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

February 2007

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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 children[2] in the Midlothian Council area took place between June and September 2006. 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 Authority Reporter, 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.

Midlothian covers 354 square kilometres and is located south of the city of Edinburgh extending south to the Moorfoot Hills and the boundary with the Scottish Borders Council. It also borders with the East Lothian Council area to the east. The administrative centre of Midlothian is Dalkeith.

Midlothian has an estimated population of 79,610. 22.6% are under the age of 18 years compared to the Scottish average of 20.8%. On the whole, the socio-economic context is relatively good with unemployment at around 3% which is slightly less than the Scottish average and the average in comparator authorities.[3] Average earnings in Midlothian are lower than the rest of Scotland. Midlothian has pockets of deprivation, but only one area is within the 15% most deprived areas in Scotland. In 2005/2006 the incidence of domestic abuse recorded by the police in Midlothian is higher than almost all comparator authorities. It had increased significantly in comparison to the average increase across Scotland since 2004/2005.

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[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] Comparator authorities include West Lothian, Fife, Clackmannanshire, South Lanarkshire and East Lothian.

2. Key strengths

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

- Services intervened quickly in crisis or high risk situations.
- The support provided to some children as a result of information shared between services in cases of domestic abuse where there were concerns about children's safety.
- The sharing of information by the police with other services when children's safety was at risk due to the misuse of drugs.
- The strategic direction provided by the Edinburgh, Lothian and Borders Executive Group to partnership working and child protection.

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

Children identified as being at immediate risk received help and support from services. Whilst the initial contact with children was mostly good, some staff did not sustain sufficient contact or establish a positive relationship with children and their families. Some children were helped by the support provided by various services. The needs of many of the most vulnerable children were not always met and some children were left in high risk situations without adequate support.

Being listened to and respected

In routine contact with children most staff, but particularly those in schools and the integration teams, had established good communication with children who were listened to, understood and respected. However, during child protection investigations, and when children were being supported, opportunities were not always taken to obtain the child's views about what would help them. Some children were moved from placements without their views being sought. Others who were subject to formal supervision arrangements, on the child protection register or looked after and accommodated by the local authority, were not always seen regularly by social work staff and not provided with an opportunity to share their views or concerns. Some children with additional support needs and those who had experienced difficulties around their sexuality sometimes found it difficult to communicate with staff.

At children's hearings, panel members encouraged children to take part, asked them for their views, listened carefully to what they said and discussed their circumstances and needs with them. Older children had the opportunity to complete a *"Having your say*" form to enable them to say what they wanted the outcome of the children's hearing to be. This form was used well by panel members to assist them in reaching their decisions. Health professionals generally established good relationships with children and took time to explain their role and obtain the child's views, particularly when deciding whether or not to carry out a medical examination. At formal meetings some children found it difficult to make their views known when plans were being made for them. They felt they did not always get the support needed to help them express their views through, for example, advocacy services. Overall, communication between staff and children and their families was weak.

Being helped to keep safe

Steps taken to minimise harm were weak. Some children and families benefited from services to improve parenting skills through, for example, "Sure Start" and from those provided by the Hawthorn Children's Centre. Adult services identified children living in households where parents had additional needs and they alerted other services to the child's needs. There was, generally, a consistent approach by the police, health, education and the Scottish Children's Reporters Administration (SCRA) when providing services to children and their families. Although social work staff provided some effective support this often reflected individual workers' contributions rather than a co-ordinated and consistent approach to helping vulnerable children and families. Staff did not always follow up issues or respond appropriately to concerns from families, carers or other services. In some cases supports that were put in place for the short term, usually following a crisis, were not sustained or were withdrawn too quickly, sometimes without any inter-agency consultation or assessment. The effectiveness of the help provided for children, parents and carers was not regularly and

systematically reviewed or evaluated and staff were often unclear about the extent and nature of any improvement in the child's situation.

