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

August 2007

Contents	**Page**

Introduction	**1**
1. Background	**2**
2. Key strengths	**3**
3. How effective is the help children get when they need it?	**4**
4. How well do services promote public awareness of child protection?	**7**
5. How good is the delivery of key processes?	**8**
6. How good is operational management in protecting children and meeting their needs?	**12**
7. How good is individual and collective leadership?	**14**
8. How well are children and young people protected and their needs met?	**17**
9. What happens next?	**18**
Appendix 1 Indicators of quality	**19**
How can you contact us?	**20**

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 Orkney Islands Council area took place between February and March 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.

The Orkney Islands Council area consists of approximately 100,000 hectares spread over 70 or so islands and skerries, 19 of which are inhabited. The sea separates Orkney from the Scottish mainland. Orkney's mainland and island communities are also separated from each other. There are two main populated communities in mainland Orkney, Kirkwall and Stromness. The headquarters for Northern Constabulary is based at Inverness. Specialist health services are provided from Aberdeen.

The population is around 19,590, with two-thirds located mostly in rural and remote areas. Twenty one percent are aged 18 and under, which is in line with comparator authorities[3] and the national average. At 31 March 2006, the percentage of children looked after and cared for in residential rather than a family or community setting was 31%. For Scotland as a whole, the average was 13%. From April 2005 to March 2006, there had been 58 child protection referrals. This had increased significantly over the last year with 137 referrals being made. The number of children on the Child Protection Register (CPR) increased from ten to 34 in the period from April 2006 to March 2007. Recorded incidents of domestic abuse in 2006 were well below national and comparator authorities' averages.

---

[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 Highland Council, the Moray Council, Scottish Borders Council, Shetland Islands Council and the Comhairle nan Eilean Siar.

2. Key strengths

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

- Professionals took prompt action in response to concerns raised about children's safety.
- Children's views were listened to and respected when staff were discussing ways to help them.
- Support from staff at Camoran Resource Centre and Aurrida House which was improving children's wellbeing.
- Strong relationships between Community Social Service (CSS) staff and police which contributed to effective working partnerships.
- Ways in which young people were consulted and involved in developing services.
- High priority given to child protection from elected members, chief council officers and senior police officers.

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

Children identified as being at immediate risk received effective support from services. The initial contact with children was good. They were positive about their relationships with staff and knew who to go to for help. Communication with children and their families was very good. Children placed on the Child Protection Register (CPR) benefited and their lives had improved as a result. Children assessed as being at lower risk were well supported. Those with longer term needs did not always have these met due to a lack of specialist health services.

Being listened to and respected

Overall, communication between staff and children and families was very good. Across services, when child protection procedures were being implemented, staff listened to and respected children and their families. Staff were knowledgeable about children and families with whom they worked. They had developed various means of communication. Children used the *Having Your Say* forms appropriately to write down their views and comments for Children's Hearings. This was carried out in an atmosphere of trust and respect. Overall, families were clear about why decisions were taken and what actions they could take if they wanted to challenge those decisions. In addition, children and families were able to use an advocacy service to ensure that their views were represented at case conferences and Children's Hearings. Children with communication difficulties were provided with very effective help by specialist staff at Camoran Resource Centre and Aurrida House to make their views and feelings known.

Members of the Child Protection Committee (CPC) encouraged children and families to give their views at core groups, case conferences and reviews. Core groups successfully encouraged families to attend and agree on actions with professionals. Before attending Children's Hearings, staff from Community Social Services (CSS) worked well with children to help them prepare for these meetings. At Children's Hearings, children were encouraged to participate. As a result, panel members had clear understanding of children's views and opinions. Across the Council, children were able to express their views and opinions through various ways, including the Orkney Youth Council and questionnaires. Children organised successful conferences, supported by the Council, to discuss issues and policies and had successfully influenced plans of the Council, in particular the Integrated Children's Services Plan (ICSP).

