

**Joint interim follow-through inspection of services  
to protect children and young people in the  
Highland Council area  
January 2007**

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## 1. Introduction

A report was published on the Pilot Inspection of Services to Protect Children and Young People in the Highland Council area in June 2005. This interim follow-through inspection was undertaken in June 2006 to evaluate the progress made in meeting the recommendations. In addition, Scottish Ministers requested that the inspection team evaluated the progress made in meeting the recommendations of the report *Danielle Reid: independent review into the circumstances surrounding her death* published in April 2006 and identify any issues of national significance.

The Pilot Inspection report concluded that ‘Children and young people in Highland were well protected but effective meeting of needs was more variable.’ The report identified a number of key strengths and made the following recommendations.

- Children and young people should be more actively and consistently involved in decision-making and policy planning.
- Planned developments to improve assessment of risks and needs should be prioritised, supported by improved record keeping.
- Arrangements for providing medical examinations should be reviewed and improved.
- Prioritisation and shared responsibility for child protection work, within and between agencies, and staff support and safety should be improved.
- The Child Protection Committee (CPC) and the agencies within it should more consistently evaluate the effectiveness of work to protect children and young people, including evaluating, and if necessary, raising public awareness.

There were 68 recommendations contained within the report *Danielle Reid: independent review into the circumstances surrounding her death*.

The Highland CPC prepared a workplan to address the recommendations of the Pilot Inspection Report and the self-evaluation exercise which preceded the inspection. The CPC Commissioning Group Response to the independent review aligned the 68 recommendations contained within the report *Danielle Reid: independent review into the circumstances surrounding her death* with the existing items in the CPC workplan.

The Pilot Inspection Report evaluated the provision of services for children who required child protection within the Highland Council area whereas the independent review report concentrated on the circumstances surrounding the death of a child. A detailed analysis was completed by inspectors of the recommendations of both the pilot inspection report and the independent review report. This enabled the inspection team to identify common areas across both reports and structure inspection activities to evaluate progress in meeting both sets of recommendations. Six areas were identified:

- effectiveness of help for children and young people;
- public awareness of services to protect children and young people;
- assessment of risks and needs;
- information-sharing and communication;
- effectiveness of the management of services to help children and young people; and
- leadership of services to help children and young people.

This inspection covered the range of services and professionals 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 agencies.

## **2. Effectiveness of help for children and young people**

There were clear signs that progress had been made to ensure services provided a positive outcome for children and young people. Young people were treated with respect and with a clear focus on improving their welfare. Children and families who met with inspectors welcomed the high level of commitment and help they had received from staff. They enjoyed good relationships with staff and benefited from staff in agencies working closely together. Services provided or actions taken had a positive impact on children and young people. Examples included children thriving in the care of effective foster carers, children demonstrating improved attendance and achievement at school, children managing their anger or self-destructive behaviour more effectively and children developing greater confidence, self-esteem and skills.

Targeted resources and support were provided by social work, education, health and the voluntary sector to meet the particular needs of children and young people, including the most vulnerable and those with disabilities. Children who attended recovery services benefited from this intervention. Health visitors and early years' workers provided intensive home visiting to support vulnerable families. Parents were assisted to improve their parenting skills and to reduce the harmful effects of behaviour such as alcohol misuse.

Children and young people were able to access a range of support across agencies. Most children who were involved in the development of a care package knew what was going to happen and why. Some young people had developed sufficient confidence to inform or challenge decisions made by professionals. Progress had been made, and further developments were planned to increase the range of support. School Liaison Groups (SLGs) had been established across Highland to undertake early intervention and prevention work. They were commended by parents and foster carers. However, there was some variation in thresholds for referral to SLGs and in securing the attendance of all relevant staff.

Some aspects of social work, speech therapy, child and family mental health and sexual health services were difficult to access quickly. The challenge of delivering services across a wide rural area was not always met, with some targeted services only available in an urban centre or to users travelling long distances.

Recent progress had been made in improving the arrangements for medical examinations. A 24 hour rota of paediatricians had been introduced to provide advice on the need for medical examination. The involvement of health professionals in discussion of referrals, and the auditing of medical examinations by the police were welcome developments. However, too few medical examinations were undertaken for therapeutic reasons. Those undertaken were primarily for evidential reasons. There had been a review of the existing arrangement with the contracted locum organisation, but this had not yet led to benefits for children.

