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

May 2008

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Introduction

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

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

[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 North Ayrshire Council area took place between December 2007 and January 2008. 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.

North Ayrshire covers an area of 885 square kilometres and has an extensive coastline. It is located to the south west of Glasgow. There are diverse communities living mainly in urban areas but also in small towns, rural settings and on the islands of Arran and Cumbrae. The centre of administration is Irvine.

North Ayrshire has a population of 135,490 people. The percentage of children under 18 is 21.3 %, compared to the national average of 20.5%. North Ayrshire is the sixth equal most deprived local authority area in Scotland. Twenty nine percent of families are headed up by a single parent, compared to 27% in comparator authorities and 25% in Scotland as a whole. In the year ending March 2007, 2,020 children under 16 years were referred to the children's reporter on care and protection grounds. This was 8% of the child population compared to the national average of 4.8%.

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[2] Throughout this document 'children' refers to persons under the age of 18 years as defined in the Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006, Section 7(1).

[3] Comparator authorities include North Lanarkshire, Inverclyde, Clackmannanshire, West Dunbartonshire and West Lothian.

2. Key strengths

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

- Housing services exemplified best practice both in protecting children and minimising the impact of homelessness on vulnerable children.

- Campus police officers provided positive role models and made children feel safer in school and in their communities.

- Innovative work by the Child Protection Committee (CPC) development team had raised public awareness of child protection.

- Support provided by the Children 1st advocacy service for all children over eight years of age on the Child Protection Register (CPR).

- Inter-agency staff development improved the quality of child protection services experienced by children and families.

- Leadership of the Child Protection Committee (CPC) resulted in significant achievements in keeping children safe.

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

Effective action was taken when children were in immediate need of protection. Family support, parenting, community safety and homelessness strategies reduced risks to vulnerable children. Children benefited from trusting relationships with staff and were well informed about keeping safe. Overall, the lives of children placed on the Child Protection Register (CPR) were improved. Some children experiencing neglect and children being accommodated had difficulties accessing health services to meet their needs. Staff in pre-school establishments and schools did not always work effectively with other services to help children at risk. Some children lived with uncertainty too long due to delays in placing them in permanent families.

Being listened to and respected

Communication between children, their families and staff was very good. Health visitors were alert to signs of distress in young children. Almost all children could identify staff from a wide range of services who knew them well and to whom they would speak if they needed help. Children were encouraged to share their worries with trusted adults. Those with communication difficulties and from minority groups were listened to and understood by staff working with them. Staff in nurseries and primary schools established caring relationships with families. Some secondary school pupils had doubts about teachers being prepared to help them sort out their problems. Children's trust in the police had increased due to positive relationships with campus police officers. Families were generally treated with respect and experienced helpful relationships with staff. They particularly appreciated outreach workers who visited them regularly at home to support them with their difficulties.

The views of children and parents were sought and taken seriously. All children over eight years whose names were placed on the CPR were referred to a Children 1st advocacy worker. This service helped them to explore their feelings about their situation and to have their views represented at meetings. Children benefited from the continuity of working with the same social worker, often over several years. However, social workers did not spend sufficient time doing planned work with individual children to help them make sense of what was happening in their lives. Children's Panel members spoke sensitively to children. Residential staff and foster carers supported children to complete *Having Your Say* forms to tell panel members their views. Children looked after at home did not get the help they needed from staff to complete these. Safeguarders ensured the child's voice was heard. Staff were persistent in their efforts to work with hard to reach families.

