care inspectorate

Joint inspections of services for children and young people in need of care and protection

Review of findings from the inspection programme 2018-2020

HAPPY TO TRANSLATE

Contents

Words highlighted in bold, within the text, can be found in the glossary.

Foreword

This report is a review of the findings of joint inspections of the delivery of services to children and young people in need of care and protection by community planning partnerships in eight areas across Scotland, undertaken 2018 – 2020. We are grateful to our scrutiny partners (Healthcare Improvement Scotland, Her Majesty's Inspectorate of Constabulary for Scotland and Education Scotland), who supported us in these joint inspections. Together, we gathered significant evidence which helped us to evaluate the difference these partnerships made to the lives of children, young people and their families.

It is notable that most partnerships have invested in, and made commitments to, supporting children and young people in need of care and protection, particularly in a climate of reducing resources. There were clear strengths made in areas such as increasing community based and **kinship care** placements as well as reducing out of area placements. Many children and young people were benefitting from investment in relationships by committed and caring staff and many experienced positive health and wellbeing outcomes as a result.

We are confident that improvements have been made, across most partnerships, in relation to child protection. In general, governance processes were well embedded and the operational delivery of child protection services was strategically and collaboratively led. Most children and young people were being kept safe as a result of co-ordinated responses to risk of significant harm. There remains room for improvement, particularly in addressing the impact of cumulative harm, including domestic abuse, child sexual exploitation or neglect, and the identification of risk to older young people.

We are not as confident about the approach of all partnerships in relation to their responsibilities as **corporate parents**. The collaborative leadership and governance arrangements for corporate parenting were less well evidenced across these joint inspections and not all children and young people for whom partnerships held corporate parenting responsibilities were supported to achieve their potential. In particular, young people leaving care were particularly disadvantaged and their health and wellbeing outcomes remained poorest among their **care experienced** peers.

It is an opportune time, given the findings of the independent care review, for partnerships to reflect on our findings and use these to inform their continuous improvement journey. We hope this report will influence partnerships to more effectively support all children and young people to ensure they grow up loved, safe and respected so they can reach their full potential.

Peter Macleod, Chief Executive

Key messages

The key messages have been aggregated from all eight joint inspections and do not, therefore, reflect the experiences of all children, young people and their families across all partnership areas.

1. Children and young people were benefitting from positive, caring relationships with key staff which were informed by **trauma informed practice** principles. These relationships were supported by the **getting it right for every child** approach. This gave staff a shared language and better opportunities to work effectively together with children and their families to address need and risk.

2. In most areas, there were robust processes in place to protect children and young people and keep them safe, underpinned by effective multi agency training and governance arrangements. Children under five years of age were more likely to be identified as being at risk of harm and, once identified, assessment and planning processes for this group were of a higher quality than those for older children. We were not as confident that staff recognised and responded to the needs of, and risks to, older children as well as they did with the younger age group.

3. Most partnerships had invested in targeted family interventions and parenting support programmes which had been successful at enabling many parents and carers to better address their children's needs. However. more needed to be done to ensure that all families who needed this received the right support at the right time. Partnerships must do more to ensure families are enabled to participate and engage with all key processes and promote opportunities for **independent advocacy** more systematically.

4. We saw improvements in some outcomes for **looked after** children and young people, in particular, increasing numbers of young people achieving positive destinations, an increasing proportion of community-based placements, including an increasing use of kinship care placements, and reductions in out-of-area placements. Despite the welcome increase in kinship care placements, kinship carers themselves were not being supported well enough.

5. Where children are not able to live with their families, partnerships must do more to ensure that they are enabled to keep in contact with family members, especially with brothers and sisters.

6. Transition processes between children's and adults' services were often experienced by young people as disconnected and complex. Those most disadvantaged by this were children and young people with a disability and **care**

leavers. We saw the poorest outcomes for young people in **continuing care** and care leavers. Many young people were constrained in their ability to successfully move on to adulthood by difficulties in accessing services such as mental health and wellbeing services and suitable housing options. The GIRFEC approach, while well embedded across children's services, was less well evidenced in pathways planning for care leavers.

7. The collaborative leadership of child protection was much more robust and embedded than that for corporate parenting. There must be equity in the governance arrangements for both aspects of practice to enable all children and young people in need of care and protection to achieve their potential.

8. While inspections illustrated examples of the impact of services supporting children, young people and their families, partnerships themselves were less able to demonstrate tangible evidence of impact. Performance measures focussed on process and activity-based data more than qualitative data. They were, therefore, constrained in their ability to show the differences services made to outcomes for children and young people.

Summary of all key inspection question findings

1. Overall, partnerships had in place effective processes to address risk and concern and most staff felt confident in recognising and responding to these issues. Progress is still to be made, particularly in the areas of recognition of, and responses to, children and young people affected by domestic abuse, child sexual exploitation or neglect.

2. In most areas, we saw significant investment in pre-birth planning processes and pathways to support vulnerable pregnant women.

3. Partnerships were, on the whole, more successful at engaging with parents and carers of children and young people within the child protection system than with the children or young people themselves, although the numbers of parents and carers involved remained low.

4. Staff were more likely to identify risks of significant harm for children under five years old than for older children. Once identified, the response from services was more likely to be evaluated better for younger children than older children.

5. Universal and targeted services were supporting children and young people well in their recovery from abuse and neglect. However, not all children and young people were receiving the right support at the right time to aid their recovery.

6. In the areas in which we saw investment in targeted family support and flexible parenting programmes, we saw clear positive differences being made in the lives of families. In these areas, many children and young people were helped to return to, or remain successfully in, their families.

7. Partnerships had invested in addressing the mental health needs of children and young people at universal and targeted levels. However, specialist services such as **child and adolescent mental health services** (CAMHS) continued to be under significant pressure, resulting in some children and young people having to wait too long for the help they needed.

8. We saw improvements in the assessment, planning and reviewing processes which supported children and young people who had experienced abuse and neglect. This was creating a better experience for children and young people in having their needs met more effectively.

9. The Getting it right for every child (GIRFEC) approach was well established, enhancing joined up working, providing a shared language and an even stronger focus on the wellbeing and outcomes for children and young people.

10. It was clear from our surveys completed by children and young people that staff, including social workers, and other significant adults had established trusting relationships with most looked after children and young people.

11. Most looked after children and young people had experienced at least some improvement in their wellbeing as a result of the support provided. Overall, children looked after in foster care experienced the most improvement in wellbeing and children looked after at home showed the least.

12. While our inspections demonstrated examples of the impact which services and interventions had on children, young people and their families, partnerships struggled to find the evidence to demonstrate tangible improvements in the wellbeing of looked after children and young people and in understanding performance trends concerning different looked after groups.

13. There had been some progress in narrowing the educational attainment gap between looked after children and their peers, however, it remained too great.

14. In some partnerships, looked after children and young people had been supported to remain in, or return to, family-based settings in their local communities. Although the proportion of community-based placements had increased, including kinship care placements, further work was required to improve the consistency of support for kinship carers.

15. Where children and young people were unable to remain with their families, they needed to be better supported to remain in contact with their families, particularly their brothers and sisters.

16. Not all care experienced children and young people had the same opportunities to share their views and meaningfully influence service delivery.

17. The majority of care experienced young people reported positive relationships with staff and carers, in particular with social work staff, including social workers and throughcare and aftercare workers.

18. We saw an increasing number of young people achieving positive destinations across partnerships, however, we did not see consistent improvements in other aspects of their health and wellbeing outcomes. Some young people were prevented from moving on successfully to adulthood by difficulties they faced in the accessibility and availability of appropriate housing and mental health and wellbeing services.

19. We saw variability in the approaches to, implementation of, and success of supporting young people through promoting continuing care. More needed to be done to fully enact the principles and spirit of the legislation.

20. Not all care experienced young people experienced the same opportunities to give their views to support service development. Independent advocacy was not used as widely as it could have been to support young people to be heard.

21. Processes to support the positive transition of young people between children's and adults' services were often disconnected and complex. Children and young people with a disability and care leavers were at the greatest disadvantage because of this.