Children generally had a good understanding of how to keep themselves safe and were able to identify staff and trusted adults with whom they would share their concerns. These included school staff, parents, carers and family members. In one school, the local community policeman had made a significant impact on the children who regarded him as someone they could talk to and who would listen. Most school children were aware of the service provided by ChildLine and how to make contact with them. The education authority had clear and effective policies for monitoring the safety of children who were educated at home. Children who were absent from school without explanation were referred to the Education Welfare Officer to follow up in accordance with procedures which the education authority had put in place.

Some examples of what children said about keeping themselves safe.

> *"Police officers come into the school to talk and tell us how to keep safe".*
>
> *"This is a good place to go when things get too much at home" – (child attending young carers group).*
>
> *"The guidance teachers are really good and listen to you when you are worried".*
>
> *"The older children in the school watch out for the younger ones".*

Response to immediate concerns

Overall, the help children received when immediate concerns were raised about them was weak. When initial concerns were raised about children these were, mostly, dealt with quickly by professionals through inter-agency initial referral discussion. Services did not always feed back to staff who had referred the child and as a result they were sometimes unclear about what was happening. There were good examples of multi-agency involvement in pre-birth planning to ensure an infant's safety. However, the help and support provided to children and families was inconsistent and they were not always clear about what was happening and why. Some staff tended to focus more on the needs of parents with substance misuse problems or mental health issues, without sufficient consideration being given to the impact on the child. Social work staff did not always gather all the available information about a child from other services. Issues of neglect were not always given sufficient recognition by social work staff and interventions tended to occur only when the situation reached crisis point. There was a failure by some staff to acknowledge the long-term impact of neglect on children. There was a lack of clarity on procedures for re-housing parents who had been subjected to domestic abuse which sometimes resulted in children being at increased risk.

Meeting needs

Overall, the impact of steps taken to meet children's needs was unsatisfactory. When there was a crisis in a family or a high risk situation involving a child was identified, services intervened quickly. However, in many cases these interventions were too brief and did not result in effective longer term multi-agency care planning. As a result, the needs of many of the most vulnerable children were not always met and some children were left at risk. In some cases, insufficient attention had been paid to patterns of previous incidents and accumulating concerns, particularly in cases of neglect.

Some parents and children were supported at home and given help from services such as Children 1st, health visitors, the integration teams and the Hawthorn Children's Centre. However, changing patterns in health visiting and high workloads had reduced health visitors capacity to protect all children. Some children were placed with foster or kinship carers to help protect them, but support for them was sometimes lacking. There were waiting lists for homelink workers and other specialist support, for example, help with play and help for children with challenging behaviour.

The approaches taken to help and support children with complex emotional and psychological needs were inconsistent. Child and adolescent mental health services (CAMHS) were difficult to access due to long waiting times before children could be seen. Children who had experienced sexual abuse were able to access specialist therapeutic services, but sometimes had to wait several months to do so. However, good progress was being made across some services, including Women's Aid, to support children affected by domestic abuse and some children had benefited from specialist staff employed to work with them.

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

Mechanisms were available for members of the community to report their concerns about children at any time of the day or night. These were used well by the public and initial responses were generally appropriate. There had been no co-ordinated effort to raise public awareness about child protection services in Midlothian.

Being aware of protecting children

Overall, the extent to which services had raised public awareness of child protection and the awareness of children about protecting themselves was adequate. Individually and collectively, services had made progress in delivering personal safety awareness to children, particularly through school based programmes. School pupils had been provided with contact telephone numbers for national organisations providing assistance to children on a range of protection issues. Midlothian Child Protection Committee (CPC) was in the early stages of developing publicity materials to raise awareness of child protection in the community. Leaflets had been published, but had not been widely distributed. A Lothian wide child protection internet website had been launched by Edinburgh, Lothian and Borders Child Protection Office (ELBCPO), but Midlothian CPC had not contributed to it. Across services there was a lack of a strategic approach to raising awareness of child protection and plans to develop this through an inter-agency communications strategy had not yet been progressed.