Being helped to keep safe

Strategies to minimise harm were very good. Staff across services helped children to cope better with difficult circumstances and enabled parents and carers to develop their parenting skills. Staff in housing services supported vulnerable families to stay in their homes. Homeless children were helped to remain at their own school and to sustain social activities and friendships. More nursery and day care places had been provided for very young and vulnerable children. Families on Arran were assisted to access childcare. Children with disabilities were supported to take part in a range of childcare services. Children and parents benefited from regular respite services. Parenting programmes had improved parents' relationships with their children and their encouragement of good behaviour. A strategy was developing to consistently match parents to programmes which best met their needs. Family

support services made a positive difference to children's social skills and enabled parents to share their experiences of bringing up children. Partnership Forums for pre-school, primary and secondary school aged children were being introduced in one locality. These were beginning to deliver better coordinated support, tailored to meet the needs of individual children and their families. However, services were not sufficiently well matched to meet the needs of children and families across the whole Council area.

Home school inclusion workers helped vulnerable children to be welcomed and accepted in school. Personal and social education programmes in secondary schools had been improved. Children received helpful and well designed information from health, education, police, fire prevention and social work staff about keeping safe. Children benefited from the range of advice and support services offered by school nurses, including confidential meetings and home visits. Campus police officers provided positive role models within schools and the wider community. They were effective in reducing fighting and bullying and helping children feel safe in school. Awareness of safe use of the internet had been increased through a police initiative *Clued Up Kids.* Education services had clear strategies for monitoring children missing from education and children educated at home. Staff undertook home visits to get to know children educated at home and their families.

Children demonstrated a good awareness of personal safety and knew how to seek help if they did not feel safe. However, some were not aware of the ChildLine phone number. Young people accommodated in children's homes knew how to contact the Who Cares? worker. Scratch cards promoting the CPC website were widely distributed to children in pre-school, primary and secondary schools. Some vulnerable children developed personal safety skills from being linked with a mentor. Children living in some communities stayed indoors because they did not have safe places to play or meet with friends.

Some examples of what children said about keeping themselves safe.

> *"Lunchtime clubs make us feel more safe."*
>
> *"Security cameras have helped me to feel more safe."*
>
> *"We need more police to patrol public parks."*
>
> *"We need more safe places to go where we can meet up with our friends."*

Immediate response to concerns

Immediate response to concerns was good. When children raised concerns they were taken seriously. Most staff were alert to signs of abuse and responded swiftly to situations where children were at risk. Children benefited from sensitive joint investigative interviews by police and social workers. West of Scotland Standby social workers were unavailable out-of-hours to conduct joint investigations. Children and parents were supported throughout investigations and usually received explanations at every stage about what would happen next. Legal measures to protect children were implemented and children were

accommodated away from home when necessary. Midwives and addiction workers alerted social workers to high risk pregnancies and pre-birth case conferences were convened without delay. NHS24 worked well with police and social work staff to help children whose parents became mentally ill. Referrals to social work services were prioritised ensuring that children who needed help quickly were allocated a social worker. Nursery and primary school staff did not always alert other services right away when vulnerable children were absent without explanation or when parents collecting children appeared to be under the influence of substances.

Meeting needs

Approaches to meeting children's needs were satisfactory. Children identified as being at risk of abuse or neglect were assessed and their short term needs usually met. A wide range of services provided support to children and families. Positive changes were achieved for vulnerable children through programmes delivered by staff from the Rosemount and Directions Projects. Overall, children in need of protection experienced improvements to their lives. Fostering resources were being developed to better meet the needs of older children. Some accommodated children experienced prolonged periods of uncertainty about their future. Brothers and sisters often remained too long in separate placements.

Vulnerable families received good support to take up leisure activities which gave them opportunities to enjoy being together. Home care and day care services provided effective practical support to assist families, but were not readily available in the evenings and at weekends. Services for vulnerable pregnant mothers and their partners had not been developed to reduce risks to their babies prior to birth. Children experiencing physical neglect were not always referred for a paediatric assessment when needed. Action was not taken to ensure that children received treatment when their parents failed to attend medical appointments. Children being accommodated did not have comprehensive health assessments and health improvement plans. Staff in secondary schools sometimes made decisions about restricted timetables and exclusions which increased the level of risk in the lives of vulnerable children. They did not always take sufficient account of the child's home circumstances or work with partners to find more appropriate solutions.

