

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

September 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?	13
7. How good is individual and collective leadership?	15
8. How well are children and young people protected and their needs met?	18
9. What happens next?	19
Appendix 1 Indicators of quality	20
How can you contact us?	21

Introduction

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

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

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

1. Background

The inspection of services to protect children² in the City of Edinburgh 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 City of Edinburgh is the capital city of Scotland. It covers 264 square kilometres and is situated on the south side of the Firth of Forth. The City of Edinburgh Council area includes urban Edinburgh and a 48 square kilometre rural area. It has borders with West Lothian, East Lothian and Midlothian Council areas.

Edinburgh has an estimated population of 457,830 with 18.14% under the age of 18 years compared to the Scottish average of 20.79%. On the whole, the socio-economic context is relatively good with unemployment at around 2.8% which is slightly less than the Scottish average. Average earnings in Edinburgh are higher than the Scottish average. There is a growing community of migrant workers and 18% of the total ethnic minority population in Scotland live in Edinburgh. However, there are areas of deprivation across the city. Whereas 33% of Edinburgh's children live in the least deprived areas of Scotland, 20% live in some of the most deprived areas. In 2005/2006 the incidence rate of domestic abuse recorded by the police in Edinburgh was higher than across Scotland as a whole. There has been a significant increase in child protection referrals over the past three years and the number of accommodated children rose from 516 in March 2006 to 580 in March 2007.

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).

2. Key strengths

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

- Effective early identification of concerns, assessment and information-sharing across services about parental substance misuse which affected unborn babies and young children.
- Staff across services, including those in child and family centres kept children and families informed and involved in meetings and discussions.
- Information-sharing by staff who were co-located including police, health and social work and with education and housing staff.
- Approaches taken by staff in health and the local authority to gathering children's views to inform service plans.
- Strategic leadership and 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?

Most children who were recognised as being at serious risk received help and support to keep them safe. For some children the action required was identified, but not taken quickly enough. As a result they were not adequately protected and sometimes left at serious risk. Children generally knew how to keep themselves safe and initial contact with staff was usually beneficial. Some children who were being supported and receiving help were not seen regularly or staff working with them changed too frequently. The needs of many of the most vulnerable children were met, but for some others the help and support they required was not always available when they needed it.

Being listened to and respected

There was generally effective communication between children and families and staff in all services, particularly those in schools, child and family centres, health and the voluntary sector. In most cases staff were able to establish a positive relationship built on trust and respect. However, changes in social work and health visiting staff sometimes made this more difficult. Some children who were looked after and accommodated by the local authority, on the Child Protection Register (CPR) or subject to formal supervision arrangements were not seen regularly by a named social worker or another professional. Children and families were not always able to share their views or concerns with staff. When concerns about a child were raised most services sought the views of the child and family, listened to what they said and kept them informed about what would happen next. Children with additional support needs were not always helped to communicate with staff.

At Children's Hearings panel members made a considerable effort to involve children and their parents and carers. They asked them for their views and took account of these when making decisions. In some cases children had been helped by social workers, residential staff or foster carers to complete a *Having your Say* form telling panel members what they thought about their situation and what should happen next. At child protection case conferences, core group meetings and child care reviews, parents and carers were encouraged to participate and their views were listened to and recorded. Children were not invited to attend most of these meetings and the extent to which their views were sought and shared was variable. Overall, communication between staff and children and families was adequate.

Being helped to keep safe

Children benefited from a range of services to help keep them safe, but these were not available for all vulnerable children. Some children, particularly those who were older, did not receive help until concerns about them had escalated. There was no coordinated approach to ensure that vulnerable children who moved from one area of the city to another continued to have access to services. Actions in response to earlier concerns about them were sometimes delayed until they had been re-assessed. Effective support was provided by child and family centres and through outreach workers who worked well with voluntary and statutory services to meet children's needs. However, as places were limited some children were unable to benefit from this support. Addiction services provided helpful support for parents and 'PrePare' provided intensive support to substance misusing pregnant women. Education and health staff jointly provided parenting programmes, but these were not available to all parents who needed them. There were delays in getting specialist help for children including those with challenging behaviour or mental health issues. Children who

attended young carer support groups were helped to cope with their circumstances. The Multi Cultural Family Base provided effective help to Sikh and Pakistani families in Leith.