Children of a wide age range were able to speak knowledgeably about various safety and protection issues, but were much less aware of potential risks from people known to them. They were aware of how to contact national child protection organisations, including ChildLine. Good approaches were in place in schools to prevent bullying and these had promoted mutual respect and responsibility amongst the children. 'In the Child Protection Loop' materials had highlighted to staff within schools and pre-schools their duties to report child protection concerns. Members of the public, including family members and neighbours, had contacted services when concerns about children arose. The Emergency Social Work Service (ESWS), contracted by Midlothian Council from the City of Edinburgh Council, and the police service ensured that staff could be contacted at any time. There were examples of anonymous information being passed which was dealt with appropriately.

5. How good is the delivery of key processes?

Parents, carers and children usually attended formal meetings and were involved in decision-making. However, they did not always receive the help they needed to participate fully and to understand what was happening. Information-sharing between services was inconsistent. Although assessment of high levels of risk was usually good, there was not a sufficiently systematic approach to the assessment of risk and needs across all services. The assessment of longer term risks and needs was much weaker. There were systematic weaknesses in planning to meet needs particularly during child protection case conferences and core groups. This had left vulnerable children exposed to risk of abuse, harm or neglect.

Involving children and their families

Arrangements for involving children and their families were weak. Parents and carers were invited to attend child protection case conferences and children's hearings, but the extent to which they were able to contribute was variable. Some parents did not fully understand the process and had not received sufficient help to prepare them for the meetings. This was particularly significant for parents with mental health problems and learning difficulties. Social background reports were not always available for consideration by a children's hearing and social work attendance was inconsistent. In unallocated cases a social worker was often allocated just to produce the report and the assessment and their relationship with the child and family was superficial. Reports to be considered by the case conference or the children's hearing were often not shared with parents or carers in advance or were shared with them just prior to the meeting with insufficient time to read and fully understand them. As a result some parents and carers were unclear about why certain decisions had been made. Parents and carers were sometimes unaware of the plans for their children. Whilst some children had received advocacy support, there were significant gaps in advocacy services for vulnerable children, including some children in foster care. The potential of family group conferences to involve children and families and help them to resolve problems had been recognised, but some staff were reluctant to arrange them because of the additional workload and need to produce a plan.

Services across the local authority area had clear complaints procedures in place, but these were not always well publicised. Some parents and carers who expressed dissatisfaction with the service they received did not know how to complain. Of the few recorded incidents of client dissatisfaction in case files, there was no information regarding how these issues had been dealt with.

Sharing and recording information

Overall, the processes of sharing and recording information in the interests of protecting children were weak. Staff shared information when they identified that a child was at risk, but this was not always sustained following the initial contact. Some staff were still reluctant to share information despite the recent introduction of new guidelines for protecting children living in families with problem substance misuse.

Particular features of information-sharing included the following:

- Most staff shared their concerns with social work, but referrals were mainly verbal and few were followed up in writing.
- Midwives and hospital staff shared information when there were pre-birth concerns.
- Regular information-sharing between the police, social work and authority reporter to discuss children affected by domestic abuse.
- Police shared drugs information where there were concerns about children.
- Improvement in the administration of child protection case conferences, although appropriate staff who knew the child were not always invited to attend.
- Social background reports for children's hearings were not always completed.
- Some staff were reluctant to share information, particularly when there were concerns about parental drug misuse.
- Social work information systems did not allow any sharing of information within and across services and the results of computer searches carried out by staff were unreliable
- Inconsistent information-sharing within the integration teams and between health visitors and social workers

The management and recording of information in case files held by services was variable. Some, including health visitor and authority reporter's files, were clear and easy to follow, but only a few contained a chronology of significant events. Social work case records were not well structured and lacked clarity. It was not always clear who had recorded certain information as many entries were unsigned. Hand written notes within the social work files had been typed up and the file contents re-ordered. Many of these notes had been destroyed before staff could check the typed copy for accuracy.