Children who had experienced domestic abuse received good support from Women's Aid workers. Services had not been developed to meet the needs of growing numbers of children affected by substance misuse, including those misusing substances. Children with disabilities and their families benefited from the support of specialist health staff and respite fostering services. Children with complex emotional needs were helped by Child and Adolescent Mental Health Services (CAMHS). CAMHS prioritised new referrals, once treatment began children received a service for as long as necessary. The range of services to assist children recovering from abuse was limited and not always available when needed.

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

The Child Protection Committee (CPC) had achieved a high level of public awareness of child protection services. The public had confidence in reporting child protection concerns to the police and local social work services. The West of Scotland Standby Service did not always deliver emergency social work services promptly.

Being aware of protecting children

Public awareness of protecting children was very good. The CPC development team distributed a wide range of publicity materials and used a variety of imaginative approaches to communicate with the public. These included children's competitions and messages displayed on a plasma screen in the main shopping centre. The CPC successfully used local press coverage of its activities to promote child protection awareness. Leaflets and posters about protecting children produced by the CPC and individual services were displayed in reception areas. The Council's Community Partnership and Young People's Panel questionnaires showed a significant increase in public awareness of child protection. There were increasing numbers of hits to the CPC website and referrals from the public and extended family members. *CPC Kids* and the Strathclyde Police *SP Station* were child friendly, informative websites. NHS Ayrshire and Arran and the Council websites did not have links to the CPC website on their front pages.

Child protection concerns brought to the attention of staff by the public were generally dealt with appropriately. Feedback was usually provided to the person who made the referral. Anonymous referrals were taken seriously. Family protection police officers were on duty until midnight daily and then an on-call system was operated. Local social work reception services were available to respond to referrals from the public, but only on week days during office hours. The out-of-hours service on Arran, provided by local social workers, responded promptly to concerns. Emergency social work services on the mainland were provided by the Glasgow based West of Scotland Standby Service. There were often long delays in staff answering phone calls. The Council's social work information system was not always checked to ensure an appropriate response was made. Some foster carers did not get the help they needed in an emergency.

5. How good is the delivery of key processes?

Successful partnership working resulted in children and parents being fully involved in decision-making processes. While information-sharing was improving across services, staff sometimes did not have the full information they needed to protect children. Services were beginning to work together more effectively to assess risks and needs and agree the best response to help the child. Staff did not focus sufficiently on the child's needs when working with substance misusing parents. There were significant delays in assessments of children to find them a new family. Overall, implementation of plans reduced risks for children.

Involving children and their families

Involvement of children and their families in decision-making meetings was very good. The CPC had produced an information pack on child protection processes which was easy to understand as well as explanatory leaflets for children. When children's names were placed on the CPR, social workers drew up written working agreements involving both key professionals and parents. Parents were clear what changes they were expected to make to reduce the risks to their children and what help they would receive from services to do this. Older children on the CPR knew why they had a social worker and the steps taken to help them. Extended family members were often involved in decision-making meetings. Social workers, foster carers and residential staff sought the views of children, families and carers and accurately represented these at meetings. They shared their reports with children and parents before meetings and explained the reasons for their recommendations. Any differences of opinion were openly discussed. Health visitors, nursery staff, teachers and school nurses did not routinely seek and record children and parents views and include these in their reports to meetings. At child protection case conferences and child care reviews, the chairperson always invited families and children to speak and tried to keep them fully involved. Involvement of parents in core groups gave them the opportunity to get regular feedback on the progress they were making. Parents received prompt well recorded minutes of meetings. The manager chairing initial child protection case conferences was always a different person to the manager chairing reviews which did not provide continuity for families. When a child on the CPR became accommodated, then the child and their parents attended both child protection case conferences and child care review meetings. This caused unnecessary confusion, when meetings could have been combined to review the child's plan. At children's hearings, panel members listened carefully to what children and parents had to say. Children and their parents benefited from a range of support services to help them participate actively in decision-making processes. Advocacy workers were available to help parents with learning disabilities and mental health problems.