Most children were able to identify staff and trusted adults with whom they would share concerns. Some schools provided effective personal safety programmes. Individual headteachers decided whether or not to involve other services in their delivery, for example, police or health. Some schools had trained ‘buddies’ who were older children who provided help to younger ones. Child and family centre staff and foster carers provided information on personal safety to individual children. Effective procedures were in place to alert parents when a child did not turn up for school. However, some education staff were unsure about the children missing from education procedures if they lost contact with a family. Education Welfare Officers (EWOs) monitored and supported children absent from school without explanation, but their extensive remit and current staffing levels made it difficult for them to reach all children with high levels of absence. Procedures were also in place to ensure that children educated at home were monitored by education staff.

Most children had a good understanding about keeping themselves safe, but some did not have a sufficient level of awareness. Work on the development of a ‘Keeping Myself Safe’ programme was nearing completion and feedback from training on the programme was positive. Children identified opportunities to talk at circle time, bubble time or Place 2B as well as to individual teachers, school nurses, the community police officer and education officers. They knew how to contact ChildLine and were aware of the dangers of using internet chat rooms. Almost all children who responded to school inspection questionnaires said that they felt safe and well looked after in school.

Some examples of what children said about keeping themselves safe.

“We know our guidance teachers and they know us well.”

“School is safer than outside.”

“This area is not safe, there are drug dealers, there are places we won’t go.”

“The youth action team work with the police to make the streets safer.”

Overall, the provision for keeping children safe was adequate.

Response to immediate concerns

The actions taken in immediate response to concerns were unsatisfactory. Overall, staff were alert to the needs of children and recognised when they were at risk of abuse and neglect. However, some children were not protected and left at risk. For these children there were significant delays in responding to allegations and concerns about abuse. Investigation did not always happen quickly enough. When concerns were raised there were often delays in carrying out an assessment of risk and some children were left for long periods in situations which had not been assessed as safe. Some children who needed to be removed immediately

from their home were sometimes left there because no safe place was found. This put them at risk of significant harm. Staff in health, police and social work worked well together and gave thoughtful preparation to joint investigative interviews. They clearly explained the concerns to children and families and worked hard to develop trusting relationships. Staff in police, health and education ensured that children who were the focus of investigations received good support. There had been recent improvements in the early recognition and response to unborn babies at risk due to parental substance misuse. Newborn babies who needed immediate protection were kept safe.

Meeting needs

Overall, meeting the needs of children was weak. Many children who were identified as being at risk of abuse or neglect were assessed and their short term needs met through the help and support provided for them and their families. However, often there was a lack of direct work with them by social work staff. Insufficient foster care and residential unit placements meant that some vulnerable children were not placed or placed inappropriately and did not have their needs met. The delays in planning processes meant that the longer term needs of children were not always appropriately considered or addressed.

Some children and families were supported through effective help provided by individual workers and child and family centres. Some specialist services were delivered locally through these centres, for example, by community paediatricians and speech and language therapists. However, there were waiting lists for places in some child and family centres and the amount of time children and families could spend there was often less than they needed. Fewer supports were available for older children. Some children who needed to be protected were placed with friends and relatives, but there was sometimes no assessment made of their suitability to care for them and keep the children safe.

A range of services to help children recover from abuse was available. Children who had experienced sexual abuse were able to access effective specialist therapeutic services through the Child Sexual Abuse Service or through the Barnardo's 'Skylight' project. However, places were limited and there were waiting lists. Child and Adolescent Mental Health Services (CAMHS) were difficult to access due to long waiting lists. The Barnardo's 'Lighthouse' project provided effective help and support for children showing sexually aggressive behaviour. Children affected by disability, and for whom there were concerns about their safety, did not always receive the help and support they needed.