22. Collaborative leadership of child protection was well embedded across most partnerships, with robust governance being evidenced through child protection committees and **chief officers groups** which functioned well.

23. The collaborative leadership of child protection was much more robust and embedded than that for corporate parenting. There must be equity in the governance arrangements for both aspects of practice to enable all children and young people in need of care and protection to achieve their potential.

24. Leaders need to work collaboratively better and more effectively to ensure that service provision and prioritisation are based on a comprehensive assessment of need. For this to be robust, partnerships need to pay further attention to effective joint strategic needs assessment which would give a greater understanding of needs both now and in future. This needs to be complemented by the understanding generated by **joint self-evaluation** in order to focus on continuous improvement. From this, effective **joint commissioning** practices would ensure a holistic approach to service delivery.

25. Performance measures were, in the main, focussed on organisational activity and processes. This meant partnerships were at a disadvantage in being able to demonstrate tangible differences which services made to the lives of children, young people and their families.

26. We saw improvement in the implementation of high-quality support and supervision for staff. Leaders had worked hard to create a learning culture in which staff felt valued, respected and listened to.

Introduction

Our quality framework for children and young people in need of care and protection 2018 (revised August 2019) was informed by the findings from our joint inspection programme 2012 - 2017[1], which reviewed how effective partnerships were at meeting the needs of all children and young people.

The joint inspection programme for 2018 – 2020 was further refocussed.

The joint inspection programme 2018 - 2020

From April 2018 to March 2020, the Care Inspectorate led joint inspections of services for children and young people in need of care and protection across eight community planning partnership areas:

- Aberdeen
- Argyll and Bute
- Edinburgh
- Fife
- Midlothian
- Orkney
- South Lanarkshire
- Stirling

These inspections looked at the differences community planning partnerships were making to:

- the lives of children and young people in need of protection
- the lives of the children and young people for whom community planning partnerships have corporate parenting responsibilities.

Inspections included the full range of local authority services (including social work, education and housing), NHS services (such as primary health and child and adolescent mental health services – CAMHS), Police, Fire and Rescue, Scottish Children's Reporter's Administration (SCRA) and services provided by the third sector. We focussed on children and young people already known to services through both the child protection system and those who were care experienced. Within this, while we met children and young people involved in the youth justice system, those in secure care and children and young people with disabilities, we

[1] Review of Findings from the Inspection Programme 2012 – 2017

were not able to comment on their experiences in as much detail as we would have liked as contact varied across our inspections.

This report explores the key findings across joint strategic inspections undertaken during 2018 - 2020. Throughout this report, we have referenced the findings of the joint inspection programme 2012 – 2017 and, where it is appropriate to do so, we have reviewed findings from that programme against those of the joint inspection programme 2018 – 2020.

Applying our quality improvement framework

In August 2019, we published an updated quality framework for children and young people in need of care and protection which was developed in partnership with our stakeholders. It aimed to support **community planning partnerships** to review and evaluate their own work. Inspection teams used this same framework to reach evaluations of the quality and effectiveness of services provided by partnerships. The framework supports the key principles of the National Health and Social Care Standards[2].

Inspectors collected and reviewed evidence against all 17 quality indicators in the framework and used this understanding to answer the five inspection questions.

1. How good are partnerships at recognising and responding when children and young people need protection?

2. How good are partnerships at helping children and young people who have experienced abuse and neglect stay safe, healthy and recover from their experiences?

3. How good are partnerships at maximising the wellbeing of children and young people who are looked after?

4. How good are partnerships at enabling care experienced young people to succeed in their transition to adulthood?

5. How good is collaborative leadership?

In addition to answering the inspection questions, we used a six-point scale to provide a formal evaluation of three quality indicators about the impact of partners' work on the lives of children, young people and their families and the outcomes partners are achieving.

[2] Dignity and respect, Compassion, Be included, Responsive care and support, Wellbeing

These were:

1.1: Improvements in the safety, wellbeing and life chances of vulnerable children and young people
2.1: Impact on children and young people
2.2: Impact on families.

We also provided an overall evaluation for leadership, comprised of four individual quality indicators (9.1 to 9.4 inclusive). These are:

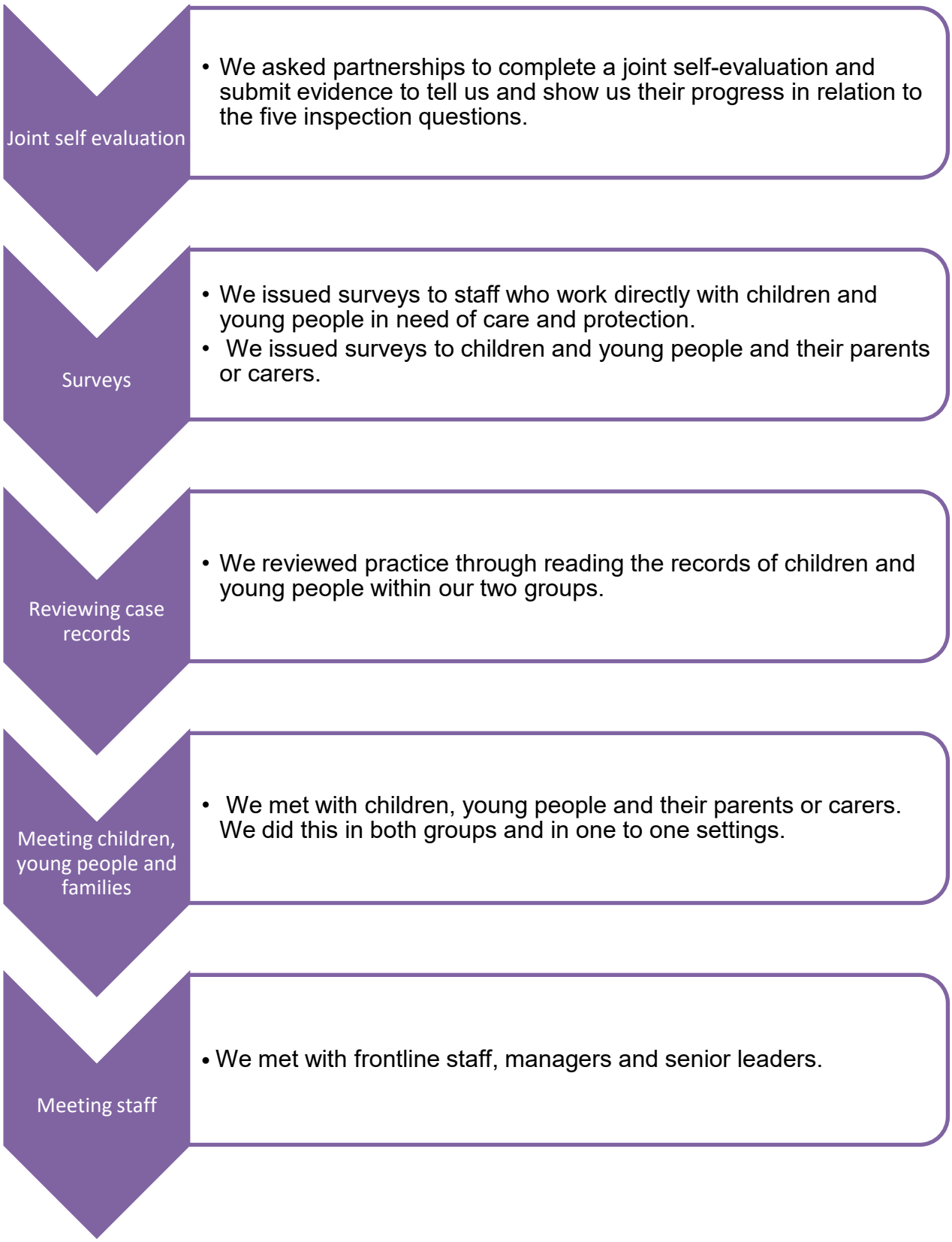
9.1: Leadership of vision, values and aims
9.2: Leadership of strategy and direction
9.3: Leadership of people and partnerships
9.4: Leadership of improvement and change

We did this because we recognised the importance of effective leadership in ensuring children, young people and families experience consistently high-quality services which meet their needs and improve outcomes.