Consent to share information about their circumstances with other services was not obtained regularly from children and families. In many cases there was no record of them being informed of what, why and with whom certain information was being shared. However, police referral forms did record when children and parents were informed that information was being shared with other services. They had signed the integration team's records to agree what information would be shared about them.

Information about risk assessments undertaken on registered sex offenders was shared with other services at child protection case conferences by the police Sex Offender Assessment Officer (SOAO). Good links had been established between the SOAO and the criminal justice social work Sex Offender Liaison Officer (SOLO). The children and families social work practice team manager attended the inter-agency joint discussions on registered sex offenders. This had improved the sharing of information. There was a heightened awareness amongst police officers of the need to record information about allegations of abuse or neglect against named individuals at the outset of an investigation in order to ensure that such information was available for enhanced disclosure checks.

Recognising and assessing risks and needs

Although there were some strengths in recognising and assessing risk and needs, there were important weaknesses. Staff were generally clear about their responsibilities. They were alert to signs that a child might be at risk and notified social work staff appropriately. When

there were immediate concerns about a child an initial referral discussion (IRD) took place. The IRD's involved social work, police and health and were generally effective. Initial background information was not always sought from other services and therefore decisions about the child and family were sometimes taken on limited information.

There was no common approach across services to assessing the level of risk to a child and, in many cases, staff relied heavily on their own experience. Some more structured assessment of risks and needs was undertaken by the children's centre, Mid and East Lothian Drugs Project (MELD) and health visitors at the early intervention stage. However, there was no ongoing comprehensive risk assessment undertaken by any service. There had been a lack of progress towards establishing a process for joint risk assessment. This had been made more difficult by disparate and sometimes outdated information systems which did not help staff to gather all relevant information known about a child. Social work reports for the children's panel had generally improved over the last few years. They gave much clearer analytical assessments of risk and needs, although in some cases unqualified social workers had been writing reports for the children's panel. NHS 24 and the Scottish Ambulance Service played an effective part in recognising and assessing when a child was at risk.

When further investigations were required police and social work staff usually planned them together. If it was considered necessary to carry out a medical examination of a child they obtained the services of a paediatrician and a forensic medical examiner. In most cases, police and social work staff who interviewed the child had undertaken joint investigation interview training, but in some cases untrained social work staff were used. On some occasions the unavailability of trained staff caused unacceptable delays. Medical examinations were generally carried out in a child friendly environment and children were offered follow up medical treatment and counselling if necessary.

Adult services were, generally, alert to children who may be affected by parental substance misuse and passed any concerns to social work staff. The Substance Misuse Service prioritised referrals to ensure that clients with dependent children were seen as soon as possible. However, on-going assessment by social work and health staff was limited and home visits, where the client's children could be seen and the home circumstances assessed, were not always carried out. A screening group had been established by the CPC and Midlothian Drugs and Alcohol Action Team (MDAAT) to identify and assess children living in families with problem substance misuse, but progress had been slow.

Planning to meet needs

The processes for planning to meet children's needs were unsatisfactory. There was an inconsistent approach towards meetings to consider a child's circumstances and plan for their care and protection. In most cases there was no clear, well defined care plan for the child and roles and responsibilities of staff were unclear. Processes for monitoring and reviewing child protection care plans when a child's name was placed on the child protection register were unclear. This resulted in children being left in high risk situations without the help and support they needed. Some children remained on the child protection register for long periods of time with no improvement in their circumstances.

A number of children placed on the child protection register did not have a named social worker or a lead professional. In many cases the care plans provided insufficient detail about the actions required, who would be responsible for implementation of the various actions and

the timescale for carrying them out. There was no contingency planning to take account of changing levels of risk or needs due to changing circumstances. As a result, some children had remained on the register for significant periods of time and had been removed without any identifiable improvement.