Chairs of child protection case conferences routinely informed children and parents how to appeal if they disagreed with decisions made about registration on the CPR. All services had sound procedures in place for handling complaints. Individual services included useful information about how to make a complaint on their websites. Leaflets about complaints procedures were available for adult readers on request, but were not always on display in public reception areas. Services had not involved children in producing child friendly versions of their complaints procedures. Formal complaints were thoroughly investigated with the aim of ensuring that high standards of service were maintained.

Sharing and recording information

Sharing and recording of information to protect children was good. Communication between most staff allowed information to be shared appropriately and promptly. Housing staff effectively shared information with social workers, police and health staff. When visiting homes, they knew if a child living at that address was on the CPR. Good administrative support for the recording and distribution of minutes of core group meetings contributed to timely information-sharing. Staff were sharing information about vulnerable children in one area using the same format, as part of piloting an integrated assessment framework (IAF). General Practitioners (GPs) on Arran were fully involved in information-sharing with staff from other services.

Particular features of information-sharing included the following:

- Early information-sharing took place between staff in the domestic abuse unit, midwives and health visitors.
- Information systems in schools supported the work of campus police officers but not school nurses.
- Staff made effective use of the social work information system to support their work.
- Health, education and social work staff used the social work information system to produce assessments using the IAF.
- The lack of secure e-mail between the family protection unit and other services resulted in faxes and paper based information-sharing.
- While information systems within hospitals alerted Accident and Emergency when children were on the CPR, they did not cover other areas of the hospital where children were seen, including outpatient clinics.
- Information-sharing about vulnerable children was fragmented and inconsistent amongst staff working with children across health services.
- Children's Reporters did not routinely seek information or request reports from health professionals or nursery staff.

Social work records were easy to follow and contained three monthly summaries of the progress made. Social work managers regularly reviewed and countersigned records. Education had introduced separate files to hold child protection and looked after children information. However, procedures for using these were unclear to staff. School and nursery staff did not always record contacts with other services and parents. Staff across services were unsure what to include in a chronology of significant events in a child's life. This information was not made into one chronology for children on the CPR. Health and nursery staff did not routinely provide written reports for child protection case conferences.

Most staff sought consent from families to share information. This was often done verbally and not recorded in the child's record. When an assessment of needs and risks was undertaken using the IAF, children and families were given helpful leaflets about sharing their personal information amongst staff from different services. A lead professional had responsibility for ensuring that children and families gave their written consent to information-sharing at the beginning of the assessment. Families benefited as they did not have to keep giving the same information to different staff. Children 1st and Barnardo's staff obtained written consent to share information.

Police officers with responsibility for the management of sex offenders, family protection and domestic abuse worked closely together in the same office. They shared information with colleagues from criminal justice social work, children and families social work, housing, education and health at regular risk management meetings. Housing services had recently appointed a dedicated Sex Offender Liaison Officer further strengthening this process. Regular risk assessment meetings were held to monitor sexually aggressive children and those not covered by the Multi Agency Public Protection Arrangements (MAPPA) process. Police officers ensured information was logged on their database following any allegation of neglect or abuse.

Recognising and assessing risks and needs

Recognising and assessing risks and needs was satisfactory. Staff working with children monitored any changes in their presentation and behaviour as an indication they may need help. Home school inclusion workers provided a valuable link between school and home, enabling early identification of concerns. There was some variation in the levels of risk leading to child protection referrals amongst professionals and across different areas. Domestic abuse referrals were not assessed and prioritised on an inter-agency basis to deliver support for children in proportion to the level of risk involved. The Children's Reporter received many inappropriate domestic abuse referrals from the police. The involvement of health staff in planning child protection investigations along with police and social work was being piloted. The aim was for health information to be available at an early stage and for decisions to be made jointly about child protection medical examinations. This new arrangement did not operate out-of-office hours. Sometimes investigations were subject to delay and the time between completing an investigation and the initial child protection case conference was too long. Routine background checks were not always carried out to ensure the safety of children placed with a relative or friend.