Shortages of staff, particularly in social work teams, led to more frequent changes of workers, loss of trust from children and families and delays in receiving services. A shortfall in foster carers, and in the range of foster care arrangements, meant that movements to permanency or other longer term solutions were delayed.

### **3. Public awareness of services to protect children**

Considerable progress had been made in improving public awareness of services to protect children. The CPC had undertaken a number of initiatives to raise public awareness in advance of a planned campaign in autumn 2006. Information leaflets about child protection had been produced and distributed to pupils and staff in schools. The impact and effectiveness of these leaflets were to be reviewed with children and young people. A single telephone number for referrals from the public in respect of child protection had been established and was available on publicity materials. The CPC website was well maintained and provided a good range of information, including how to report concerns about a child. Staff and elected members gave examples which demonstrated the willingness of the public to engage with child protection agencies.

A survey of public awareness of child protection had been successfully undertaken by the local authority in 2005. The Highland Domestic Abuse Forum had also incorporated questions into a telephone survey. The CPC had recently audited and reported on public awareness of child protection. The part played by the CPC in raising public awareness was beginning to have an impact.

### **4. Assessment of risks and needs**

Within child protection services assessment of risks and needs had improved. Comprehensive assessments were presented at decision-making meetings and assessments took account of the views of children, young people and parents. Parents and children understood assessments and recognised the risk factors identified by social work and health staff. New documentation and tools to support more effective assessment of risk had been introduced by the health, social work and police services.

The link between assessment and planning was clear in decision-making meetings including case conferences, core group meetings and children's hearings. The development of inter-agency operational planning was given a high priority. Sound progress had been made in establishing helpful structures for planning. For example, Looked After Children Reviews were scheduled to take place before children's hearings to inform decisions. Some weaknesses remained in planning for the longer term needs of children, including those children for whom the local authority had parental responsibilities.

Across child protection services the pace of progress in assessment was slower. As part of the pathfinder project for '*Getting it right for every child*', piloted initially in the Inverness area, agencies had begun to improve procedures for information-sharing and assessment. An enthusiastic and skilled multi-agency team had been deployed to implement the project and to train front line staff. Strategic and operational managers had a good level of understanding of

the aims of the project and showed enthusiasm and commitment to successful implementation. Awareness of the project varied amongst staff across the Highland area.

There was a lack of shared understanding by staff at all levels within and across agencies of 'the lead professional role' and conflicting assumptions about the impact on agencies' workloads. A variation in agencies' recording and information technology systems posed considerable challenges for the implementation of shared and integrated assessment. The timetable for implementation of the project had been delayed. Shared and integrated assessment of risks and needs was limited. Responsibility for assessment of risk rested mainly with social work services. In a few cases there was a need for more detailed and thorough consideration of risk. The need to improve assessment of risk and needs within the traditional model of service delivery remained, particularly for areas outside the pilot area.

## **5. Information-sharing and communication**

Information-sharing and communication between staff in all services had improved, particularly with colleagues in the health service. Staff increasingly shared information to identify and protect vulnerable children. Joint working was supported by information-sharing protocols and by the example of senior managers. Significant progress had been made in enhancing communication between services. In particular, there had been improvements in the range of information available from the police and in the contribution of health and medical practitioners to key processes, including decision-making meetings. Highland Council had implemented effective systems for locating children missing from education. Professionals increasingly shared information about adults who might be a risk to children and young people.

Progress on the development of information technology to enable quick and effective information-sharing across individual services was variable. Police made information accessible to other services for the purposes of protecting children. The incompatibility of information systems within and between agencies limited the scope of effective information-sharing.

Children and young people were helped to express their views and participate in meetings. Professionals within services gave high priority to involving children and young people in making decisions which impacted on their lives.

## **6. Effectiveness of the management of services to help children and young people**

There were clear signs of improvement in operational management of services. Individual services had an appropriate range of policies and procedures in place which related well to the CPC's policies for protecting children and young people. Staff took account of the national reform programme for child protection and national guidance when developing policy, for example, guidance on substance misuse. Overall, staff across agencies were well supported and policies were in place to promote their safety. The social work service had recently introduced standards for supervision of social workers by line managers which included requirements regarding the frequency of meetings and recording notes from

supervision meetings. The Chief Executive of the Council received regular reports on the implementation of these standards. Managers within police, health, and SCRA ensured that staff were supervised and accountable in their work. Clear and detailed child protection guidance was regularly reviewed. This was helpful in directing the actions and responses of staff to children in need of help. Networks of professionals, both formal and informal, were meeting regularly and working well.