The approach to Child Protection Case Conferences was inconsistent. Reviews for those children who were registered as in need of protection did not occur in a systematic manner. Reviews were held at irregular intervals and sometimes there were considerable delays in holding them. Delays of several months were not uncommon. There was no independent chair of the case conference or effective monitoring to ensure consistency of decision making. There was a lack of clarity and understanding about arrangements for reviewing pre-birth case conferences which resulted in some very young babies not being assessed adequately.

There was an inconsistent approach to the use of core groups. They were not held in every case when a child's name was placed on the child protection register. Decisions about whether or not to hold a core group were made on a case by case basis with no clear guidance available to staff. When a decision had been taken to convene a core group, meetings were often held at irregular intervals and sometimes there were considerable periods between meetings. The attendance of relevant staff at core group meetings was variable.

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

Child protection policy was clear at the strategic level and a number of individual services had well established child protection procedures and training in place. However, at local level, there was not a sufficiently clear focus on the development of inter-agency working and the establishment of common procedures. There was no planned approach across all agencies to involve service users in the process of service improvement. The impact of staff shortages within some services had not been identified or addressed by themselves or others. There was a lack of inter-agency child protection training across all services.

Aspect	Comments
Policies and procedures	Services had a broad range of policies and procedures which helped staff in their work. The current inter-agency child protection guidelines were outdated, but work on updating them by the ELBCPO was nearing completion. Work was ongoing to develop other policies, procedures and protocols. Social work policies and procedures did not always provide the necessary advice and guidance to staff or reflect the changes and improvements that had been identified by senior managers. There was not yet a systematic approach across all services to evaluating and updating child protection policies and procedures. Overall, policies and procedures were adequate.
Operational Planning	Operational planning was weak overall. The 2005-08 Integrated Children's Services Plan set out areas for improvement in keeping children safe. A range of sub-groups had been established to take forward objectives in the plan, but progress made was limited. The integration teams had developed a strategy for action which had the potential to combine purposeful early intervention with a focus on key individual cases. However, the necessary links with children and families social work remained unclear and under-developed. Management information regarding child protection services was not readily available or systematically reviewed. Operational planning within social work was at times ineffective in maintaining an appropriate level of support for all vulnerable children.

Aspect	Comments
Participation of children, their families and other relevant people in policy development	Overall, participation of children, their families and other relevant people in policy development was weak. There was some informal involvement of clients by services when auditing the quality of their performance. However, there was no planned approach across all services to involve service users more formally in the process of improving services. The local authority had begun to involve children more to inform strategic planning through initiatives such as the youth conference, Dialogue Youth and Youth Platform. However, these initiatives had not yet fully involved certain hard to reach groups or vulnerable children.
Recruitment and retention of staff	Arrangements to ensure appropriate staffing levels to protect children were weak. A collective approach had not been taken to identify and address staff deficiencies, particularly in social work. Within health services, the non filling of temporary posts had increased waiting lists greatly. There was no specific reference to safer recruitment within the council's recruitment and selection policy. All agencies had carried out enhanced disclosure checks on newly appointed staff who were involved in direct work with children. Gaps in employment history were explored and references taken up. The local authority did not automatically ratify qualifications, but checked with a regulatory body where registration was a requirement.
Development of staff	Child protection training and supervision provided by some services had increased staff competence and confidence. The council had attained "Leisurewatch" status through a heightened awareness of child protection amongst staff in leisure services. Whilst some recent inter-agency training had been carried out on the *"Protecting children living in families with problem substance use – 2005"* guidelines, the CPC had no training strategy. Little multi-disciplinary training had taken place over the last two years. Housing staff had received no child protection training. The policy for supervising social work staff was applied inconsistently. Many social workers did not have a personal development plan, despite the need to evidence their continuous professional development to retain their social work registration. Overall, the development of staff had some strengths, but important weaknesses.