Comprehensive assessments which resulted in a sound analysis of risks and needs had been completed by social workers. However, some social workers' assessments focused too much on parental difficulties. Insufficient attention was paid to the impact of their behaviour and lifestyles on the day-to-day experiences of children. In some cases, assessments had been delayed or not completed before decisions were made to remove a child's name from the CPR. In one area, children were referred to Partnership Forums when they needed help from more than one agency. The Partnership Forum was made up of local managers from health, education and social work who appointed a lead professional to work with relevant staff to produce an integrated assessment within a specified timescale. After brothers and sisters were accommodated in separate placements, assessments were not routinely carried out to inform a plan to reunite them. There were often lengthy delays for children needing placements with relatives or substitute families. Social workers often did not complete assessments for the adoption and fostering panel within agreed timescales. They did not always get to know children well enough to complete these assessments well.

Joint investigative interviews were usually well planned and thoroughly carried out by police and social workers. A copy of the interview notes was not always given to social workers for their records. In order to provide well equipped and suitable premises for child protection medical examinations at all times, an additional venue had recently been opened. Police and social workers were not well informed about when this was to be used. The CPC did not have an overview of all child protection medical examinations to assess children's experiences and identify appropriate improvements.

Staff were alert and quick to identify children at risk of harm due to parental substance misuse. Addiction staff from social work and health services worked closely together to assess and support parents with substance misuse difficulties. Pregnant women and those with children were given priority. Addiction staff held pre-birth case discussions when women known to their services became pregnant. However, they did not routinely see children or meet with children's workers. They did not regularly attend core group meetings to help monitor any changes in parent's circumstances and their potential impact on children. Some GPs did not always identify children who experienced neglect due to parental alcohol misuse.

Planning to meet needs

Overall, planning to meet the needs of children was good. Secondary schools, but not primary schools, used multi-agency meetings to make early plans when there were concerns about a child. There was good representation from all services at initial child protection case conferences. Review child protection case conferences were convened regularly. Social workers generally provided timely reports for child protection meetings and including proposals for a child protection plan. These plans were not always clearly linked to assessments of risks and needs. Police did not attend relevant review case conferences and sometimes submitted reports about new incidents after meetings had taken place. Attendance at review case conferences and child care reviews and the provision of reports by health and education staff were inconsistent. For some accommodated children, staff were asked to attend both review child protection case conferences and child care reviews, when progress of the plan could have been reviewed effectively in one meeting.

All children on the CPR had an allocated social worker. Overall, the implementation of child protection plans reduced risks and improved children's circumstances. Plans were generally comprehensive and set out actions to be taken and how these would be monitored. They did not always state what would happen if no improvements took place within agreed timescales. When there was more than one child in a family, plans took account of individual children's needs. Parents contributed to the preparation of plans and knew what they needed to change. Housing staff supported plans by helping families obtain and maintain suitable housing. Plans to meet identified health needs of children remained unmet when their parents did not take them to medical appointments. Sufficient attention was not given to raising the attainment of children on the CPR. Children's education plans were not clearly linked to child protection plans.

Partnership Forums were beginning to provide better coordinated local solutions to meeting children's needs. Joint funding had been agreed to support this approach between education and social work, but not health services. Care plans for accommodated children were regularly reviewed. Chairs of review meetings did not always take sufficient steps to address delays in progressing plans for some children. Planning in the best interests of children could be improved by a greater common understanding amongst panel members, social workers and education staff. Panel members needed more training in decision-making about reducing parental contact to help children accept that they were unable to return home.