Being helped to keep safe

Services provided a good and effective range of approaches to help children keep safe. Health visitors and midwives worked well to provide support to parents. Primary and secondary aged pupils were very well supported by staff. They felt that teachers and other staff members knew them well. They had confidence in approaching these adults with their concerns. School staff knew child protection procedures and were confident in reporting their concerns about vulnerable pupils. Services worked well together through core groups to provide effective support to children who were on the CPR. If required, children continued to receive this support after they were removed from the register. As appropriate, core groups continued to support them in the longer term. Police actively helped children feel safe within the community. Staff from Homestart and CSS provided effective support and assisted parents to manage their own learning, health and finances. Where children were not

placed on the CPR, but specific needs had been identified, support was not always provided. At times, children and families were unable to access specialist services, including clinical psychologists, physiotherapists and occupational therapists.

Primary and secondary pupils had very good awareness of how to keep safe through effective programmes on personal safety, including safe use of the internet. Older children received support from various services on sexual health, alcohol and domestic abuse. School nurses and police delivered appropriate aspects of the programmes. Children did not feel sufficiently knowledgeable about substance abuse issues. At Aurrida House, children who had additional support needs effectively learned about keeping themselves safe. Education officers maintained contact with children who were educated at home. Parents who educated their children at home received support from education managers and school staff. Staff worked hard to keep pupils safe and very few pupils were excluded from school. They had clear procedures for dealing with children who were absent from school without explanation. Children trusted a wide range of people. In schools, pupils were clear about being able to approach teachers and pastoral care staff over issues such as bullying. They were confident that action would be taken to ensure their wellbeing.

Most children were aware of services provided by ChildLine and how to use them. Children felt that police respected them and helped them to keep safe. They knew where to go and what to do when they had concerns. Older children were becoming more aware of what they had to do to keep themselves safe when they went out at night to various activities, including local dances.

What children and young people told us:

"Teachers are good and listen to what we have to say."

"We can speak to teachers or put a note in the worry box. We can go to the dinner club if we are having a problem in the playground."

"We have discussed how to keep safe and what we need to know."

"My life is better. I feel things are getting better all the time."

Response to immediate concerns

Staff in all services were well aware of their responsibilities to protect children. Overall, their initial response to immediate concerns was good. Senior managers in CSS and police held an Initial Referral Discussion (IRD) promptly on the same day, consulted with health and education, and assessed courses of action. A multi-agency initial planning meeting was held quickly and consideration given to whether to proceed to a child protection case conference. At times, not all services were represented appropriately. Decisions about the need for a child's medical examination were normally taken by police and social work without input from a medical professional. Some medical staff lacked awareness of the importance of considering child protection when examining a child. A few medical

examinations of children were carried out at home when they would have been more appropriately undertaken within a clinical setting. Parents and children were treated with respect, supported and kept informed of what was happening. Some parents did not fully understand the reasons for action being taken. Referring agencies received feedback on action taken.

Meeting needs

Overall, services were good at meeting children's needs. Children were positive about the support offered to them and recognised the impact this had made on their lives. Most services were available to those children who were at immediate risk and those on the CPR. A new children's advocacy worker had recently been appointed and was beginning to work with those children who needed support. However, overall, children's short term needs were better met than their longer term requirements. They were not always able to access specialist services easily and quickly and some services were not available.

Staff from services which were available provided practical and emotional support to vulnerable children and their families. Staff from CSS provided effective support to those children and families most in need. Children and families received effective outreach support from staff in Camoran Resource Centre who worked well with education to maintain children at school. Staff at Aurrida House, together with a nurse who was jointly funded by health and the Council, offered a good service to children with disabilities. Holders of a number of key specialist posts were not resident in Orkney. A high turnover of staff in the local hospital had had a detrimental impact on the level of awareness of child protection within health. The Council's throughcare and aftercare service had improved support for young people leaving care. Overall, there was a good multi-agency approach to meeting children's needs and actively involving them and their parents in the process.