Satisfactory progress had been made by all agencies in enhancing staff development by providing high quality training in child protection. Designated lead professionals for child protection had been established across all agencies and they provided good support to colleagues. The CPC had appointed an inter-agency child protection trainer who had reviewed the child protection training strategy. There was now a clearer training strategy in place and an intention to review the impact of training on participants. Services provided a tiered model of child protection training and included staff whose main function did not include child protection. Across services, some staff were yet to undergo basic awareness training. Overall, there was a high level of multi-agency training which was valued by staff and developed their skills. In particular, during the past year a significant amount of awareness raising and training had been undertaken in relation to meeting the needs of children living with parents who misused drugs or alcohol.

Although, social work staffing numbers had increased, some children and families' social work teams had a high level of inexperienced workers and one had a high number of agency staff. The social work service had employed creative strategies to fill vacant posts, including the recruitment of agency staff, the development of an award winning trainee scheme and consideration of recruitment from abroad. There were also staff shortages in speech and language therapy and in the provision of child and adolescent mental health services. Although steps had been taken to address these matters, staff shortages had reduced the range and quality of work that services provided.

## **7. Leadership of services to help children and young people**

Leadership and direction within and across all agencies had been further strengthened. There was a high level of commitment, ambition and capability for leading change and improvement. Elected members demonstrated knowledge of the strengths and challenges of the area and were confident of the capacity of senior management to improve services. Practitioners and operational managers generally had confidence in their leaders and recognised their ability to lead improvement of services. There was also a strong ethos of partnership working between public services and voluntary organisations, based on a collaborative culture promoted successfully by senior managers.

The implementation of recommendations from inspection, review and self-evaluation had been taken forward by individual agencies and on a collaborative basis. Action plans were reviewed and progress monitored on an individual and collective basis. Senior managers valued each other's contributions and demonstrated a strong ethos of partnership and collaborative working. The vision, values and aims of the Integrated Children's Services Plan were clear. They were well understood by senior staff and managers, but less so by front line staff.

The CPC had strengthened its capacity for change and improvement. Additional posts in development and training were contributing to the development of a detailed and evaluated child protection training programme and there had been a renewed focus on quality assurance. A sub group of the child protection committee had been established recently to develop procedures for quality assurance and self-evaluation. The early work of this group had led to identification of areas for improvement. Self-evaluation was not yet firmly established across all agencies.

Services in the Highland area had deployed additional resources to improve provision of early intervention and prevention services. Developments included the planned opening of a new family resource centre in Merkinch and the provision of two midwives at Raigmore Hospital, Inverness, to support substance misusing and vulnerable mothers.

The participation of children and young people in policy and planning had improved. Examples of thoughtful and considered work included consultation on the development of a respite care centre and the involvement of young people in producing information leaflets on sexual health, drugs and alcohol. Children were consulted on all new policy proposals presented to the Highland Joint Committee for Children and Young People.

## **8. Conclusion**

Overall, considerable progress had been made in meeting the recommendations in the pilot inspection report and the report *Danielle Reid: independent review into the circumstances surrounding her death*. A high priority had been given to improving services to protect children by all services in Highland. The CPC and agencies across Highland had worked well together to improve services.

Stronger and more ambitious strategic leadership continued to provide a clear commitment to implementing change and continuous improvement. Progress made in meeting the recommendations was based on careful planning, review and monitoring that was undertaken jointly between agencies. Staff had successfully introduced changes which had improved outcomes for children and young people.

The pace of progress was encouraging in most areas but the assessment of risks and needs required further improvements to ensure that appropriate services reached all children.

## **9. What happens next?**

Inspectors were confident that the CPC and senior managers in Highland, working within the context of the national programme for reform of child protection services, were well equipped to implement further change and improvement. The focus of this inspection was determined by the earlier recommendations and mainly directed towards the delivery of key processes. There will be some follow-through inspection activities of services to protect children and young people in the Highland area within 12 months of the publication of this report which will further evaluate and report on progress in implementing recommendations.