7. How good is individual and collective leadership?

The establishment of the Edinburgh, Lothian and Borders Executive Group (ELBEG) provided strong strategic direction to child protection and partnership working. There was strong individual leadership and direction in some services, but significant weaknesses in others. The CPC had not set a sufficiently clear direction for joint working locally. A performance sub-group had made an early start to improving services though self-evaluation, but progress had been limited. The CPC did not make sufficient use of statistical data to inform planning. Although it had identified areas for development, it had not yet translated these into a clear action plan with prioritised targets, timescales and responsibilities.

Vision, values and aims

Overall, the vision, values and aims to protect children was adequate. Some individual services had a clear vision for child protection. This had led to a heightened awareness and commitment amongst staff and a shared understanding of individual and collective responsibilities. However, in other services there was a lack of clarity about the statements of vision, values and aims which had not been communicated effectively. Some staff were unclear of their responsibilities and felt that child protection was not always appropriately prioritised within and across services.

- Senior elected members in Midlothian Council did not have a clear vision for keeping children safe and were unaware of the impact of social work staff shortages. The Chief Executive was clear about his vision. Some senior officers were also clear about the vision, but some staff in social work and housing felt it was unclear. The corporate commitment to child protection could be articulated better.

- The Chief Executive of NHS Lothian and senior managers had a clear vision for protecting children. It had been communicated effectively to staff who were aware of their responsibilities to keep children safe. NHS 24 and the ambulance service had taken effective steps to ensure that their staff had an appropriate level of awareness of their services' commitment to protecting children and the expectations of them.

- Within Lothian and Borders Police there was a strong focus on public protection, including the protection of vulnerable children. This had been communicated effectively to staff and child protection featured as a policing priority within a widely distributed local policing plan. Staff were clear about their individual responsibilities and the commitment of their senior managers.

The Integrated Children's Services Plan set out a vision and aims for children in Midlothian. However, it lacked detail on responsibility for specific actions and methods for monitoring performance and outcomes within specific timescales. Through ELBEG, Chief Executives and the Chief Constable had agreed a shared vision for child protection and communicated this in the strategic child protection policy and action plan.

Leadership and direction

Overall, leadership and direction was unsatisfactory. ELBEG provided strong, strategic leadership and direction and most senior managers across all services were, generally, clear about their individual and collective responsibilities for protecting children. There was evidence of strong leadership and direction within some services, including the police, health and education service. However, within the local authority social work department there was a lack of leadership and direction. There was poor communication between managers and staff at all levels and strained relationships between some senior managers and between some senior managers and staff. This had clearly impeded the communication of critical management information and improvements in overall effectiveness and efficiency.

Midlothian CPC, formally established in September 2005, had made an early start to developing its role and collective responsibility, but it had not provided sufficient leadership and direction. Little progress had been made in implementing their annual business plan. Individual responsibilities, timescales for implementation and monitoring of performance and improvement objectives were unclear. This had not been challenged by ELBEG or any of the services. The very recent appointment of a lead officer should strengthen the role of the committee and their relationship with ELBEG and the ELBCPO.

ELBCPO under the direction of ELBEG provided a shared resource for developing policies, procedures and protocols to be applied consistently across services. Within Midlothian the statutory services and the voluntary organisations worked well together. Strategic managers across all services did not have a clear overall view of the gaps in the provision of some services for children.

Leadership of People and Partnerships

Overall, leadership of people and partnerships across services was weak. There was a broad level of support for ELBEG across services. It had been effective at creating and promoting an ethos of partnership working at a strategic level. However, some staff and managers at a local level were unclear about the role and remit of ELBEG and how that should impact locally. More needed to be done to develop polices and procedures in a number of key areas to ensure a more consistent approach to practice and maximise the benefits of sharing resources.

The Children's Services Planning Group, which had representation from across services, was responsible for implementation of the Integrated Children's Services Plan. They had not provided sufficient leadership and direction to staff in order to progress the improvement objectives for child protection which were outlined in the plan.