The National Health Service (NHS) in Orkney was negotiating with NHS Grampian to deliver a more comprehensive child and family mental health service. Children who required compulsory mental health services were dealt with on an emergency basis and had to be transferred to Aberdeen. Children requiring a forensic medical examination had to travel to Aberdeen. There was no provision in Orkney for access to a paediatric specialist. All sex offenders were jointly assessed by police and social work.

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

A broad range of public information was available. Services also raised awareness of child protection through focused initiatives. There was a good level of awareness of how people could raise concerns about the welfare of children and young people. Police and Community Social Services (CSS) had a robust system in place to respond to concerns.

Being aware of protecting children

Services were good at promoting public awareness of child protection. Children used various opportunities and experiences to explore issues, including internet safety, substance misuse, road safety, domestic abuse and neglect. Services had promoted children's safety and their need for protection well. Single and joint agency work was effectively developing public awareness of the need to keep children and families safe. Work supported by the Community Safety Partnership, including leaflets on bullying, and the Drug, Alcohol and Smoking Action Team (DASAT) provided good information on substance misuse and community responsibility. Services also ensured that the public had access to a broad range of Scottish Executive and other public information leaflets and posters. These were prominently displayed in public areas and set out local and national helpline numbers. Services engaged with the local radio and local press to assist them in providing the public with information on how to keep children safe. As a result, children and their families had access to a range of information on how to keep themselves safe.

Members of the public and staff had good awareness of how to raise concerns about children. They were confident that police and staff in CSS had robust systems to respond to concerns. Police and CSS operated an out of office hours service that was accessible to all. They had systems in place for members of the public to contact them at any time. The CPC had not yet taken effective steps to promote the safety and protection of children in their community through local awareness campaigns. The CPC was also considering how to engage people in evaluating their experience of child protection processes. Child Protection Coordinators had been appointed in all schools to respond to parents' and pupils' concerns. Across agencies, staff were alert to specific issues relating to children, particularly on the impact of drug and or alcohol misuse.

5. How good is the delivery of key processes?

Overall, staff worked well together to provide services to protect children and ensure they were not exposed to continued risk of harm. In most cases children and families were actively involved in decision making. Police and staff in Community Social Services (CSS) had well-established processes for sharing information with each other. Information sharing with health staff needed to be further developed. Most staff who had contact with children recognised when they needed help or protection. Not all staff fully contributed to assessments of risk and decision making. Planning for children's longer term needs was not always fully effective due to a lack of specialist health services.

Involving children and their families

Arrangements for involving children and families were good. Staff ensured that processes were easily understood through informative leaflets. Overall, children and families received good information about what was happening through minutes and reports. Staff took account of individual family circumstances and worked sensitively to involve children and families in the processes. For example, home support team members effectively engaged with families. Staff had high expectations that parents would participate in meetings and worked with families to help them prepare to be involved. Most staff consulted well with children and families and took account of their views. Most children felt included and involved in determining courses of actions. Where practice was very effective, children were confident in expressing themselves at Children's Hearings and checked that panel members understood their views. They asked appropriately for clarification when they did not understand what was being said. Overall, panel members at Children's Hearings encouraged families to become involved and to express their views clearly. They made sure that children and families understood the hearing process and their right of appeal. As a result, most children and families felt informed. Most staff encouraged and assisted children to submit *Having Your Say* forms for Children's Hearings. However, at times their use was inconsistent. Advocacy workers met with clients before meetings and reviewed any documentation. Families were very supportive and spoke highly of this service. Advocacy workers discussed with families what they wanted to say at meetings. An advocacy worker for children had been recently appointed but had not yet gained the full trust and confidence of some children. Children were routinely included in child protection case conferences. Some documents were made available to families just before case conference meetings. As a result, children and families lacked information prior to these meetings. A few parents reported that their views and opinions were not taken into account and that they had limited involvement with staff prior to meetings. At a few meetings, there was no discussion on how children who were looked after would be informed of decisions made at meetings or recommendations made to the panel.