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

There was a broad range of services which allowed members of the community to report their concerns about children. Some services had distributed information to raise public awareness and signpost services. The public used these services and staff usually responded appropriately. However, there was no coordinated approach across services to raise public awareness about child protection.

Being aware of protecting children

Overall, the promotion of public awareness of child protection was adequate. Child protection information was available from public areas in most services. The City of Edinburgh Council had produced and distributed clear and attractive information leaflets which were also available in other languages. The Scottish Executive's child protection information leaflets including local contact details had been distributed. Posters were displayed in child and family centres and social work centres. The new national 24-hour 'Child Protection Line' had been advertised in newspapers and on posters and leaflets displayed in public areas. Health visitors promoted child safety and protection and provided leaflets including one on how to keep children safe from methadone. The Edinburgh Lothian and Borders Child Protection Office (ELBCPO) website provided some information, but this was not user friendly or easily accessible. The police and NHS Lothian websites lacked child protection information. Across services there was no strategic approach to raising public awareness and the Child Protection Committee (CPC) had no agreed communication strategy.

Members of the public, including family members and neighbours, had successfully contacted services about child protection concerns. While appropriate action was usually taken feedback was not always given or details recorded in files. Anonymous calls made to services were taken seriously and acted upon. The Emergency Social Work Service (ESWS) and the police service ensured that staff could be contacted at any time. The new neighbourhood access system and out-of-hours service had not been well publicised. Some parents, carers and staff in other services found it difficult to contact social workers by telephone, both during office hours and at night. They were sometimes unsure about which social work centre to contact. Some parents and carers were frustrated at having to deal with several members of social work staff before reaching the right member of staff.

5. How good is the delivery of key processes?

Services had ensured that children and families were involved and were heard in most of the key child protection processes. However, children's views were not consistently sought and recorded in all decision-making meetings. Information-sharing between services was good with some very good aspects, although recording practices were more variable. Approaches to the assessment of risk and need were inconsistent and weak overall. Planning to meet children's needs was not sufficiently robust. Plans often lacked detail, were not monitored closely enough or their implementation was delayed which left some children at serious risk. Planning to meet the longer term needs of children was often delayed.

Involving children and their families

Overall, the involvement of children and their families in key processes was good. When they were invited to attend formal meetings, staff worked hard to help them prepare. In cases where they had been invited to meetings, but felt anxious about speaking, they were helped to express their views by other means, for example through a letter. Their views were recorded by the appropriate worker. When families disagreed with professionals in meetings, staff skilfully managed conflict whilst maintaining working relationships with them. Outwith formal meetings staff used a variety of ways, including text messaging and e-mailing, to keep in touch with families. Staff from child and family centres and the Domestic Violence Partnership Project were especially good at this. The Children and Families Department had carried out research into the experiences of children within the child protection process. However, the lack of a systematic approach to obtaining their views resulted in some children not being given the opportunity to have their say in meetings where decisions were being made about them. This was particularly the case in child protection case conferences and Pupil Support Groups in schools. Most children were not invited to attend these meetings and no reasons for this were recorded. The City of Edinburgh Council provided some advocacy services for looked after and accommodated children, but these were not routinely available to children in the child protection process. In a significant number of cases there were frequent changes of social work staff. Families had to get to know and repeat their story to several workers within a short period of time. Some families attending important decision-making meetings did not know the social worker who was attending. Delays in circulating reports meant that sometimes families had to read reports at the same time as contributing to the meeting. In some instances delayed reports meant meetings, including children's hearings, had to be postponed and rescheduled.

