessment during the Inter-agency Referral Discussions (IRDs) had been maintained. Revised inter-agency child protection procedures were implemented in June 2007. These included a responsibility to share assessments and case histories at Child Protection Case Conferences (CPCCs) to reach a joint understanding of significant events to assist in the joint assessment of risk. However, the length of time between IRDs and CPCCs was still too long to support effective and timely sharing of assessments. This had been identified by senior managers and was being addressed. Overall, the quality of assessments was still variable. A variety of tools were available to help social workers carry out initial and more comprehensive risk assessments. Staff were not always clear about which assessment tool they should use or about the guidance available to support them in this process. There were a large number of unallocated cases within social work of children who were looked after by the local authority. The ongoing assessment of these vulnerable children was not being carried out effectively. There was limited improvement in the assessment of children for whom there were increasing concerns and those experiencing long term neglect.

### **3.3 Improve planning to meet children's needs ensuring that all children assessed as requiring a service have a social worker or lead professional allocated to their case.**

Overall, there was very limited progress in improving planning to meet children's needs. All children on the child protection register were allocated a social worker. In contrast, an increasing number of children subject to formal supervision arrangements were not allocated a social worker. Children's Reporters were not informed of this which could delay the decision-making of the children's hearing.

Recent improvements ensured that the same social worker retained responsibility for the child's case from the date of referral until a CPCC was held. This improved continuity for the child and family. The lack of availability of a Chair contributed to significant delays in holding initial CPCCs. Senior managers were aware of this and taking action. At initial CPCCs core group participants were clearly identified and the child protection plan developed. Core groups were held regularly and were well attended. Monitoring of child protection plans had improved. Core group minutes were distributed promptly although the standardised format for recording these was not always used. Core group minutes generally provided an update on contact with the family with little reference to the child protection plan. Some child protection plans did not identify time scales for actions.

Pre-birth case conferences were held promptly. Children suffering chronic neglect were not prioritised effectively unless they were on the child protection register. They did not always have an allocated social worker. Multi-agency planning meetings were held following de-registration from the child protection register which offered continuing help and support to children and their families. Arrangements for longer term planning were improving. A policy about providing children with long term care had been drawn up. Staff were encouraged and helped by their managers to make this one of their main priorities. Managers monitored individual cases. Children who were looked after by the local authority waited too long for an initial review of their circumstances and for future care plans to be developed. Family members acting as carers were not always supported well by social work staff and the children did not always have an allocated worker. Some children accommodated with family carers did not have their needs reviewed regularly. When a decision was taken to discharge a baby from hospital when significant risks had been identified in a small number of cases key

staff were not involved. The decision was taken by the core group without the involvement of police or paediatricians. CPCCs were not routinely held following the birth of a vulnerable child.

### **3.4 Improve performance monitoring of key child protection processes, including assessment and planning, to ensure continuous improvement in how staff carry out their work.**

Firm foundations had been laid to improve performance monitoring of key child protection processes.

A Quality Assurance Sub-Group of the CPC was set up during the summer of 2007 and had met regularly. It received monthly reports on performance in key areas from the police and social work service. This had helped the CPC and senior managers identify improvements and monitor progress. Health service performance information was still being developed.

The Department of Children and Families within the City of Edinburgh Council had established a child protection performance monitoring group which was chaired by the Director. A performance framework and reporting process for children and families social work was finalised in March 2008. The performance monitoring group was leading on service improvement. An audit of social work case records had been completed in April 2008 as part of a planned three year rolling programme of audits. Findings from the initial audit had been reported to the Quality Assurance Sub-Group of the CPC and the social work performance monitoring group. Strengths had been identified and action was being taken to improve areas of weakness. In May 2008 procedures had been set up to ensure that chairs of CPCCs monitored practice and reported their findings. Services had carried out an analysis of the effectiveness of the IRD process. The health service had conducted an audit of public health nurse records and attendance of health staff at CPCCs.

Many of these positive developments were relatively new and in some instances efforts were hampered by difficulties in obtaining detailed and reliable information from systems which were sometimes paper based.

### **3.5 Improve training to raise awareness and understanding of staff across services of their roles and responsibilities in child protection.**

Overall, encouraging progress had been made in improving training to raise awareness and understanding of staff across services of their roles and responsibilities in child protection.