All services had clear policies and effective procedures for dealing with complaints. The Council provided written information which clearly explained how to make a complaint and specified procedures for providing feedback to the complainant. This information was available in a wide range of public offices. Staff in CSS provided a very good leaflet, written in user friendly language, for children explaining the complaints procedures and how to use these. Staff investigated complaints within specified timescales. Most children and families were confident that they could express dissatisfaction with a service and that staff would address and resolve issues quickly.

Sharing and recording information

Processes for sharing and recording information were adequate. Most staff understood their responsibilities to share relevant information. Police and CSS acted appropriately when they received information on individual children and their families and provided appropriate feedback. Staff used their good working relationships to share information on an informal basis. At times, they did not make enough use of more formal systems. There was no system to inform General Practitioners (GPs) that a child's name was on the CPR. Records of hospital visits and examinations were not always passed to community health staff promptly.

Particular features of information-sharing included the following:

- Police and staff from CSS communicated quickly when concerns were raised about a child.
- Housing officers attended case conferences, core groups and had regular contact with CSS workers.
- Health visitors exchanged information with school nurses when children started school.
- Children's Hearings received good quality information from most services. Overall, decision making was clear and transparent and panel members ensured that children and families knew what information had been shared.
- Minutes of case conferences did not consistently record the reasons why decisions were taken.
- GPs did not always provide reports to case conferences or attend to provide verbal reports. They did not pass relevant medical information routinely to school nurses.
- The CPR was not held electronically which limited its accessibility to out of hours staff, particularly medical staff.

The recording of information in case files varied. Where practice was effective, files were organised well, contained chronologies of critical events in children's lives and detailed outcomes of meetings appropriately. Most police records were organised well. In other services, practice was not consistent. Education files did not always contain child protection plans or clearly indicate where confidential, but relevant, information could be accessed. CSS' files were sometimes supervised and managed to ensure correct procedures had been carried out. Outcomes of meetings were not always recorded well. Health visitors' files contained limited information. Information contained in the SCRA files was not always clearly presented and easy to read.

Children and families were well informed about information shared between services verbally rather than in writing. Staff ensured that concerns about children's safety took priority over children and families' concerns on confidentiality. A few staff were not clear on the freedom of information legislation and the implications for their work when sharing information with others. Overall, staff took appropriate account of the circumstances in which they needed consent from children and families to share information they held. Information on sex offenders was shared at regular meetings involving Northern Constabulary, Criminal Justice, CSS and other statutory services working with sex offenders. Police and CSS staff jointly completed risk assessments, management plans and background reports. Staff had no guidance to enable them to support children who were displaying inappropriate sexual behaviours. However, strong working relationships between police and CSS ensured that staff were active and alert to circumstances and acted quickly when issues

arose. Police had recently implemented the Violent and Sex Offender Register (VISOR) to enhance the management and recording of information. Police officers recorded information appropriately in order that it would be identified by enhanced disclosure applications.

Recognising and assessing risks and needs

Strengths in recognising and assessing risks and needs just outweighed weaknesses. Most staff who had contact with children were alert to issues of child protection and referred them to CSS and the police. An IRD was promptly arranged when there were immediate concerns. Police and CSS responded quickly by convening an informal meeting, often on the same day, to develop an immediate plan of action. They sought information appropriately from education and health to inform initial planning. Most relevant people attended the subsequent formal planning meeting or provided information when they were unable to attend. Staff used these meetings to give careful consideration of risk and need. The practice of recognising when help or protection was required varied. Police and staff from CSS, including those working with adult services, recognised the need for protection. Health staff who provided accident and emergency services were not confident in recognising risk or reporting to the relevant staff. Some health staff did not always intervene when children were potentially at risk.