All services had appropriate and clear policies in place for handling complaints and reviewed these from time to time. Complaints were investigated in accordance with these policies, but not always within the stated timescales. If there was a delay an explanation was usually provided. Written information about how to make a complaint was available in many of the public offices. Individual services also included information about how to make a complaint on their websites. Services monitored and analysed complaints to identify trends. ELBEG was planning to develop procedures for the joint investigation of child protection complaints.

Sharing and recording information

Overall, the processes for sharing and recording information were good. Staff across services had access to clear guidelines and arrangements to support effective information-sharing. They clearly understood the need to share information when there were concerns about children. There were good relationships and effective communication between health visitors, social workers, staff in adult services, police and staff in child and family centres. Staff made good use of meetings to share information. There were good examples where staff, including General Practitioners, made a significant contribution to meetings through written reports. However, there were examples where staff held important information and were not involved in key meetings.

Particular features of information-sharing included the following.

- Police, health and social work staff shared information quickly and effectively during the Initial Referral Discussion (IRD) when concerns about a child were raised.
- Consistent and accurate recording of initial concerns across services demonstrated a commitment to information-sharing and a joint understanding of that information.
- The new electronic system for recording information in social work enabled information to be shared more effectively across social work services including the ESWS and with other services.
- Effective communication among staff in all services, particularly between those on adult drug services, criminal justice social work and children and families social work when there were concerns about parental drugs misuse.
- Firmly established arrangements for sharing information about sex offenders among police, social work and housing which helped to protect children.
- Good arrangements for the transfer of information and records between health visitors and school nurses.
- Difficulties in making telephone contact with children and families social work staff in neighbourhoods, particularly when there was no named worker, which sometimes delayed information-sharing.
- Feedback was inconsistent to staff who passed on their concerns about children. Staff who needed to know the outcome of child protection investigations were not always informed, for example, some school and health staff.

The management and recording of information in children's records was variable. Some records included a chronology which helped staff analyse significant events in the child's life, but there was an inconsistent approach to recording this information. Health visitors' records were well organised, clear and accurate. The quality of social work and education records was variable. Social care worker records were not included in children's social work records. In some cases which were not allocated and instead managed by duty social workers there were gaps in recording. All activities and contacts undertaken by social work staff were not always included with the case summaries. Education records were not well organised and it was sometimes difficult to clearly identify child protection information.

There were clear and effective arrangements for the sharing, recording and distribution of restricted information at child protection case conferences. Some families were made aware that information was shared among services. The Drug Treatment and Testing Order (DTTO) team, CAMHS, child and family centres and some voluntary services provided information to parents about what would be shared and how this would happen. Staff in

these services obtained written consent to share information when a service was provided. Parents regularly read and countersigned their child's records at child and family centres. However, the approach to obtaining consent to share information was not consistent across services.

The co-location of the local authority Sex Offender Liaison Officer and the police Offender Management Officers had significantly improved information-sharing about sex offenders. They shared information with housing, criminal justice social workers and children and families social workers through regular risk management case conferences. However, some police officers were not aware of the importance of recording information at the start of an investigation when allegations were made against named individuals. As a result, information about those individuals might not be available when disclosure applications were considered.

Recognising and assessing risks and needs

The recognition and assessment of risks and needs was weak. Most staff who came into contact with children recognised when they needed help or were at risk and shared their concerns appropriately. When there were immediate concerns about a child an IRD involving police, health and social work staff took place to share information and plan any investigation. However, social work staff in practice teams did not always agree with the decisions made. Effective procedures were in place for staff to jointly assess concerns about unborn babies through pre-birth meetings. However, there was a slow response to children for whom there were mounting concerns, especially older children and those affected by poor parenting. Assessments of children in families who moved around the city were delayed. Some risk assessments of sex offenders were not fully taken into account by children and families social workers. Initial assessments by social work staff were undertaken for all children involved in child protection case conferences and made effective use of a standard assessment framework. However, the quality of the analysis of risk was variable and initial assessments were not always followed by more comprehensive assessments where required. Police officers and social workers sometimes placed children in another household without assessment of the suitability of their alternative carers.