An inter-agency training strategy had been developed by the Training Sub-Group of the CPC. It provided clarification of responsibilities for the development, delivery and monitoring the effectiveness of child protection training. There had been a delay in taking this forward due to difficulties in obtaining joint funding, but these had been overcome. The Training Sub-Group had developed strong links with the Quality Assurance Sub-Group and Practitioners Sub-Group of the CPC. Since November 2007 several inter-agency training events had been held. These included Joint Investigative Interviewing Training (JIIT) and inter-agency training for staff about children affected by parental substance misuse. Social work, voluntary sector and health staff had been provided with additional training opportunities and were encouraged and supported to attend. Social work staff and children's panel members had been provided with joint development opportunities locally. Some staff in health and social work still had difficulties in

accessing the inter-agency training they required. The provision of JIIT training for staff had improved. Some social workers had to wait a long time for their initial training. Across services staff had Professional Development Plans (PDPs).

### **3.6 Ensure Chief Officers monitor the effectiveness of the Child Protection Committee (CPC) and key child protection processes to achieve better outcomes for children.**

Chief Officers had taken positive steps to monitor the effectiveness of the CPC and key child protection processes to achieve better outcomes for children.

A Chief Officer's Group had recently been established to strengthen management responsibility and accountability for public protection, including the work of the CPC. A Child Protection Project Board chaired by the Chief Executive of the City of Edinburgh Council and attended by senior managers had been established in January 2008. It was responsible for overseeing improvements in child protection within the Council. The Convener of the Education, Children and Families Committee of the City of Edinburgh Council had begun to receive regular reports on performance. She met regularly with the Chief Executive and senior managers, including the chair of the CPC. These meetings were helpful in establishing a shared understanding of key areas for improvement and strategic priorities. The performance data supplied by the local authority and the CPC was reviewed at regular meetings of the Education, Children and Families Committee. The CSWO reported on performance to the CPC, the Child Protection Project Board and the Convener of Education, Children and Families Committee.

## **4. Conclusion**

In some areas for improvement progress had been slow and a few still required urgent attention. This had been recognised by most, but not all managers. There was clearly a need to consolidate and build upon the improvements that had been made.

Nevertheless, there was a change in culture within and across services which had been pivotal in establishing a shared understanding and ownership of improvement at a senior management level. There was an acceptance of collective responsibility for securing improvement, improved partnership working, particularly within the CPC, and improved communication between managers and staff within and across services. The leadership and direction provided to the CPC and children and families social work had also improved.

However, significant challenges remained, not least in securing the commitment of all managers and staff to making improvements, particularly within the local authority. Staff recognised and welcomed improvement in leadership and direction. However, not all of them recognised the need for change and improvement. Senior managers needed to ensure that this was communicated more effectively to all children and families social work staff. All services had a part to play in identifying and resolving such issues.

## **5. What happens next?**

Within one year of publication of this report, HM Inspectors will re-visit the authority area to assess further progress made in meeting the main points for action.

Kevin Mitchell  
Inspector  
September 2008

## **How can you contact us?**

### **If you would like an additional copy of this report**

Copies of this report have been sent to the Chief Executives of the local authority and Health Board, Chief Constable, Authority and Principal Reporter, Members of the Scottish Parliament, and other relevant individuals and agencies. Subject to availability, further copies may be obtained free of charge from HM Inspectorate of Education, First Floor, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA or by telephoning 01506 600262. Copies are also available on our website [www.hmie.gov.uk](http://www.hmie.gov.uk).

### **If you wish to comment about this inspection**

Should you wish to comment on any aspect of this inspection you should write in the first instance to Neil McKechnie, HM Chief Inspector at HM Inspectorate of Education, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA.

### **Our complaints procedure**

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If you are not satisfied with the action we have taken at the end of our complaints procedure, you can raise your complaint with the Scottish Public Service Ombudsman. The SPSO is fully independent and has powers to investigate complaints about Government departments and agencies. You should write to the SPSO, Freepost EH641, Edinburgh EH3 0BR. You can also telephone 0800 377 7330 (fax 0800 377 7331) or e-mail enquiries to [ask@spsa.org.uk](mailto:ask@spsa.org.uk). More information about the Ombudsman's office can be obtained from the website: [www.spsa.org.uk](http://www.spsa.org.uk).

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