Our inspection teams

Our inspection teams were made up of inspectors from the Care Inspectorate, Healthcare Improvement Scotland, Her Majesty's Inspectorate of Constabulary for Scotland and Education Scotland. Teams also included young inspection volunteers, who have direct experience of care or child protection services. They received training and support to contribute their knowledge and experience in order to help us evaluate the quality and impact of services. Some inspections also included associate assessors who were senior managers from different partnership areas to those being inspected who contributed their expert knowledge of child protection and corporate parenting to support joint inspections.

How we conducted these inspections



In all partnership areas we:

- analysed and took into account inspection findings of care services for children and young people and findings from relevant inspections carried out by other scrutiny bodies
- reviewed national and local data relating to children and young people
- reviewed the self-evaluation undertaken by the partnership, and the evidence that supported it
- read a wide range of documents provided by the partnership
- conducted a survey of staff working directly with children and young people in need of care and protection
- met with children and young people, parents and carers in order to hear from them about their experiences of services and what difference they thought the support they received was making
- spoke with staff at all levels across the partnership, including senior officers, elected members and large numbers of staff who worked directly with children, young people and families
- reviewed practice through reading a sample of records held by services for children and young people in need of care and protection
- observed key interagency meetings.

As inspections were designed to answer the questions we had, specific to each community planning partnership area, we used the intelligence we gathered to tailor the scope of each inspection according to the design and delivery of services locally.

Our evidence base

Over the course of the eight joint inspections, we have gathered a significant volume of evidence to assist us to evaluate how well partnerships collaborate to meet the needs of children and young people in need of care and protection.

We read 754 case records for children and young people.

The five inspection questions

1. How good is the partnership at recognising and responding when children and young people need protection?

Key messages

1. Overall, partnerships had in place effective processes to address risk and concern and most staff felt confident in recognising and responding to these issues. Progress is still to be made, particularly in the areas of recognition of, and responses to, children and young people affected by domestic abuse, child sexual exploitation or neglect.

2. In most areas, we saw significant investment in pre-birth planning processes and pathways to support vulnerable pregnant women.

3. Partnerships were, on the whole, more successful at engaging with parents and carers of children and young people within the child protection system than with the children or young people themselves, although the numbers of parents and carers involved remained low.

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Recognition and response to concerns

In our review of findings from the inspection programme 2012 – 2017, we commented that the signs of risk and neglect were not being recognised consistently. We had noted that, as a consequence, interventions were not happening early enough or effectively enough to protect children and young people from harm, leaving some living in situations of risk for too long[3].

This had improved in most of the partnership areas inspected in the eight joint inspections 2018 – 2020. For most partnerships, we saw effective and prompt responses to concerns being raised about potential or actual harm to children or young people. These included situations of cumulative harm, including risks posed

[3] "Many children and young people continue to be at risk of harm from the behaviour of adults. We saw many partnerships continue to develop strategic approaches to addressing domestic abuse, including programmes which identify families in which women and children may be at risk, address the causes, address behaviour change, reduce repeat incidents, and work with perpetrators. These multi-layered approaches are having a positive impact on children and young people, although domestic abuse continues to be a significant issue in our country. We will continue to discuss with partners their approaches to domestic abuse in our next inspection programme and collect and share examples of good practice". Review of Findings from the Inspection Programme 2012 – 2017Care Inspectorate.

to children and young people living in situations of domestic abuse, neglect or experiencing child sexual exploitation, although there remains room for improvement.

Much had been done to strengthen staff knowledge, skills and responses to children and young people impacted by the behaviour of adults. In some partnership areas, Women's Aid children's support workers were providing valuable therapeutic support to children and young people to help them recover from their experiences of domestic abuse.

Multi Agency Risk Assessment Conferences (MARAC) were providing opportunities for all agencies to share information and jointly assess and plan to address the needs of adult victims of domestic abuse and their children. Partnerships had put in place targeted initiatives, complemented by bespoke training for staff, in order to strengthen their responses to support children and young people left vulnerable in these situations. We still recognise from national statistics, however, that domestic abuse, and its impact, remains a significant issue in Scotland[4].

In the joint inspections 2018 – 2020, most partnerships had invested heavily in training, guidance and procedures to help staff share information and jointly assess and plan in order to meet the needs of children and young people living in situations of neglect. This had resulted in greater staff confidence in recognising the signs of risk and neglect. Training on **Adverse Childhood Experiences** (ACES), a feature in several of the partnerships, and referred to in our own publication on learning from significant case reviews[5], was helping staff to understand the impact of a child's experiences on their learning and life chances. Overall, we saw a wide range of approaches and services in place to help children and young people recover from their experiences of neglect. However, despite improvements, for a small number of children and young people, more could be done to ensure that the right help was consistently available at the right time.

In just over half of the case records for children and young people which we reviewed, the child or young person had been at immediate risk of harm in the previous two years. For them, the response by services had been good or better in three quarters of cases and adequate in just under one fifth of cases. It is interesting

[4] Police Scotland statistics recorded 60, 641 incidents of domestic abuse in the 2018-19 year, an increase of 2% on the previous year. The Scottish Government, Crime and Justice Bulletin 'Domestic Abuse Recorded by the Police in Scotland 2018-19'

[5] Care Inspectorate 'Learning from Significant Case Reviews March 2015 to April 2018' highlighted that a "systematic shift is needed from focusing on addressing the symptoms to addressing the core cause. However, this requires an understanding of the wider social, economic and cultural factors that impact on neglect and on other adverse childhood experiences."

to note that these figures are very similar to those in the findings of joint inspections 2012 – 2017.

Responses to harm were informed, in the main, by clear and accessible single and multi-agency procedures which gave clear direction to staff. Two thirds of staff surveyed had confidence that local child protection arrangements supported staff to respond in an effective and timely way to reports of child abuse, neglect and exploitation. Most staff said they were confident in recognising and responding to risk. Information was shared effectively, respectfully, and timeously across and between professionals. In most inspections, we found that legal measures were being used appropriately in order to secure a child's immediate safety.

In most partnerships, we saw that the 'Getting it right for every child (GIRFEC)' approach was embedded and staff were using the shared language and wellbeing indicators to effectively work with each other and families to assess and plan to address risk and need.

In the findings from the joint inspections 2012 – 2017, we saw significant improvements in pre-birth planning pathways where there were concerns about the safety or wellbeing of both vulnerable pregnant women and their unborn children. In the joint inspections 2018 – 2020, we continued to see progress being made. Pre-birth services and pathways to support vulnerable pregnant women were well established across most partnerships. These pathways facilitated earlier identification and intervention. For example, in the Stirling joint inspection report, we reported: 'Pre-birth planning services were well established with steadily increasing referrals over the last three years. Vulnerable women were followed through their pregnancies up to just after the birth by their named midwife in the team. This continuity of care also facilitated better collaboration between social work, police and alcohol and drug services in identifying child concerns.'

Staff confidence and competence

In our staff surveys, most staff were of the view that children and young people were being protected from abuse, neglect, harm or exploitation. Most areas had comprehensive approaches to single and multi-agency learning and development in place which had supported staff to be confident, competent and curious in their practice. Overall, two thirds of staff surveyed believed their participation in regular multi-agency training had strengthened their contribution to joint working.

Child protection committees commissioned training in this area of practice and led and directed audits and evaluations in order to support practice improvement. They were also responsible for comprehensive multi agency protocols which gave effective guidance to staff. In most partnerships, staff were being supported through a strong culture of learning. Most staff told us they had the knowledge, skills and confidence to recognise and report signs of child abuse, neglect and exploitation and

that this supported their ability to assess the risks and needs of the children and young people they were working. Almost all staff said they were able to analyse risks and needs and understand the implications of these for children and young people. However, only just over half of staff said they knew how to prepare an outcomes-focussed child's plan. Over one third of staff were not confident that effective plans for children and young people were produced in a timely way with an active contribution from their families and all relevant agencies.