Child protection case conferences and core group meetings were generally well attended by a wide range of staff who were able to contribute relevant information. They identified family strengths and areas of concern. This provided a good forum for the joint assessment of risk and needs. Case conferences identified the immediate action required to ensure the risks to a child's safety were reduced or removed. They considered the need to refer children's circumstances to the Children's Reporter. However, there were significant delays in the submission of some reports to enable Children's Reporters to make a decision about the need for compulsory measures of care. Core group meetings were held regularly for most children whose names were placed on the CPR. These meetings allowed new information and changing circumstances to be taken into account when reviewing and assessing risk. Overall, staff focused well on the progress made in relation to initial assessments. A number of children on the CPR did not have a social worker allocated to their case and it was not always clear who was responsible for assessing progress against identified risks. There were often considerable delays in circulating the minutes of child protection meetings.

Police and social work staff jointly planned and carried out interviews and investigations. However, some social workers were inexperienced and had not undertaken joint investigative

interview training. A rota of experienced paediatricians ensured that they were routinely involved in IRDs. Medical examinations were carried out in a child friendly environment and children were offered medical follow up treatment and counselling if required. Forensic medical examiners worked effectively with paediatricians. IRD review meetings attended by police, health, social work and education staff ensured that information was shared and agreed actions had been carried out.

Staff in all services, including adult addiction services, were highly aware of the risks posed to unborn babies and children by parental substance misuse. They recognised concerns at a very early stage and made appropriate referrals to children and family social work services. Multi-agency pre-birth case discussions and child protection case conferences carried out clear and comprehensive assessments of risk. Inter-agency guidance and training on *Protecting children living in families with problem substance use – 2005* had helped to achieve this consistency of approach. However, only a few community midwives had received the training.

Planning to meet needs

Planning to meet children's needs was weak. Professionals planned together, but plans often lacked detail. They were sometimes delayed or not monitored sufficiently. Increasing risks were not always identified or responded to. Delays were often associated with a lack of resources, particularly foster care placements. There were frequent delays in the submission of social work reports to the Children's Reporter and delayed decision-making by the Children's Reporter. Some children on the CPR or subject to formal supervision arrangements did not have an allocated social worker or named professional. Some children's cases were inappropriately allocated to student social workers and inexperienced social work staff.

Many child protection case conferences and most pre-birth case conferences were held promptly. However, for some children there were significant delays in holding these meetings. The quality of child protection plans varied. Some plans set clear objectives and timescales and staff responsible for taking the plan forward were clearly identified. Some plans did not set out clearly what was to be achieved, who was responsible for taking action and when this had to be completed. It was not always clear how progress in these plans was monitored and evaluated. Independent chairs of child protection case conferences and looked after children reviews did not have sufficient authority to challenge lack of progress of plans. For a few children who moved around the city there was not enough joint planning or monitoring of changing circumstances and risk.

Generally, planning to meet long term needs was less effective. For a few children long term plans progressed well, but for others there were significant delays in identifying what the long term plan was and moving it forward. When the plan was to seek a parental responsibilities order or adoption there were substantial delays. For younger children in particular, as they became older, this reduced the opportunities for successful adoption. A number of children in the care of the local authority had not had their care plans reviewed for significant periods of time.

Plans for children were reviewed at core group meetings attended by a range of staff from across services. Many were held regularly, but others were not. The child's social worker usually arranged and chaired core group meetings and recorded and circulated a minute of the

meeting. However, for those children and families who did not have an allocated social worker there were often delays in holding these meetings. Minutes of child protection case conferences and core group meetings were seldom completed within the set timescale. Initial core group meetings often took place before the child protection case conference minute had been circulated. Staff attending core group meetings did not always receive the information they needed in advance.