Core group meetings took place regularly to monitor the progress of children on the CPR in partnership with parents. These were usually well attended by staff. However, school nurses were not routinely involved. Cover arrangements for health visitors when they were unavailable for meetings and expectations regarding attendance by education staff during

school holidays were unclear. Core groups took full account of changing circumstances, reconvening sooner if necessary, and carefully considered how best to modify the child protection plan. These meetings benefited from good administrative support. Chairs of review child protection case conferences received copies of minutes to monitor their progress.

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

The Child Protection Committee (CPC) had recently produced a range of policies and procedures which were not yet familiar to all staff. The Integrated Children's Service Plan (ICSP) had limited impact on developing services to improve outcomes for children. Provision of information to inform service planning was underdeveloped. There were good examples of children and their families being consulted about service development. Dedicated child protection posts had taken forward the work of the Child Protection Committee (CPC). Inter-agency training had successfully raised staff awareness and increasing skills. Health and social work staff with responsibility for child protection cases, were not all provided with regular support and challenge.

Aspect	Comments
Policies and procedures	Overall, policies and procedures were good. All services had appropriate child protection procedures. Revised West of Scotland Inter-Agency Child Protection Procedures were due to be published. The CPC had produced interim inter-agency procedures, but these were not yet applied consistently across services. A range of very useful guidance had been launched by the CPC. Well coordinated area based inter-agency staff forums helped to introduce these. However, the pace and volume of change made it difficult for some staff to keep up-to-date and make adjustments to their practice. An inter-agency agreement supported effective information-sharing. There was no systematic process in place to evaluate the impact of policies on practice.
Operational planning	Operational planning was weak. The ICSP had not set out a clear vision for children's services. All partners were not fully involved in the production or delivery of the plan. Staff had limited awareness of the ICSP and of its relevance to their work. There had been little impact on operational planning to improve children's safety. Progress of the ICSP in improving outcomes for children was not monitored and reported. Recently revised planning structures and clear time limited remits for working groups had helped to develop more effective partnership working. The CPC Business Plans were delivering improvements in child protection services. Some useful research had been carried out to gain a better understanding of local variations in child protection referrals. Effective links were not established between the CPC Business Plan, ICSP and Community Plan. There was no agreement about joint funding to deliver on the ICSP. Management information was not being used systematically to inform policy or planning within or across services.

Aspect	Comments
Participation of children, their families and other relevant people in policy development	Participation of children and their families in policy development was good. An annual good practice event organised by the CPC, effectively involved children. Children were becoming more involved in the work of the CPC. Police gathered feedback from children and parents to evaluate the impact of campus police officers. Health services involved children in developing a strategy to prevent self-harming. Parents were consulted as part of developing a family support strategy. However, participation tended to be restricted to one off events rather than ongoing participation in the continuous development and review of services. Children and their parents did not always receive feedback on how their views had influenced policy.
Recruitment and retention of staff	Recruitment and retention of staff was very good. The CPC development team posts had all been made permanent. Services jointly funded posts, for example, campus police officers and school nurses. All services had well established safer recruitment practices in place and robust vetting arrangements for staff and volunteers who had direct contact with children. The CPC had produced clear guidance for voluntary and community groups on safer recruitment procedures. There were insufficient paediatricians with expertise in child sexual abuse medical examinations. Social worker's caseloads were effectively monitored. Experienced social workers with expertise in child protection were not deployed in areas where there was the highest demand for their skills.
Development of staff	Development of staff was very good. Services delivered well planned single agency child protection training programmes. These were complemented by comprehensive inter-agency annual training programmes led by the CPC training subgroup. A database identified child protection training needs. There were flexible approaches to delivering training in the evenings, at weekends and in different locations. Feedback from participants three months after receiving training assessed the impact on their practice. Social work team leaders did not have time to spend with staff analysing the effectiveness of their interventions. Health staff with responsibility for child protection cases did not all have their work reviewed.