Child protection case conferences were well attended by representatives from all relevant services with the exception of GPs. Overall, staff balanced individual children's needs and the needs and actions of their parents well. Case conferences identified a core group of key staff who, along with parents, met regularly. Core groups effectively ensured plans were appropriate to meet needs and that planned actions were undertaken. They provided an effective mechanism to review changing circumstances and levels of risk. Staff from Camoran Resource Centre had effective assessment practices which they used well. However, staff in CSS did not always make consistent use of agreed approaches to assessing risk. Health visitors did not have access to appropriate advice on ways of assessing risk to children. Case conference minutes lacked clarity about reasons for referring to SCRA. Minutes alone were often used as the basis for a referral, but a delay in their distribution sometimes delayed the legal process.

Medical staff in Orkney did not have sufficient links with the consultant paediatrician, based at Aberdeen. Occasionally, children were taken off the islands for specialist or joint-paediatric examinations. They were also seen by doctors at the Accident and Emergency department at Balfour Hospital, Kirkwall. However, when children were admitted, staff did not always check the CPR. Staff, across services, were sometimes cautious in requesting medical examinations, partly due to the impact this could have on families and staff working in small communities and the necessity for travel.

Tackling alcohol misuse was a key objective within the Community Plan. DASAT was developing an appropriate strategy to involve families and their children in tackling substance misuse. Police were very alert to circumstances when violent or drunk adults were in the family home. They took appropriate action to keep children safe. Children's misuse of alcohol was recognised by all services as a developing problem in the community. Children were not fully aware of the long term effect on their health or relationships. In response, the Council was recruiting for the first time, a post of young person's substance misuse worker.

Planning to meet needs

Overall, services had good planning arrangements to meet the needs of children who required protection. Staff followed local guidelines for convening planning meetings and case conferences. They planned carefully together to protect children and took into account, assessments and the resources required. They considered preventative and early intervention approaches when deciding how best to meet children's needs. Their plans had a positive effect in improving outcomes for most children. Longer term planning across services was less effective. Children did not always have direct access to specialist services to help them overcome the effects of abuse.

Staff were clear on child protection planning processes. Chairpersons of case conferences discussed available reports appropriately with parents before initial and review case conferences. Staff explored issues of risk and need and overall, considered family circumstances in making referrals to other agencies. When planning they took good account of resources required, including voluntary services, home support and parenting skills. However, they did not consistently outline expected and desired outcomes, targets and deadlines in plans. In most cases, staff ensured the needs of each child in the family were considered. Overall, appropriate decisions were made and incorporated into child protection plans which were signed by parents and children. Both police and staff from CSS agreed decisions and signed minutes. Children who required statutory measures were referred appropriately to the Authority Reporter. Panel members ensured that the reasons for their decisions were clear. They set appropriate timescales for review.

Child support plans were regularly updated and amended in most cases. Changing circumstances were largely taken into account but, at times, insufficient attention was given to children's long term needs. Services had clear arrangements for transferring responsibility when children moved to adult services within CSS. Staff from each agency were not able to attend all meetings, but most submitted written reports. However, staff from a few agencies were unaware of developments on account of delays in circulating minutes. Specialist staff at Camoran Resource Centre and Aurrida House provided good support plans.

Members of core groups ensured tasks and responsibilities contributed to improving circumstances for children. Overall, they planned well and effected change for children. In a few cases, core groups had met for long periods of time without any evidence of change in children's lives. On occasions, core groups focused too much on the needs of parents rather than children. The system for managing throughcare and aftercare had improved. However, practice still varied, and not all young people leaving care were offered a plan to support them at this time.

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

Services used an effective range of policies and procedures to protect children and keep them safe. Most staff used these well to help them in their work. However, some health staff lacked awareness of policies and did not use them. Services were at the early stages of using management information for planning improvement. Children and families' participation was actively encouraged through effective arrangements to seek their views. Staff accessed some good training opportunities. However, a comprehensive training strategy for staff involved in working with children had not yet been established. Services had effective systems in place for recruiting and retaining staff.