Involving children, young people and families in child protection processes

We saw a varied picture in relation to participation. In most partnerships, the participation of care experienced young people was more embedded in practice than the participation of children and young people within the child protection system.

Some partnerships had invested in staff who had an independent reviewing role within the child protection system. While this role positively brought independent challenge and accountability to practice, we saw differences in how this role supported the active participation of children, young people and their families in child protection processes. In some areas, the independent reviewing officer role had a significant positive impact on involving families at this challenging time, in other areas, less so. In partnerships without this independent role, we saw similar variability. Overall, there was a lack of consistency but opportunities to learn from good practice.

In some partnerships, a clear relationship-based approach was driving practice that was inclusive and child-centred. In some partnerships, independent advocacy, provided by the third sector, was enabling children's and young people's views to be heard in meetings as part of the child protection system. However, this was not consistent across partnerships which were at various stages of addressing participation and engagement in child protection.

In our staff surveys, just over a third of staff agreed that independent advocacy support was routinely made available to children and young people in need of protection. However, of the children and young people whose names were on the child protection register and whose case records we reviewed, independent advocacy was offered to them in only a few cases and to their parents or carers in just under one fifth of cases. Other forms of advocacy, for instance from key members of the **team around the child**, were offered to the individual and to the child's parents or carers in just under one fifth of cases.

Assessment, decision making and planning

Multi agency meetings to discuss referrals (**IRDs** - variously referred to as **initial referral discussions, interagency referral discussions** or **initial referral tripartite discussions**) were taking place across most partnerships. These were an effective route to make decisions about appropriate responses to concerns, however, we commented on the need for improvements in IRD supporting processes including the

recording of decisions taken by this forum and on the need for greater quality assurance of the IRD process in almost all joint inspections.

Good practice example: Midlothian

The initial referral discussion (IRD) process was highly effective in supporting staff to share information and make joint decisions in response to child protection concerns. The public protection committee provided strategic oversight of the use of IRDs through routine quarterly reporting and exceptions reporting via the IRD oversight group and the performance and quality improvement sub-group.

We consider the robust approach to quality assurance of the IRD process and the subsequent impact on child protection practice to be an area of good practice.

In our review of findings from the inspection programme 2012 – 2017, we noted that the quality and consistency of chronologies in informing decision making was a challenging area of practice across services for all children and young people. In the joint inspection programme 2018 – 2020, while we could see partnerships had invested in this area of work to support practitioners working with children and young people in need of care and protection, we again noted the need for improvements in this area in half of the inspections we carried out. In our review of case records, while we saw that almost all of the case files we read contained a chronology, the quality of these varied. Just under half were good or very good, however, one third were adequate. One in five were weak and a few were unsatisfactory.

Without a satisfactory chronology, staff cannot be as fully informed as they should be about the impacts of significant events on the life and experiences of a child, therefore, the ability to analyse these to inform decision making and planning to meet his or her needs will not be as robust as it could be[6] [7].

The assessment and management of risks for children and young people were not as robust as they could have been in one quarter of the partnerships we inspected. In these cases, risk assessments and risk management plans were either not always

[6] 'Chronologies provide a key link in the chain of understanding needs/risks, including the need for protection from harm. Setting out key events in sequential date order, they give a summary timeline of child and family circumstances [or those of an individual using adult services], patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment' Care Inspectorate 'Practice Guide to Chronologies 2017.

[7] We have emphasised the importance of chronologies in various publications, including 'Learning from Significant Case Reviews March 2015 to April 2018' where we stated, 'The absence, quality and effective use of chronologies, both single and multi-agency, to help practitioners understand and appraise the nature and level of risk and impact of significant events on the child was a recurrent finding in 11 of the [25] significant case reviews we reviewed.'

in place or not effective at managing identified risk to or from a child or young person.

For children and young people for whom there had been concerns about risk of immediate harm in the preceding two years, we saw that assessments of risk were of a higher standard than assessments of need. In the Aberdeen City joint inspection report we commented: 'Staff were confident at recognising the signs of risk, which was supported by good information sharing processes and early discussions. Responses to immediate risk of significant harm were effective.'

Risks for young people

At times, young people can be faced with risks in the community (such as child sexual exploitation (CSE) or human trafficking), risks to themselves (including risk taking behaviour, self-harm and suicidal ideation) and in a small number of instances, risks to others. There was differing practice from partnerships in the processes used to assess and manage such risks. In a few of the areas we inspected, we highlighted the use of vulnerable young people's procedures, for example in the City of Edinburgh joint inspection where 'Staff had been supported to proactively respond to a significant need and had built a collaborative model with daily oversight of risks and concerns.' Such procedures helped staff to identify and respond to risk and concern for young people[8].

Risks for younger children

Within our inspections, we noted that younger children (those under five years old) were more likely to be identified as being at immediate risk of significant harm than older children and, once identified, the response from services was more likely to be evaluated higher for younger children than older children. Over three quarters of files for under-fives were evaluated as good or better for response to risk, whereas just over half of files for those aged 11 and over were evaluated as good or better.

Risks to others

A small sample of our review of case records was in relation to children and young people for whom there were concerns that they posed a risk to others. Almost all of these case records held an assessment of risk and need. We evaluated the quality of the risk assessment as good or better in just under two thirds of cases. In relation to their needs' assessments, we evaluated just over two thirds as good or above. For most of these children and young people, there was a plan in place to address risks and needs.

[8] We also highlighted the use of vulnerable young person's procedures in our publication 'A report on the deaths of looked after children in Scotland 2012 – 2018'. We commented, "Vulnerable young person procedures can be a useful tool in assessing and meeting the needs of young people whose behaviour may place them at risk. We would like to see them adopted more widely; child protection committees that have not done so already may wish to consider whether practice would be strengthened by developing and implementing them."

We evaluated these plans as good or above in just under two thirds of cases, however, one in ten cases were evaluated as weak or unsatisfactory.

In the review of findings 2012 – 2017, we noted that the policy landscape had broadened and the National Action Plan to Tackle Child Sexual Exploitation was being implemented. In our joint inspections 2018 – 2020, we saw that most partnership areas had undertaken significant work to upskill staff to recognise and respond to children and young people who may have experienced CSE. This included young people who had gone missing from children's houses. In several partnerships, such as **South Lanarkshire**, we saw reductions in the numbers of young people who had gone missing from children's houses and improved processes in return interviews. In that area, the fully embedded multi-agency protocol for responding to and minimising risk to children and young people who went missing from children's houses, kinship care or foster care placements was supporting good collaborative working.

In the Fife joint inspection report, we commented on the use of 'a multi-agency screening group [which] had been established to share and review concerns around CSE and plan a response to protect young people. In this area, a CSE pilot had also consulted with 170 children and young people to understand CSE in the local area and inform future interventions. This work was informing training for social workers and led to a review of personal and social education programmes in schools, with police providing awareness raising sessions at parents' evenings.'

Many partnerships were using nationally recognised assessment tools to assess and plan to meet need when a young person was at risk of CSE. Some areas, often with the support of third sector partners, had established specific groups to help young people to recover from these experiences.

2. How good is the partnership at helping children and young people who have experienced abuse and neglect stay safe, healthy and recover from their experiences?

Key messages

1. Universal and targeted services were supporting children and young people well in their recovery from abuse and neglect. However, not all children and young people were receiving the right support at the right time to aid their recovery.

2. In the areas in which we saw investment in targeted family support and flexible parenting programmes, we saw clear positive differences being made in the lives of families. In these areas, many children and young people were helped to return to, or remain successfully in, their families.

3. Partnerships had invested in addressing the mental health needs of children and young people at universal and targeted levels. However, specialist services such as child and adolescent mental health services (CAMHS) continued to be under significant pressure, resulting in some children and young people having to wait too long for the help they needed.

4. We saw improvements in the assessment, planning and reviewing processes which supported children and young people who had experienced abuse and neglect. This was creating a better experience for children and young people in having their needs met more effectively.