7. How good is individual and collective leadership?

Leaders gave child protection a high profile within their individual services. The Chief Officers Group (COG) had not agreed a shared vision, values and aims for services to protect children. The work of the Child Protection Committee (CPC) made a positive difference to keeping children safe. Community planning partners had not acted collectively to redress the lack of impact of the Integrated Children's Services Plan (ICSP). The Community Health Partnership (CHP) was not working effectively with the Council to integrate planning and resource sharing to meet the needs of vulnerable children. An encouraging start had been made to self-evaluation led by the Child Protection Committee (CPC).

Vision, values and aims

Vision, values and aims were satisfactory. Leaders gave staff a clear message that child protection was a priority. However, children's rights did not feature strongly enough in their collective approach to improving outcomes for children, including looked after children. The COG had not agreed shared aims to protect children and communicated these to staff.

- Elected members aimed to improve child protection services through promoting joint working across council services. The Chief Executive and corporate directors were taking this approach forward. Senior officers from education, housing and social work services worked well within their own services and together to raise awareness of child protection and the work of the CPC amongst all Council staff.

- The Chief Executive of NHS Ayrshire and Arran communicated to staff that keeping children safe was a priority. Key staff provided leadership through the Child Protection Action Group and aimed to strengthen the contribution of health services to protecting children. There was a growing awareness amongst staff working with adults of their responsibility to identify child protection concerns.

- There was a strong vision to protect children within Strathclyde Police. The Divisional Commander and Superintendent for North Ayrshire effectively communicated this to police officers through regular briefings. Officers were alert to child protection concerns when carrying out their day-to-day duties. The work of the Family Protection Unit was of central importance to the division.

Elected members, the COG and the CHP had not developed a shared vision for children's services. They had not worked together to assess the needs of children in the Council area. Agreement had not been reached about priorities for integrated planning and development to tackle inequalities for vulnerable children. Planning for child health services did not fully involve partners from other services.

Leadership and direction

Leadership and direction provided by the CPC was very good. Members of the CPC took collective responsibility for improvement in both child protection and children's services more widely. The work of the CPC was driving up practice standards and developing services. As a result children were better informed about keeping themselves safe and the experiences of children and families involved with child protection services had improved.

The COG approved CPC annual business plans but had not ensured that progress could be measured. They had not agreed a shared budget for the CPC to sustain current achievements and take forward further developments. There was a delay in publishing plans.

Effective partnership working within the CPC resulted in a high level of commitment to implement the business plan. This was due to the determined leadership of the chair, effective contributions made to subgroups by committee members from social work, housing, education, health, police, SCRA and the voluntary sector and the support of a dynamic development team. The CPC had successfully raised public awareness, produced a range of policies and procedures and delivered extensive inter-agency training. The CPC had commissioned research to help develop a family support strategy and were acting upon the resulting findings and recommendations.

The Council had made a commitment to maintain funding levels for the CPC into the next financial year allowing time for an agreement to be reached with health and police services about future arrangements. Strathclyde police had agreed to contribute 10% on top of the Council's financial contribution for the next year to support a period of transition. Services were well represented at CPC meetings. Police had agreed additional staff time to be represented on the CPC training subgroup. CPC decision-making was sometimes held up as many services did not always provide substitutes when members were unable to attend.

Leadership of people and partnerships

Individual and collective leadership of people and partnerships was satisfactory. Senior managers across services gave a strong commitment and lead to partnership working which was well understood and supported by staff at all levels. The ICSP Steering Group and subgroups actively promoted partnership working. However, the absence of a shared vision and agreed priorities for children's services restricted partnership approaches and the further development of joint working. Overall, staff in health, the local authority, SCRA, police and voluntary services worked well together to protect children. However, the delay in producing revised inter-agency child protection procedures was leading to inconsistencies developing within and across services.

The IAF and Partnerships Forums were improving partnership and team working. However, these initiatives were at an early stage of development and some staff were unclear of their roles in joint arrangements. Partnership working had impacted positively on service delivery through agreements about joint procedures and inter-agency training. Health professionals contributed well to joint working arrangements. However, the lack of effectiveness of the CHP placed a major constraint on further developing partnership working between the Council and health services. The Alcohol and Drugs Action Team (ADAT) had concentrated on developing adult services and had not worked jointly with the CPC to meet the needs of children affected by substance misuse.