Aspect	Comments
Policies and procedures	Services had good policies and procedures to protect children. Recently updated inter-agency guidelines clearly outlined what action should be taken to protect children. Individual services had clear and appropriate guidance to keep children safe. These were easily available to staff and regularly used by them. NHS Orkney had not updated their guidelines to reflect changes in personnel and to ensure consistency with inter-agency guidelines. Some NHS Orkney staff were not familiar with NHS Orkney or inter-agency guidelines. Formal and agreed arrangements between services ensured consistent approaches in relation to sex offenders and domestic abuse. Across services, there was no regular or planned approach to review and update policies and procedures or monitor their impact.
Operational planning	Operational planning to protect children was adequate. The Integrated Children's Services Plan (ICSP) 2005-08 set out appropriate areas for improvement to keep children safe. Operational managers actively contributed to service developments and cooperated well to take forward agreed priorities. Overall, it was not always clear how services measured progress of the ICSP. Some use of statistical information had been used to develop services further. For example, a children and families team was being established to undertake longer term work with families. Managers were actively taking forward a priority to reduce alcohol use by young people through strategies aimed at promoting responsible drinking. Some health staff were unclear about how services would be delivered and the impact for their work. Council and NHS Orkney recording systems did not allow managers or staff to regularly gather and analyse management data.

Aspect	Comments
Participation of children, their families and other relevant people in policy development	Children and families' participation in policy development was very good. Services provided opportunities for them to comment on services they had received through questionnaires, feedback forms, meetings and the new children's advocacy service. Children had very good opportunities for consultation in the education service. NHS Orkney had yet to find ways of involving children and families in planning. Dialogue Youth, the Scottish Youth Parliament and an annual youth conference provided children with very effective opportunities to make their views known on a wide range of local and national issues. Children had contributed well to the development of the ICSP.
Recruitment and retention of staff	Overall, services had good arrangements for recruiting and retaining staff resulting in appropriate staffing levels. CSS had secured additional funding to expand provision and establish a 'preventative' team. The Council and NHS Orkney worked together to establish a fully integrated, personnel function for both services. NHS Orkney had encountered difficulties in recruiting staff to some key posts, which limited their capacity to deliver services. Across all statutory services and most of the voluntary sector, very good policies and procedures were in place for vetting staff. Some agencies had begun to undertake retrospective disclosure checks.
Development of staff	Staff development and training was good. Staff whose key responsibility was child protection had access to effective and appropriate training. They had good opportunities to undertake external training and attend courses. The CPC had provided awareness training for a range of staff. New staff received good, basic child protection training through induction programmes or supervision sessions across services. Some staff, particularly GPs and other front line health staff, were sometimes unclear about their role and responsibilities within child protection processes.

7. How good is individual and collective leadership?

Most services shared a vision for protecting children. The new Chief Executive of NHS Orkney was developing a vision aimed at developing and improving children's services. This was still to be communicated and established at all levels of staff within NHS Orkney. Multi-agency approaches and partnerships, particularly within the Council and Police Services, were effective and resulted in positive outcomes for children and their families. Partnerships with health were at an early stage. The purpose of the Child Protection Committee (CPC) was not always well understood by staff and knowledge of its work was variable across services. Individual agencies were developing systems to review practice. These were not yet fully systematic or sufficiently rigorous across all services involved in protecting children.

Vision, values and aims

Overall, the vision, values and aims to protect children were good. Individually and collectively, services had vision, values and aims for protecting children. Chief officers for child protection were clear about their roles in developing a shared vision. The newly appointed Chief Executive of NHS Orkney recognised his role and had already been active in establishing structures for improved collaboration. The voluntary sector was now appropriately represented on the Chief Officers' Group (COG). The Council and police placed a strong emphasis on collective responsibility across services. They were clearly committed to promoting diversity in services to protect children. Good attention was paid to ensuring equal opportunities for children in all parts of the Orkney Islands Council area.

- Elected members, the Chief Executive, the Assistant Chief Executive and other senior council officers were clear about and placed a strong emphasis on, their individual and collective responsibilities to protect children. They had established child protection as a very high priority to help ensure the safety and wellbeing of children. Staff clearly knew their individual responsibilities in taking this forward.