The establishment of the Midlothian Community Health Partnership (CHP) had begun to strengthen partnership and joint working between health staff and their partners. However, there were communication difficulties between social work and health at a senior management level and very little joint working, joint budgeting or joint funding. There was good partnership between NHS Lothian and NHS 24, including the sharing of resources.

Leadership of change and improvement

Overall, the leadership of change and improvement was weak. Strategic leaders and managers recognised the need to take a systematic approach to quality assurance and self-evaluation as a means of improving services to protect children. Some services including the police and health had developed their approach to quality assurance and self-evaluation. This was not yet firmly established across all services. Arrangements for carrying out joint self-evaluation were not well developed.

Performance monitoring and the review of management information about key child protection processes were not well established. As a result, senior managers within the local authority, elected members and the CPC collectively did not have a sufficiently clear view of the overall effectiveness of services and the weakness which existed. The CPC's performance sub-group had made a start to reviewing some significant cases and child protection reports, but progress had been slow and the tasks had not been completed. A limited internal audit of social work case files had been carried out in 2005, but the areas identified as requiring improvement had not been addressed.

The police had carried out a single service structured self-evaluation of child protection across the Lothian and Borders area. Good practice and areas for development were circulated to senior and key staff, and changes in practice had led to improvements. NHS Lothian monitored the delivery of key service priorities, including child protection, and reported on these to their Board. A recent audit of compliance with child protection procedures had been undertaken and results were due to be reviewed by the clinical governance committee.

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

Summary

Inspectors were not confident that all children who had been identified as being at risk of harm, abuse or neglect, and in need of protection, were receiving the help and support they needed. Some children had received help from services and their situation had improved, but others had not received the help and support they needed and had not been sufficiently well protected. Work was required urgently to develop clear policies and procedures to guide staff, particularly on planning to meet needs.

The CPC and the individual services they represent, working in co-operation with the ELBCPO and guided by ELBEG, have appropriate structures in place to identify and implement improvement objectives to strengthen the services for protecting children in Midlothian. In doing so they should take account of the need to:

- implement a strategy to raise public awareness of child protection;
- improve joint planning to meet children's needs;
- ensure that improvement objectives in the Child Protection Committee and Integrated Children's Services Plans are achieved;
- ensure the views of children and their families are taken into account when planning and delivering services;
- improve training to raise the awareness of staff within and across services of their roles and responsibilities in child protection;
- ensure Chief Officers monitor and review the effectiveness of the Child Protection Committee and key child protection processes; and
- improve performance monitoring to ensure continuous improvements in how staff carry out their work.

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 to 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.

Kevin Mitchell
Inspector
February 2007

Appendix 1 Indicators of Quality

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	Weak
Children benefit from strategies to minimise harm	Weak
Children are helped by the actions taken in response to immediate concerns	Weak
Children's needs are met	Unsatisfactory
How well do services promote public awareness of child protection?	
Public awareness of the safety and protection of children	Adequate
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	Weak
Recruitment and retention of staff	Weak
Development of staff	Weak
How good is individual and collective leadership?	
Vision, values and aims	Adequate
Leadership and direction	Unsatisfactory
Leadership of people and partnerships	Weak
Leadership of change and improvement	Weak

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

How can you contact us?

If you would like an additional copy of this report

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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, Director Services for Children at HM Inspectorate of Education, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA.

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If you have a concern about this report, you should write in the first instance to Hazel Dewart, Business Management Unit, HM Inspectorate of Education, Second Floor, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA. A copy of our complaints procedure is available from this office or by telephoning 01506 600258 or from our website at www.hmie.gov.uk.

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 Scottish Public Service Ombudsman is fully independent and has powers to investigate complaints about Government departments and agencies. You should write to The Scottish Public Service Ombudsman, 4-6 Melville Street, Edinburgh EH3 7NS. You can also telephone 0870 011 5378 or e-mail enquiries to enquiries@scottishombudsman.org.uk. More information about the Ombudsman's office can be obtained from the website: www.scottishombudsman.org.uk

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