Effective partnership working with voluntary services was developing through the support given by the Council to the voluntary forum. Staff from voluntary organisations made a significant contribution as strategic planning partners. Action taken by the Council had not yet been sufficient to improve understanding and confidence between Children's Panel members, education and social work staff. There was no shared understanding of policy direction. All staff were generally well supported by senior managers and their work was

valued and appreciated. Many staff remained in their posts for lengthy periods of time. This enabled trusting relationships and partnership working to be built up across services.

Leadership of change and improvement

Capacity for improvement was good. There was a commitment to continuous improvement established within the CPC. A good start had been made to self-evaluation using a variety of approaches including case audits, focus groups and questionnaires. Some performance information had been analysed by the CPC audit subgroup, areas for improvement identified and action taken. Staff involved in self-evaluation had been convinced of the value of this approach. Self-evaluation was still to be established within and across agencies requiring more robust challenge amongst partners. The views of children and families using services were not routinely sought to provide evidence of impact from their perspective.

Child death enquiries and child protection inspection reports were analysed systematically and lessons to be learned identified. The CPC used electronic methods of communication and child protection practitioner forums to help communicate practice change to staff. Health services had invested in training members of the CPC to use a shared approach to learning from significant case reviews. This approach had not yet been tested out in practice. The effectiveness of children's individual plans was not analysed and performance reported to the CPC, the COG and elected members. Steps were being taken to strengthen the quality assurance role of chairs of child protection and Looked After and Accommodated Children meetings.

The CPC was analysing research findings about the increase in child protection referrals in one area in order to develop an action plan. An evaluation of the effectiveness of the new approach to involving health services in planning child protection investigations was underway. The IAF and Partnership Forums were being piloted to evaluate their impact on reducing risks for children and better meeting their needs. Work had started on delivering an out-of-hours emergency social work service across the three Ayrshire council areas which was integrated with other locally delivered out-of-hours services.

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

Summary

Inspectors were confident that when children were identified as being at risk prompt action was taken to protect them. As a result of services working together more effectively, children were safer and families experienced better coordinated support. The CPC had made a positive difference to the lives of vulnerable children and their families. There was a lack of clarity about how the ICSP and the CHP would improve outcomes for children.

Elected members, Chief Officers and senior managers should strengthen their collective leadership of services to protect children.

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

- develop services to meet the needs of children and families affected by substance misuse;
- set improvement targets and monitor progress to meet the needs of looked after children;
- progress inter-agency approaches to responding to child protection referrals and incidents of domestic abuse;
- develop a shared vision, values and aims for children's services and communicate this to all staff; and
- work together to plan, deliver and evaluate improved outcomes for vulnerable children.

9. What happens next?

Chief Officers have been asked to prepare an action plan indicating how they will address the main recommendations in this report, and to share that plan with stakeholders. Within two years of the publication of this report HM Inspectors will re-visit to assess and report on progress made in meeting the recommendations.

Emma McWilliam
Inspector
May 2008

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	Very Good
Children are helped by the actions taken in immediate response to concerns	Good
Children's needs are met	Satisfactory
How well do services promote public awareness of child protection?	
Public awareness of the safety and protection of children	Very Good
How good is the delivery of key processes?	
Involving children and their families in key processes	Very Good
Information-sharing and recording	Good
Recognising and assessing risks and needs	Satisfactory
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	Weak
Participation of children, families and other relevant people in policy development	Good
Recruitment and retention of staff	Very Good
Development of staff	Very Good
How good is individual and collective leadership?	
Vision, values and aims	Satisfactory
Leadership and direction	Very Good
Leadership of people and partnerships	Satisfactory
Leadership of change and improvement	Good

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
Satisfactory	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

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