- The Chief Executive of NHS Orkney recognised his role in shaping vision, values and aims. He identified child protection as a key priority to be achieved through services working more closely together. Not all staff within health shared the same vision and values. They were not clear who was accountable for leading this work.

- The Chief Constable of Northern Constabulary and the Police Area Commander within Orkney had provided and promoted a strong vision and high priority for protecting children within the force. Overall, officers understood the vision and knew their role and responsibilities in keeping children and their families protected and safe from harm.

Strategic leaders within the Council and Police Services worked very well together. Their work in promoting the collective vision, values and aims was having a positive impact on helping to protect children. Aims within the ICSP established child protection as a key priority. There were early signs of improved multi-agency working with health at a strategic level since the appointment of the present Chief Executive of NHS Orkney.

Leadership and direction

Overall, leadership and direction was adequate. The commitment and leadership provided by elected members, chief officers and senior managers within the Council and Police Services were good. They were all very clear about their responsibilities for protecting children. The Director of CSS provided effective leadership. His involvement in national groups kept other Chief officers aware of the national context and the implications for the Orkney Islands Council area. The Assistant Chief Executive of the Council was recently appointed as the new Child Health Commissioner. This appointment had a positive impact and provided enhanced opportunities to improve joint working. Until recently, constant changes and inconsistencies at senior management level within health had led to a lack of direction.

The CPC had experienced difficulties in the previous year due mainly to several changes of staff. However, the interim chair of the CPC ensured that it met regularly and reviewed critical cases. Health had not always been appropriately represented. Senior health managers' lack of involvement had led to limited health input into developing policies and procedures, resulting in significant delays in improving multi-agency working arrangements. A new health manager had been recently appointed who was committed to children's services and child protection. The Authority Reporter's role as a member of the CPC was not always clear. The CPC's purpose was not always well understood or articulated by its members or by staff in services and knowledge of its work and priorities was limited across services. Its lines of accountability were not clear. The CPC did not have a viable business plan, for the forthcoming year in accordance with national guidance.

Elected members and the Chief Executive had transferred additional resources to CSS for preventative work, for example, through more home-link and child mental health workers. Police deployed available resources appropriately and accessed child protection officers from Inverness when required. Senior health managers had not always managed appropriate resources or targeted them effectively towards protecting children. There was a lack of paediatric, psychological and psychiatric services and input for children with disabilities. Health had not always joined up with other services to provide appropriate resources to meet children's needs to ensure their safety.

Leadership of people and partnerships

Overall, individual and collective leadership of people and partnerships was good. Orkney Islands Council's chief officers and senior police officers had strong relationships and a well established approach to working together. Other strategic managers within these services also worked effectively together through appropriate partnership working arrangements. Improved and developing relationships were emerging under the leadership of the Chief Executive of NHS Orkney. Relationships and working partnerships with SCRA were variable. The Council's Chief Executive and other senior officers from police and health met routinely to share relevant information and ensure effective communication links.

Multi-agency forums, including the COG and the CPC, enhanced joint working practices amongst staff. The Assistant Chief Executive was developing more appropriate plans with health for sustainable and improved levels of service delivery, for example, through joint funding of a mental health post for children. Senior managers from Housing, Education and Recreation Services, and CSS were active members of health's 'Creating Sustainable Services Project' (CSSP) which focused on improving children's services. The voluntary

sector chief officer also provided advice to the group. Senior managers from Education and Recreation, and CSS worked effectively together. The Director of CSS chaired a group, aimed at improving life for young people who were not in education, employment or training.

Council and police senior managers promoted collaboration successfully within their organisations. Their active participation on the COG, the CPC and working groups was developing appropriate practices to keep children safe. The Chief Executive of NHS Orkney had plans in place to promote a more collaborative ethos and improve communication systems. Difficulties in involving the voluntary sector at a strategic level had now been addressed. Their involvement on the COG was already having a positive impact on developing partnerships with the voluntary sector.