5. The Getting it right for every child (GIRFEC) approach was well established, enhancing joined up working, providing a shared language and an even stronger focus on wellbeing and the outcomes for children and young people.

Consistent, caring relationships

Our joint inspections between 2012-2017 provided evidence of the work undertaken by staff across services to build supportive and trusting relationships with children and young people and to support their wellbeing. These positive trends had continued, supported by a growing emphasis on the importance of consistent, caring relationships with trusted adults. In the eight inspections carried out during 2018-2020, inspectors and young inspection volunteers talked to children and young people about the kind of relationships they had formed with key workers, including social workers, residential care staff and teachers.

Consistently, we heard positive accounts of the quality and sustainability of such relationships from almost all the children and young people we met. At the heart of this were strengths-based approaches and relationship-based practice models

which were having a positive impact on relationship building. For example, we commented on this in the Aberdeen City joint inspection report: 'Strengths-based and relationship-based practices were embedded throughout interactions between professionals from all agencies and children, young people and their families. Relationships were characterised by trust, warmth, compassion and staff demonstrated a genuine desire to support families to the best of their abilities. The values of strengths and relationship-based practice were evident from all staff we spoke to and reflected by almost all children, young people, their parents and carers'.

Evidence from the case records we read supported this view. Most children and young people had received consistent support from at least one key person in the previous two years, and the same proportion had experienced a level of contact with a lead professional that was commensurate with their child's plan.

Often, a high turnover of front-line social work staff created a perception that this was impacting negatively on relationships between social workers and some children, young people and families. However, in most partnerships, this perception was challenged by the results from our survey of children and young people, where the majority of those surveyed agreed that their worker[9] was always available when needed, and a further one in four agreed that the worker was available at least sometimes.

Change and improvement

Across the eight inspections, a range of multi-agency, targeted, and universal interventions were having a positive impact on the wellbeing of children and young people in need of care and protection. This was reflected in our evaluation of the relevant impact quality indicators[10], where 13 out of 16 evaluations were 'good' or 'very good' (see Appendix 2).

There was a wide range of universal and targeted support provided by statutory and third sector partners to help parents and support children and young people in their recovery from abuse and neglect. In the Stirling joint inspection report we commented that the partnership was providing a 'comprehensive, well-considered range of services that helped children and young people, including those recovering from past trauma'. However, not all children and young people were receiving the right support at the right time to support recovery. In our staff survey, one out of five staff reported that children and young people who had experienced abuse and neglect were not receiving the support they needed to recover from their experiences.

[9] 'Worker' identified as social worker by 80% of children and young people aged 8 to 15; 50% of young people aged 16+.
[10] Quality indicator 2.1: Impact on children and young people; Quality indicator 2.2: Impact on families.

Efforts were being made to address the mental health needs of children and young people by universal, targeted and specialist services. In some areas, child and adolescent mental health services (CAMHS) were providing consultation to colleagues working in other agencies, as well as individual and family sessions. However, despite such efforts, there was a continuing shortfall of therapeutic help for children and young people recovering from experiences of abuse and neglect. In that sense, we saw little improvement from the situation we found and reported on in the previous overview report where we highlighted this as a key finding.

Parenting assessment and support

In the 2012-2017 overview report, we commented on a growing emphasis on prevention and earlier intervention that had in turn contributed to:

- improved parenting capacity
- greater parenting resilience
- improvements in family life and relationships
- improved outcomes for children and young people
- less reliance on specialised support.

In 2018-2020, we continued to witness a range of measures which had been put in place to support parents and carers. These included further embedding of parenting capacity assessments and a wide range of effective, universally available community-based supports. This provision was enhanced by the use of structured, evidence-based parenting programmes. This was reflected in a positive set of evaluations for quality indicator 2.2 – 'Impact on families.' Of the eight partnerships inspected, six were evaluated as 'Good', one as 'Very Good', and one as 'Adequate'. Three quarters of the parents and carers surveyed felt supported and agreed that staff had made both their lives and those of their children better. They were being well supported through a range of universal and targeted services and evidence-based interventions. They were benefitting from support groups and validated parenting programmes that had helped build their confidence, knowledge and skills, improving their parenting abilities to good effect. In the Fife joint inspection report, we commented, 'Helpful, targeted family support and flexible parenting programmes meant that children and young people were helped to return to, or remain successfully in, their families.'

However, in one inspection, we came across a pressing need to develop intensive family support and parenting assessments locally to keep a small number of babies safe on discharge from hospital.

We saw good examples of tailored support packages, using strengths-based approaches and trauma-informed practice, helping parents and carers to better understand their children's needs and make the changes needed to improve their circumstances. Strengths-based approaches meant that staff started their work with families by examining the strengths within the family. Trauma-informed practice

meant that staff were trained to recognise the impact of trauma on the lives of children and young people and took account of this in their work.

The South Lanarkshire partnership had a clear strategic approach and had invested in a parenting pathway comprising of a range of approaches, some of which were specifically targeted to parents of children and young people in need of care and protection. This was underpinned by comprehensive training to staff across the partnership in approaches such as the Framework for Assessment and Intervention for Attachment and Resilience (FAIAR), and other accredited parenting programmes.

Good practice example: South Lanarkshire

The Framework for Assessment and Intervention for Attachment and Resilience (FAIAR) was developed by South Lanarkshire's Psychological Services and was an example of good practice. It is a targeted programme which aims to support staff working with parents and carers to help them better understand attachment and resilience. As part of the overall parenting pathway, the approach has been delivered to over 100 practitioners across education, early years and social work resources.

The approach has three elements: resources to use, including leaflets and posters; a developmental chart; and a targeted programme which can be used as a one-to-one tool.

Practitioners have evaluated the approach highly as an effective means of supporting parents' capacity for change, at a pace which is right for them and their child.

Assessment, planning and review

Good quality assessment and planning were making a difference in supporting the recovery of children and young people who had experienced abuse and neglect. We evaluated around seven out of ten assessments of both need and risk as 'Good' or better in the eight inspections. However, in one partnership area, assessment required significant improvement. In the remainder, there was nearly always a small but significant number of case records where the quality of assessment was evaluated as 'Adequate', pointing to a need for further improvement.

Results in terms of the quality of planning and reviewing showed a similar pattern, with one in four plans and reviews deemed to be of adequate or lesser quality. In some instances, this standard of planning for individuals served to hinder the extent to which children and young people were able to recover from abuse and neglect. Such inconsistencies in the quality of assessment, plans and reviews highlighted the

need to strengthen and support improvement through more effective quality assurance and management oversight.

In a few areas, we highlighted the positive impact of independently chaired reviews. This included improved participation of children, young people and their families in their reviews and plans.

Overall, assessment, planning and reviewing were making a difference in supporting the recovery of children and young people who had experienced abuse and neglect. In most areas, performance provided a strong basis for further improvement to achieve consistently high standards.

Engagement with children, young people and their families

Partnerships stated their commitment to listen and respond to the voices of children, young people and their families. Our inspections revealed this in a number of important respects. Almost all children and young people who responded to our surveys felt their views and opinions were listened to by their worker. The majority of parents and carers who responded to our surveys felt supported, got on well with, and felt listened to by staff. Evidence from case records indicated that staff were 'good' or better at involving and seeking the views of parents and carers in eight out of ten cases. The corresponding figure for children and young people was six out of ten deemed 'good' or better – indicating room for improvement.

Getting it right for every child (GIRFEC)

Continuing the progress evident during the period of the 2012-2017 programme of inspections, GIRFEC was well established in seven out of the eight partnership areas. In the main, we saw GIRFEC contributing to joined up processes, a shared language and a strong focus on wellbeing, with most staff surveyed agreeing that GIRFEC was having a positive impact on the lives of children and young people. Many staff again told us how GIRFEC had helped to improve working relationships at the front line over the period of inspection. There was usually a culture of collaborative working across all disciplines, which was having a positive impact on work with families.