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

Services had policies and procedures in place to guide staff in their work. Senior managers in all the key services had begun to work more closely together in planning and delivering children's services. However, most of them lacked key management information to help them develop and deliver services although this was improving. All services had invested in additional resources and had appropriate procedures in place to ensure the safe recruitment of staff. Some good work had been done to gather children's views to help plan services. There was a lack of inter-agency child protection training.

Aspect	Comments
Policies and procedures	Policies and procedures were adequate. Within and across services there was a broad range of policies and procedures in place to guide staff in their work. These linked well to a shared vision for protecting children. A number of policies and procedures were relatively new and had not yet had time to make an impact on practice. Staff across services did not always have a shared understanding of them. The inter-agency guidelines being used were outdated, but publication of revised procedures was soon to take place. Within the local authority Children and Families Department, plans were underway to review and improve policies and procedures.
Operational Planning	Overall, operational planning was weak. All key services had been involved in the review of the <i>2005-08 Integrated Children's Services Plan (ICSP)</i> . The redrafted plan had the potential to improve partnership working, but progress to date was limited. The current ICSP was not well understood by staff across services. It had not sufficiently influenced planning at an operational level. The Children and Families Department had recently invested in a new computerised system to improve the recording of information by social work staff. There were plans to extend its use, for example, to child and family centres and residential units. Management information was not currently available across a range of key areas. This restricted the ability of senior and service managers to develop policy and plan services to meet children's needs.

Aspect	Comments
<p>Participation of children, their families and other relevant people in policy development</p>	<p>Overall, the participation of children and families in policy development was good. NHS Lothian had gathered the views of a range of clients and had used the information effectively to improve services. They had involved children in developing initiatives, such as <i>Healthy Respect</i>. An extensive survey commissioned by the local authority as part of applying the <i>Communities that Care</i> approach was used to gather the views of children. The views of the most vulnerable had been actively sought through questionnaires, although a very low response meant that few conclusions could be drawn. Initiatives such as ‘Young Edinburgh’ aimed to involve children more in planning. However, some children did not know whether or not their views had influenced planning and policy as they had received little feedback.</p>
<p>Recruitment and retention of staff</p>	<p>Overall, arrangements to ensure appropriate staffing levels were good. All services had recently increased staffing levels to improve services. Within social work there had been a significant reduction in vacancies, but there were continuing and significant staffing difficulties in meeting increasing demands for services, including administrative support. Inexperienced staff were used to manage difficult and demanding child protection cases. Most other services were unaware of the particular difficulties faced by social work and there had been no collective approach taken to identify solutions. All services had appropriate procedures in place for ensuring that new staff had been suitably vetted.</p>
<p>Development of staff</p>	<p>Development of staff was adequate. Child protection training delivered in all services had increased staff competence and confidence. Within the local authority and health services a more systematic approach linked to staff induction and employee development plans was intended to address outstanding training needs. Children’s panel members had no local training programme, but this was being addressed. Most staff received supervision and support from managers, but recording of this was more variable across services. Limited progress had been made in the delivery of inter-agency child protection training. There was a lack of clarity and understanding about responsibilities for planning, coordinating and delivering such training.</p>

7. How good is individual and collective leadership?

Edinburgh, Lothians and Borders Executive Group (ELBEG) provided strong strategic leadership and direction across services creating a shared vision for child protection and promoting partnership working. Senior managers across services were clear about their individual and collective responsibilities for keeping children safe. However, a lack of commitment to jointly funding the Child Protection Committee (CPC) had constrained progress in a number of areas. Within the local authority senior managers had still to address some critical resourcing issues to ensure children's safety. However, commitment within and across services to partnership working and developing more integrated services was leading to improvements. Procedures for evaluating the impact of planning and assessment processes were at an early stage of development.

Vision, values and aims

Overall, the vision, values and aims to protect children was very good. Through ELBEG chief officers had developed a shared vision for child protection which was communicated by their senior managers. There was a heightened awareness and commitment amongst staff about their individual and collective responsibilities to protect children.