Leadership of change and improvement

Overall, leadership of change and improvement was adequate. Across all services, staff recognised and demonstrated a high level of commitment to adopting a systematic approach to self-evaluation and quality improvement. The Assistant Chief Executive of the Council was represented on the CPC. As the lead officer responsible for the change agenda within the Council, she had made a positive impact on council services to ensure a more corporate approach to protecting children across all of its services. However, all services did not yet have reliable systems in place to evaluate and review the ways in which they worked together to protect children.

The CPC had conducted an internal audit and inspection of services to protect children and produced a draft report and summary evaluation of the findings. However, not all of its members had been appropriately involved. The CPC audit subgroup reviewed appropriately all child protection enquiries, but had not yet developed a clear strategy to share findings to improve practice. They did, however, have plans in place to find out more about the reasons for rising referral rates. Their arrangements included finding ways to improve responses. Commendably, CSS had commissioned three independent reviews of practice between 2002 and 2006 to help improve practice. Education and Recreation Services conducted regular ethos surveys and used this information to develop and shape services. A review of the out of hours service had been undertaken and the findings reported to senior managers. The CPC had arranged for the systems to be reviewed and to develop guidance on how to improve the management of information.

Northern Constabulary had an appropriate system in place to monitor all child protection enquiries and sampled these on a monthly basis to assess adherence to policies and procedures. The force lead for child protection reviewed the findings. Young people displaying aggressive sexual behaviour were monitored appropriately by the police. NHS Orkney had established a working group to review children’s services, incorporating services to protect children, which had been coordinated by the new Child Protection Coordinator.

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

Summary

Inspectors were confident that children in need of protection received appropriate help through well coordinated action. Staff intervened promptly when concerns were raised. They took action to protect children and ensure that their circumstances improved. Staff worked well together to provide high levels of support for families. Some children's longer-term needs were not met well due to a lack of specialist medical services. Health staff were not always sufficiently involved when assessing risk and when developing policies and procedures for child protection.

Chief officers in Orkney Islands Council and Northern Constabulary were well placed to take forward improvements in services. The new Chief Executive of NHS Orkney was at the early stages in establishing procedures for stronger and more effective partnerships. He was however, taking action to improve health's input and approaches to protecting children. Working together, Chief officers across agencies needed to establish a strategy to further improve services to protect children.

In doing so they should take account of the need to:

- ensure the full involvement of health staff in child protection processes and improve the availability of specialist health services to ensure children's needs are met;
- improve ways in which agencies share and record information, particularly in case files;
- review the purpose and membership of the Child Protection Committee and implement a child protection training programme across services; and
- continue to improve arrangements for reviewing practices, including making more use of performance monitoring and management information, to protect children.

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 two years of this report HM Inspectors will revisit to assess and report on progress made in meeting these recommendations.

Moira Cummings
HM Inspector
August 2007

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	Very good
Children benefit from strategies to minimise harm	Good
Children are helped by the actions taken in response to immediate concerns	Good
Children's needs are met	Good
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	Good
Information-sharing and recording	Adequate
Recognising and assessing risks and needs	Adequate
Effectiveness of planning to meet needs	Good
How good is operational management in protecting children and meeting their needs?	
Policies and procedures	Good
Operational planning	Adequate
Participation of children, families and other relevant people in policy development	Very good
Recruitment and retention of staff	Good
Development of staff	Good
How good is individual and collective leadership?	
Vision, values and aims	Good
Leadership and direction	Adequate
Leadership of people and partnerships	Good
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

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.

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.

Our complaints procedure

If you have a concern about this report, you should write in the first instance to our Complaints Manager, HMIE Business Management Unit, Second Floor, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA. You can also e-mail HMIEcomplaints@hmie.gsi.gov.uk. A copy of our complaints procedure is available from this office, by telephoning 01506 600200 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 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@spso.org.uk. More information about the Ombudsman's office can be obtained from the website: www.spso.org.uk.

Crown Copyright 2007

HM Inspectorate of Education

This report may be reproduced in whole or in part, except for commercial purposes or in connection with a prospectus or advertisement, provided that the source and date thereof are stated.