In the 2012-2017 overview report, the quality of plans was found to be variable. In the inspections carried out after 2016, three quarters of plans we read were 'adequate' or better. In the eight inspections carried out during the period under review, this had improved to a situation where nine out of ten were 'adequate' or better. However, with over a quarter of plans still rated as 'adequate', the need for further improvement remained.

In general, staff were working well together to implement individual plans for children and young people. We saw sufficient involvement of key partners in most of the case records we read. Health staff appeared to encounter the most difficulty in

sustaining their involvement throughout, as featured in one in ten case files we read. Education staff were also found to be insufficiently involved in a few cases.

However, in one partnership area, there were weaknesses in the operation of important mechanisms, such as case conferences and core groups designed to implement child protection plans and monitor progress to ensure children remain safe and well over time.

Staff support and supervision

In the 2012-2017 overview report, supervision had been regarded by staff as a neglected area of practice. Where it did occur, staff reported that it tended to be infrequent, curtailed or rushed, and focussed predominantly on workload management. This was concerning, as effective supervision contributes to safe practice, provides a means of quality assurance and supports staff to reflect on their practice.

Although evidence of inconsistency in supervision arrangements continued to feature in the eight inspections reported on here, there were signs of improvement. Just under two thirds of case records we looked at provided evidence of staff having regular opportunities to discuss their work. Three quarters of staff surveyed agreed that they received regular supervision that provided support and challenge. Where practitioner fora had been established, staff were extremely positive about the peer support they received, which they regarded as a platform for learning, development and continuous improvement. We saw a few examples where child protection committees had developed a **seven-minute briefing** approach, which helped committees to share learning and development with staff members. We gave an example in the Argyll and Bute joint inspection report which evidenced that staff were being supported and guided effectively: 'The approach and use of care assessment and reviewing officers (CARO), Getting it right for every child (GIRFEC) advisors and child protection officers was an effective method of providing operational support, advice and guidance that enhanced both the confidence and ability of staff to respond effectively to child protection concerns'.

Overall, there were signs of improvement in staff supervision, opportunities for peer support and guidance from more senior staff to help staff support children and young people in need of protection.

3. How good is the partnership at maximising the wellbeing of children and young people who are looked after?

Key messages

1. It was clear from our surveys completed by children and young people that staff, including social workers, and other significant adults had established trusting relationships with most looked after children and young people.

2. Most looked after children and young people had experienced at least some improvement in their wellbeing as a result of the support provided. Overall, children looked after in foster care experienced the most improvement in wellbeing and children looked after at home showed the least.

3. While our inspections demonstrated examples of the impact which services and interventions had on children, young people and their families, partnerships struggled to find the evidence to demonstrate tangible improvements in the wellbeing of looked after children and young people and understand performance trends concerning different looked after groups.

4. There had been some progress in narrowing the educational attainment gap between looked after children and their peers, however, it remained too great.

5. In some partnerships, looked after children and young people had been supported to remain in, or return to, family-based settings in their local communities. Although the proportion of community-based placements had increased, including kinship care placements, further work was required to improve the consistency of support for kinship carers.

6. Where children and young people were unable to remain with their families, they needed to be better supported to remain in contact with their families, particularly their brothers and sisters.

7. Not all care experienced children and young people had the same opportunities to share their views and meaningfully influence service delivery.

Caring relationships

In previous chapters we set out evidence of a strong ethos of valuing children and young people across the partnerships inspected. This applied equally to all those who were looked after and, in the majority of partnership areas, the importance of building strong and meaningful relationships was highlighted.

Staff worked to ensure that looked after children and young people thrived as a result of consistent and enduring relationships. This translated into positive

relationships with key adults, including foster carers, residential staff, social workers, guidance teachers and other professionals making up the team around the child. Our survey of children and young people revealed almost all children and young people reported trusting and supportive relationships with their worker[11], although just over a third of children and young people felt that their worker was not always there for them when needed, indicating issues regarding availability.

However, not all the children and young people we came into contact with were as positive in their views. In one area in particular, a sizeable minority of looked after children and young people had poorer experiences, including placement disruptions and frequent changes of staff, which made it harder to build trust and confidence. Overall, however, we came across evidence of strong and meaningful working relationships that were having a positive influence on outcomes for most looked after children and young people.

Improvements in wellbeing

The case records we looked at revealed that most children and young people had had access to required interventions, and that these had been effective to some degree in almost all cases. These efforts had resulted in most children and young people experiencing at least some improvement in their wellbeing.

However, further analysis revealed that children and young people in foster care were most likely to show the strongest indication of improvement, and those looked after at home, the least. In the eight inspection reports, just under half the children who were looked after in a foster placement were noted to have shown considerable improvement in their wellbeing as a result of the support provided, compared to one fifth of children who were looked after at home.

In all eight inspections, we found a range of services designed to improve wellbeing in a number of ways across various aspects of the wellbeing indicators[12]. In the Argyll and Bute joint inspection report, we commented: 'Many care experienced children and young people experienced improved wellbeing that was supported by trusting relationships, strengthened universal services and individually planned measures of support.'

Demonstrating improving outcomes

While we were able to see some evidence of improvements in the wellbeing of looked after children through our review of case records, partnerships struggled to

[11] 'Worker' - 81% of children, young people and parents/ carers chose to give comments on their social worker or throughcare worker.
[12] Safe Healthy Achieving Nurtured Active Respected Responsible Included – the eight wellbeing indicators as outlined in the national Getting it right for every child programme

demonstrate concrete evidence of the differences their services were making to the lives of these children and young people. This was reflected in the evaluation of quality indicator 1.1.[13] Across the eight partnership areas, this was the least well evaluated quality indicator, with over half of the partnerships evaluated as less than 'good' and none higher. Performance measures were not always used to full effect. For instance, measures often did not differentiate between young people looked after in different care settings. This meant partnerships were at a disadvantage in being able to demonstrate trends or improvements across different care groups.

In our 2012 – 2017 overview report, we highlighted that partnerships were unable to consistently, or effectively, demonstrate improvement in closing the educational gap for looked after children and young people. Overall, in the joint inspections 2018 – 2020, we found there had been progress in some areas in narrowing the attainment gap between looked after children and their peers. The majority of children and young people we surveyed felt they were getting the help they needed with schoolwork. In addition, most parents and carers agreed that children and young people were getting the help they needed with education. We found examples of partnerships supporting looked after children to improve their school attendance, reduce school exclusions and improve literacy and numeracy. Some areas had managed to carefully track attainment across the different looked after groups which was helping them target resources and provide tailored support.

Despite these improvements, partners recognised that narrowing the attainment gap continued to represent a significant challenge with the gap between looked after children and young people and their non-looked after peers remaining too large. This was identified as an area for improvement, also evidenced by the national statistics.[14]

Not all looked after children were getting the support they needed with their emotional and mental health. The difficulties experienced in accessing child and adolescent mental health services (CAMHS) have already been covered in more detail in an earlier chapter. Whilst partners, as corporate parents, were clear in their view that looked after children and young people should be afforded some degree of priority in respect of CAMHS, this made little difference in terms of those looked after having to wait too long for access to specialist mental health services[15].

[13] Quality indicator 1.1: Improvements in the safety, wellbeing and life chances of children and young people in need of care and protection.
[14] The Education Outcomes for Looked After Children 2017/18 highlighted that 39% of looked after children left school with one or more qualifications at SCQF level 5, compared to 86% of all children.
[15] We also raised this as a key message in our publication, 'A report on the deaths of looked after children in Scotland 2012 – 2018.' We stated, 'More needs to be done to ensure mental and emotional health services are available for vulnerable and looked after children and young people.'

Supporting looked after children to maintain relationships with families

In our review of children's records, we considered the support given to children and young people who were looked after away from home to maintain important family relationships. We found that staff were more effective at supporting children and young people to maintain contact with their parents than they were in supporting them to maintain contact with their brothers and sisters. In a third of relevant records, there was room for improvement in the support given to enable looked after children to maintain contact with their brothers and sisters. All partnerships needed to improve in this area, although some were able to indicate improving trends. In the Fife joint inspection report, we highlighted that 'staff were giving more careful consideration to the needs of brothers and sisters to stay together when they were unable to remain at home.'