- The elected member with executive responsibility for child protection within the City of Edinburgh Council expressed a clear vision for keeping children safe and improving services. The Chief Executive was clear about his vision for improving child protection services through improved partnership working. In the recently established Children and Families Department, senior managers were committed to the *Service Improvement Plan (2007 – 2010)*.
- The Chief Executive of NHS Lothian and senior managers were clear about their vision and demonstrated a strong commitment to partnership working and improving child protection services. The vision had been communicated well to staff who were aware of their individual and collective responsibilities to keep children safe and the priority given to child protection.
- The Chief Constable had a clear vision for child protection. It featured highly within the policing priorities of the force. There was a strong focus on public protection, including child protection, in force-wide policing plans. The Chief Constable's vision was shared by senior managers within the Edinburgh police division and the policing priorities were reflected in local policing plans. Staff were well aware of the priority given to child safety and welfare.

The recently revised ICSP was in final draft form and had set clear targets for child protection. Progress on developing it had been slow, but it provided a sound basis for effective joint working at a strategic level.

Leadership and direction

Overall leadership and direction was weak. ELBEG provided strong strategic leadership and direction. Chief officers, elected members and senior managers across services were clear about their individual and collective responsibilities for protecting children. Within the local authority there was strong leadership and direction from the Chief Executive, senior

managers and elected members to developing more integrated services. The creation of the Children and Families Department was beginning to be recognised by staff as a positive development with some early signs of an improving service. Communication between managers had also improved, but many lacked critical management information on key child protection processes to inform planning and the strategic deployment of resources.

The City of Edinburgh CPC, formally established in August 2005, was well attended and had made a good start to developing its role. Good progress had been made in developing a policy for serious case review. However, limited progress had been made in delivering inter-agency training and developing and implementing a communication strategy. This was due to a lack of commitment to jointly funding the CPC. The appointment of a lead officer had been delayed. Work had yet to start on the CPC's business plan for 2007/08 linked to the revised draft of the ICSP.

ELBCPO had taken the lead in developing policies and procedures which could be applied consistently across services. The commitment to co-locate key staff from police, health and social work had strengthened the management of child protection referrals. However, within the local authority, the leadership and direction provided by senior managers had failed to address serious issues affecting children's safety. They had not ensured that consistent and timely risk assessments were undertaken by their staff. Senior managers did not take immediate action to address a shortage of safe alternative care places which had left some children at serious risk. Senior officers across services had not worked together to provide a lead professional for all children assessed as being at risk or in need.

Leadership of people and partnerships

Overall, leadership of people and partnerships across services was good. Managers and staff were supportive of the leadership and direction for partnership working provided by ELBEG. However, the relationship between ELBCPO, the Coordinating Group and the CPCs was not always fully understood by managers and staff. The monitoring and assessment of the effectiveness and efficiency of these structures to ensure that aims and objectives are realised and resulted in better outcomes for children were not sufficiently developed.

The establishment of a Children and Families Department within the local authority in 2005 had integrated Children and Families' Social Work with Education Services. This had led to a neighbourhood model of service delivery which had achieved some improvements in communication and joint working at a local level. Strategic leaders and senior managers within police, health and SCRA were supportive of this and were working hard to align their boundaries to provide better integration of services in these local areas. The establishment of local coordinating groups in each of the neighbourhoods had helped to improve joint working and communication. However, these changes were not fully understood by all staff.

There was a lack of knowledge, understanding and ownership among senior managers in some services, including health and police, about the development and implementation of the current ICSP (2005-2008). However, senior managers from all services had committed to the establishment of the Children and Young People's Strategic Partnership. This group was now responsible for implementing and monitoring a more comprehensive and robust ICSP which was nearing completion. The Edinburgh Network of Voluntary Organisations for Children, Young People and families (The Network) was represented at partnership meetings and had contributed to the development of the ICSP.