The follow-through inspection activities will focus on the impact of services and outcomes for children and on those areas where progress in meeting recommendations has been reliant on the successful implementation of the ‘*Getting it right for every child*’ pathfinder project.

## **10. Issues of National Significance**

A number of issues raised in the interim follow through inspection report were of national significance.

### **Recruitment and Retention of Children’s Social Workers**

The Highland Council had introduced initiatives to increase the number of qualified social workers within Children and Families’ teams and improve training. Despite these initiatives there was still a difficulty in providing a stable workforce. Workers recruited from abroad often lacked detailed knowledge of the Scottish system and those supplied on an agency basis often moved on before the service derived the full benefit from their appointment. Attractive staff development opportunities, when taken up, depleted the number of experienced staff available for complex child protection cases in Children and Families’ teams. Several councils attract staff from neighbouring councils by offering financial incentives and structured professional development to new recruits. There is a need for national consistency in salary structures to ensure greater stability.

Retention of experienced staff is now a more critical issue and requires consideration of further initiatives, some already identified in *Report of the 21<sup>st</sup> Century Social Work Review*, changing lives. These include improving the public image of social workers in children and families’ teams and offering career pathways which retain experienced staff in professional practice. Introducing a skill mix to teams would ensure social workers experienced in child protection devote their time to the professional aspects of their role.

### **Child Death and Significant Case Reviews**

Arrangements for the review of child deaths and significant cases require to be improved. A review group with an independent chair has been set up by the Scottish Executive and consultation on draft guidance is underway. Clear national guidelines which indicate how the review should be conducted, the membership of review teams and the intended audience for the final report should be issued as soon as possible.

A related issue is the impact on professional and public confidence in child protection services following reporting by media of cases where there have been failings in child protection services. An important function of CPCs is proactive management of the media. National spokespersons who can provide a balanced and authoritative view on such cases should be identified to the media on behalf of CPCs.

## **Information-Sharing and Assessment**

The success of the '*Getting it right for every child*' pathfinder project is presently reliant on the e-care solution to multi-agency information exchange currently being developed in partnership with the Scottish Executive. The reliance on a technological solution led to a delay in the implementation of the intended shared and integrated assessment within Highland. Further improvements in agency practice on information-sharing as well as implementing clear legislation and technological solutions should be considered. Improved information-sharing needs to support improved assessment. The lead professional role requires professionals working in all services to develop effective assessment skills and devise plans which improve the lives of children.

Marian Martin  
Managing Inspector  
January 2007

## Appendix 1

The interim follow-through inspection was structured by analysing and grouping the recommendations from both reports into six areas as outlined below. Some recommendations cover more than one area.

Pilot Inspection Report	Independent Review Report
<b>Effectiveness of help for children and young people</b>	
<p>Arrangements for providing medical examinations should be reviewed and improved.</p> <p>Prioritisation for child protection work within agencies should be improved.</p>	<p>Recommendation 64</p>
<b>Public awareness of services to protect children</b>	
<p>The CPC and the agencies within it should more consistently evaluate, and if necessary, raise public awareness.</p>	<p>Recommendation 1</p>
<b>Assessment of risks and needs</b>	
<p>Planned developments to improve assessments of risks and needs should be prioritised.</p> <p>Shared responsibility for child protection work between agencies should be improved.</p>	<p>Recommendation 4,5,10,11,14,15,16,19,38,44,45,53</p>
<b>Information-sharing and communication</b>	
<p>Planned developments should be supported by improved record keeping.</p>	<p>Recommendation 2,3,9,17,18,21,22,27,28,29,35,36,39,40,41,42,43,46,49,50,51,54,56,57,59,60,62</p>
<b>Effectiveness of the management of services to help children and young people</b>	
<p>The CPC and the agencies within it should more consistently evaluate the effectiveness of work to protect children and young people.</p> <p>Children and young people should be more actively and consistently involved in decision making.</p> <p>Staff support and safety should be improved.</p>	<p>Recommendation 5,6,8,12,13,20, 25,30,31,37,47,48,52,55</p>
<b>Leadership of services to help children and young people</b>	
<p>Prioritisation and shared responsibility for child protection work, within and between agencies should be improved.</p> <p>Children and young people should be more actively and consistently involved in policy planning.</p>	<p>Recommendation 7,23,24,26,32,33,34,58,61,63,65,66,67,68</p>

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