However, we found some examples of effective work by staff to help children and young people maintain contact with their siblings. These included in South Lanarkshire where the skill and expertise of residential care and family placement staff were deployed to support sibling contact and the innovative Siblings Together and Reunited (STAR) project in Fife which provided opportunities for brothers and sisters to spend quality time together when they lived apart.

For children who required to be looked after away from home, partnerships were setting out to increase the proportion of children and young people placed in family settings, close to or situated in, their home communities. In some partnership areas, there had been a deliberate, positive reduction in the overall number of looked after children and young people, and an increase in the number placed in kinship care, often close to their home and community. This had been achieved through efforts at both strategic and operational levels, including a commitment to improving the quality of looked after reviews. For example, in the City of Edinburgh joint inspection report, we highlighted that more children were looked after in community settings 'as a result of planned initiatives to strengthen kinship care and keep children at home.'

In other areas, this remained an important aim or aspiration. It was important for partnerships to ensure that as well as having this as an aspiration, children and young people remained in the placements that were right for them. From the viewpoint of children and young people, the results of our survey indicated that most children and young people aged eight to 15 years felt settled where they were living.

When children required to be looked after away from home, in many partnership areas we saw that arrangements for kinship care were helping children and young people to maintain important relationships with extended families, as well as helping them to remain in local communities and school settings. In our 2012 – 2017 overview report, we saw an increase in kinship care arrangements and a growing recognition of the benefits of these placements for children and young people. In the joint inspections 2018 – 2020, we found examples of positive support to help kinship

carers provide stable and consistent placements for children and young people. However, support for kinship carers was not always consistent and while there had been improvement in support in some areas, in others, there was a lack of consistent support. In a few areas there was a low use of kinship care placements and this required greater attention and focus.

Assessment, planning and review

Again, we commented on aspects of assessment of need and risk in earlier chapters, where our review of case records found thorough risk assessments and assessments of need. These findings also applied to looked after children and young people, with seven out of ten assessments of risk and need evaluated as 'good' or 'very good'. However, this persistently left between a third and a quarter of assessments requiring improvement.

Looked after children were actively encouraged to participate in assessment, planning and review. According to our surveys, almost all children and young people who responded felt their views and opinions were listened to by their worker. This was reflected in results from our file reading. Involving children and young people in key processes, seeking and recording their views was evaluated as 'good' or better in the majority of cases. Similarly, efforts to ensure that children and young people were aware of their rights received a similar evaluation. The majority were evaluated as 'good' or better.

Occasionally, children were supported by an independent advocacy worker. Where this service was not available, we came across individual members of the team around the child taking on an advocacy role, often to good effect. However, we regularly found that, as well as being in short supply, the criteria for accessing independent advocacy was often unclear, both to children and young people and frontline staff. Overall, partnerships have further work to do to ensure that looked after children and young people are listened to meaningfully and involved in decision-making about their own care, as highlighted in the **independent care review**.

In the previous chapter, we commented how health staff appeared to encounter the most difficulty in sustaining their involvement throughout, as featured in one in ten case files we read. Moreover, in some of our inspections, the quality of the contribution made by health professionals to the assessment of need was mixed. They were not always fully involved and sometimes experienced difficulty meeting timescales. Without this health input to the assessment, health staff were not always able to contribute meaningfully to the health component of the child's plan. In other areas, improving trends in the completion of health assessments for care experienced children and young people made it more likely that their health needs were identified at an early stage and addressed more effectively.

Reviews were not always seen to be driving forward plans to meet the needs of looked after children and young people and information from reviews was not always being used systematically by managers to oversee standards and measure progress on intended outcomes. On the other hand, we came across positive signs that overall, this was an improving picture.

In other areas, well managed reviews, sometimes independently chaired, had contributed to improved quality assurance and participation of children and young people, which in turn, had contributed to improving aspects of their wellbeing.

In relation to permanency planning, children who needed alternative permanent care were benefitting from improvements in planning. Three quarters of the permanency case records we read demonstrated that plans were progressing well. However, work was still required to develop systems to monitor progress and achieve further improvement.

All but one of the partnerships had engaged with the **Permanence and Care Excellence (PACE)** programme, with encouraging results. In four of the partnership areas, PACE had helped reduce drift and delay in permanency planning through improved timeliness, target setting and decision making. In the remaining areas, it was either unclear or too early to tell. Nevertheless, the PACE programme was seen to have a positive impact on permanency planning where it had been effectively engaged by partnerships.

Participation and involvement

Although we came across positive, coherent and committed approaches to corporate parenting in our inspections, variable progress had been made in establishing corporate parenting structures, including **champions boards** where children and young people could be represented and heard. In some areas, the champions board had begun to provide a vehicle for the voice of looked after children and care experienced young people, but more needed to be done to make this voice more representative of the looked after population as a whole. In **Stirling**, we saw a good practice example of an effective and representative champions board.

Good practice example: Stirling

The Stirling Champs was an example of good practice. The group was determined to make sure all care experienced children and young people were informed of, and kept up to date with, their rights. All members were very active in networking and raising awareness of the board. Leaders, including elected members, knew the Champs members well and were keen to hear what they had to say. As a result, the Champs had been effective in raising key issues like mental health, social work and education. They were working closely with education to provide important input to schools that actively challenged stigma and preconceptions around care experienced children and young people. The Champs had facilitated meaningful engagement between care experienced young people and their corporate parents.

From our survey of children and young people, we found that young people aged 16 and over were more likely to be involved in consultations, champions board events and other consultative fora. However, we noted that, in some areas, representation and participation of young people in commenting on service provision and service improvement was on the increase, reflecting significant amounts of effort and investment on the part of corporate parents. We found that, in the areas where workers had dedicated time to support the involvement of care experienced children and young people, this had led to improved participation in opportunities to be heard. A few areas had a range of tailored groups for care experienced children and young people at different ages and stages, and this was helping them to be involved.

In Midlothian, care experienced young people had attended a residential programme with key staff. This had led to improved relationships and, in turn, improved involvement in participation opportunities. We noted that: 'Recent investment in the Columba 1400 programme enhanced relationships between young people and staff and we heard from young people how they enjoyed spending time with enthusiastic and committed staff.'

Overall, in half of the eight inspection reports, we highlighted limitations on the ability for care experienced children and young people to share their views and meaningfully influence service delivery. This meant that children and young people's experiences were mixed and therefore more needs to be done to ensure that care experienced children and young people are able to influence service delivery and be heard, which links with '**The Promise'** in the independent care review: '*The children that Scotland cares for must be actively supported to develop relationships with people in the workforce and wider community, who in turn must be supported to listen and be compassionate in their decision-making and care.'*

Children with disabilities

In one of the eight partnership areas, children and young people with disabilities and in receipt of short breaks were identified as being looked after. In Argyll and Bute, the decision to regard these children and young people as looked after had been a recent one. This change meant that reviewing arrangements had become more robust and we noted that this improvement in planning and quality assurance promised better outcomes for this group of children and young people. In one area, however, we concluded that there was a lack of a co-ordinated approach for this group and reviewing processes were not as effective as looked after reviewing processes.

Given the scope of the joint inspections 2018 – 2020, we did not fully consider the care or support arrangements for all children with disabilities (for example, those receiving support through **self-directed support**). We were, therefore, unable to draw many overall findings for children with disabilities. However, in a few of our inspections, we did note that self-directed support had been used effectively to provide personalised care and support. In the Stirling joint inspection report, we

noted: ‘Self-directed support was being promoted effectively and used regularly. The approach enabled children and young people with disabilities and their carers to have more choice and control in supporting their wellbeing needs and achieve positive outcomes. A range of communication and engagement methods was helping children, young people and their carers to be active participants in the design and delivery of their personalised care and support. On top of this, self-directed support was being rolled out across children and families’ social work and had been extended to 18 and 19 year olds to help plan smoother transitions to adult services.’