Leadership of change and improvement

Overall, the leadership of change and improvement was adequate. Strategic leaders and managers recognised the importance of taking a more systematic approach to performance monitoring to improve services and outcomes for children. ELBEG, now chaired by the Chief Executive of the local authority and the ELBCPO, had taken a lead role in improving services. Within the local authority there had been some progress in addressing previously identified areas of weakness. The quality of service planning and delivery was improving. Most staff had responded positively to internal reorganisation and shared a commitment to further improvement. A Continuous Improvement Officer provided an opportunity to help develop this work further.

An early start had been made to establishing self-evaluation across services. Within social work practice teams a number of performance management audits had recently been carried out. A number of case files had been reviewed by the Children and Families Department and health staff. A multi-agency self-evaluation of the delivery of child protection services had been completed. However, for some of these, the depth of analysis and the evidence gathered to support evaluations was not sufficiently robust to provide an accurate assessment of practice. The CPC had recently completed a critical case review and a second review was underway. A number of significant issues had been identified which were still to be addressed. A local authority review of foster care places and accommodation needs of children was carried out in 2006. Additional resources had been secured for planned improvements.

Within NHS Lothian staff monitored the delivery of key service priorities, including child protection. Audit reports were discussed at meetings of the NHS Board. Lothian and Borders Police had previously carried out a self-evaluation of child protection across the force area including Edinburgh. Good practice and areas for development had been circulated to key staff and changes in practice had led to improvements. However, in both health and police services this approach to self-evaluation was relatively new and was not yet firmly embedded in practice.

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

Summary

Inspectors were not confident that all children who had come to the attention of services needing help to keep them safe from abuse and neglect had been properly assessed and protected. Younger children who were identified as being at serious risk of harm were often receiving the help and support they needed, particularly if there were significant concerns about parental substance misuse. In those cases their situation often improved as result of the effective involvement of services. However, some children, particularly older children, were not always provided with the help and support they needed and as a result some of them were left in high risk situations or without adequate support. Within the local authority, inspectors recognised that services were improving following the publication in 2003 of an independent report into the death of a young child. However, much more needed to be done to ensure that the most vulnerable children were protected and had their needs met.

The CPC and the individual services they represent, working in cooperation with the Children and Young People's Strategic Partnership, ELBCPO and guided by ELBEG, have appropriate structures in place to strengthen the services for protecting children in Edinburgh. In doing so they should take account of the need to:

- provide, without delay, safe alternative care arrangements for all children identified as living in situations which are unsafe;
- improve assessment of risk and needs to ensure that consistent and timely assessments are carried out when there are concerns about children;
- improve planning to meet children's needs ensuring that all children assessed as requiring a service have a social worker or lead professional allocated to their case;
- improve performance monitoring of key child protection processes, including assessment and planning, to ensure continuous improvement in how staff carry out their work;
- improve training to raise awareness and understanding of staff across services of their roles and responsibilities in child protection; and
- ensure chief officers monitor the effectiveness of the Child Protection Committee and key child protection processes to achieve better outcomes for 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 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
September 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	Adequate
Children benefit from strategies to minimise harm	Adequate
Children are helped by the actions taken in response to immediate concerns	Unsatisfactory
Children's needs are met	Weak
How well do services promote public awareness of child protection?	
Public awareness of the safety and protection of children	Adequate
How good is the delivery of key processes?	
Involving children and their families in key processes	Good
Information-sharing and recording	Good
Recognising and assessing risks and needs	Weak
Effectiveness of planning to meet needs	Weak
How good is operational management in protecting children and meeting their needs?	
Policies and procedures	Adequate
Operational planning	Weak
Participation of children, families and other relevant people in policy development	Good
Recruitment and retention of staff	Good
Development of staff	Adequate
How good is individual and collective leadership?	
Vision, values and aims	Very Good
Leadership and direction	Weak
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 education authority inspections 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 600 200 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 Services Ombudsman (SPSO). 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: ask@spsso.org.uk. More information about the Ombudsman's office can be obtained from the website: www.spsso.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.