One key finding for children with disabilities arose from our review of case records, where one out of every six of the records that we read noted that the child or young person had a disability. We could see that children with disabilities were less likely to be well supported by staff to be involved in key processes or to have their views sought than their non-disabled peers. Only half of the case files we read in relation to a child with a disability were evaluated as ‘good’ or better for this, compared to three quarters of cases when children were not recorded as having a disability.

Overall, more work needs to be carried out to scrutinise the support given to children and young people with disabilities with respect to the equity of assessment, planning and reviewing and the availability of support, whilst ensuring they are fully supported to share their views.

4. How good is the partnership at enabling care experienced young people to succeed in their transition to adulthood?

Key messages

1. The majority of care experienced young people reported positive relationships with staff and carers, in particular with social work staff, including social workers and throughcare and aftercare workers.

2. We saw an increasing number of young people achieving positive destinations across partnerships, however, we did not see consistent improvements in other aspects of their health and wellbeing outcomes. Some young people were prevented from moving on successfully to adulthood by difficulties they faced in the accessibility and availability of appropriate housing and mental health and wellbeing services.

3. We saw variability in the approaches to, implementation of, and success of supporting young people through promoting continuing care. More needed to be done to fully enact the principles and spirit of the legislation.

4. Not all care experienced young people experienced the same opportunities to give their views to support service development. Independent advocacy was not used as widely as it could have been to support young people to be heard.

5. Processes to support the positive transition of young people between children's and adults' services were often disconnected and complex. Children and young people with a disability and care leavers were at the greatest disadvantage because of this.

Sustained positive relationships with staff and carers

Care experienced young people reported positive relationships with staff and carers. We heard of many examples of trusting and caring relationships during our inspections. In our surveys of young people, most referred to their social worker or throughcare worker. It was evident from the case records we read that most young people had had consistent support from at least one key person over the past two years. Whereas most children's and young people's files we reviewed showed they had had contact with the lead professional commensurate with their care plan, this was not the case for three quarters of young people in continuing care or in receipt of after care services.

Most young people who responded to our survey knew why a worker was involved with them and their family and believed that the worker cared about what happened to them and treated them with respect. In the Orkney joint inspection report, albeit in relation to small numbers, we commented that 'a high proportion of care leavers remained in touch with services, benefiting from continuing positive relationships with staff and carers.' Throughout all of our inspections, care leavers told us that they valued consistent and caring relationships with staff and carers.

Several partnership areas had invested in staff training on trauma-informed practice and, in these areas, we saw that this had supported the positive relationships which had developed between staff and young people. These relationships helped young people to grow in confidence as they became older, with most young people telling us they felt confident and felt good about themselves at least some of the time. Almost all young people responding to our 16+ survey told us that things were getting better for them. Despite this, in our review of case records for this group of young people, almost one third of care leavers' files showed no or minimal improvement. We saw less evidence of improvement in the population of care leavers and those in continuing care than we saw across the total number of files we read for all children and young people.

The right services and resources available to support transition

In our 2012 – 2017 overview report, we made a key point about the gap we saw in outcomes between care leavers and the wider population and care leavers and young people in other care placements[16].

In the 2018 – 2020 joint inspections, we continued to see a mixed picture in relation to improvements for care experienced young people. Challenges with housing services and services to support mental health and wellbeing, in particular, were causing barriers to them successfully moving on. In the case records we read, we evaluated the effectiveness of the support and guidance provided by services to care leavers as mostly or completely effective in just over half of cases. For a small but significant number of cases, the support and guidance given to care leavers by services was not effective at all.

We commented on poor experiences for care leavers regarding the access to, availability of, or delay in moving into appropriate and safe housing. We also saw variable experiences in relation to access to mental health and wellbeing services.

[16] "Positive destinations and outcomes for looked after children and young people occurred at a lower rate of improvement than those of the wider population. Partnerships were unable to consistently, or effectively demonstrate, improvement in closing the educational outcomes gap. This gap existed both (a) between looked after children and young people and the general population; and (b) between children and young people looked after in stable foster placements and other looked after children and young people, particularly those placed at home". Review of Findings of Joint Inspections 2012 – 2017, Care Inspectorate

Young people who had experienced issues in relation to mental health services described a lack of knowledge about, or problems in accessing, services which could have supported their mental health and wellbeing needs, including specialist mental health services. Some young people also told us about their negative experiences of trying to access adult mental health services and we heard from young people that these processes were complex and confusing.

In many of the partnerships, we saw an increase in care experienced young people sustaining their tenancies and most partnerships had taken steps to improve this area of support for care leavers. We saw some good examples of training flats where young people could spend periods of time learning the skills required to live independently without losing their care placement and we heard about the commitment of staff to support young people to do so.

While almost all young people who responded to our survey told us they felt safe and settled where they currently lived, this was represented less strongly by older young people. Just under two thirds of those aged 16 and over told us they felt settled. While most partnerships had systems in place to enable care experienced young people to be offered priority accommodation, often these relied on young people self-identifying as care experienced. Young people told us about the stigma they felt this entailed. In some partnerships, if a care experienced young person failed to sustain their tenancy, they would lose the tenancy and no longer receive priority. One third of young people who responded to our survey for those aged 16 and over told us they either did not get help with managing money or accessing housing or they needed more help with these tasks. A few young people felt they received no help to make decisions about their future including help with work, training or education.

Overall, we concluded from our review of records that young people in continuing care placements, as well as care leavers, experienced poorer quality assessment, planning and review processes than any other care group.

Being heard

Young people in continuing care and after care were more likely to be better involved in key processes and have their views sought. For those in continuing care or care leavers, we evaluated the quality of support given to ensure their involvement in key processes as good or better in three quarters of cases, compared to just over half evaluated as good or better for the wider total number of case records we read for all children and young people in need of care and protection.

Our review of case records showed us that, in two thirds of cases, the quality of support given to young people to understand and exercise their rights, comment on services received or express dissatisfaction by making a complaint was evaluated as

good or better. When asked if they had had the opportunity to speak with an independent advocacy worker, just under one fifth of young people who responded to our survey either said they chose not to speak to an advocacy worker or told us they did not know what advocacy was. Of the young people who told us they did not know what independent advocacy was, on learning about this, one quarter told us they would like to use this service.

In our surveys of staff across all eight inspections, just over one third agreed that independent advocacy was routinely made available to children and young people who were looked after or those who were care experienced. From our review of case records, independent advocacy had only been offered to young people in just over a quarter of cases. For the rest, other forms of advocacy had only been offered to the individual in just over one third of cases.

Transitions between children's and adults' services for children and young people with a disability

Approaches to supporting children and young people with a disability and in receipt of short breaks varied across partnership areas. Only a small number of case records we read were for this group of children and young people, although a larger proportion of the case records we reviewed had recorded that the young person had a disability. Some partnership areas had multi-agency meetings to support young people to transition smoothly between children's and adults' services, while others did not. Transitions protocols varied in their quality and implementation across partnership areas.

Over our inspections, we saw a few examples of positive transitions planning for looked after children with complex needs. For example, in the Midlothian joint inspection report, we highlighted an example where 'well planned and effective transition planning resulted in two commissioned residential homes within Midlothian for young people with complex needs. The joint operational planning arrangements and long-term vision for these young people enabled these young people to remain living close to their families.'

We commented on disconnected transitions processes in several of the joint inspections, particularly for children and young people with a disability and in receipt of short breaks and for those young people transitioning into adult mental health services.

Young people supported into sustained positive destinations

Six of the eight partnerships were able to demonstrate improving trends in care experienced young people entering initial positive destinations. Several partnerships had multi-agency programmes, such as 'Opportunities for All', the 'Family Firm' and

employability fora in place to support young people to move into positive destinations. In most partnerships, we saw multi-agency commitment to support young people into sustaining these positive destinations through key agencies such as Skills Development Scotland, higher and further education institutions and employers working together with statutory agencies to tailor support to these young people. In the South Lanarkshire joint inspection report, we highlighted that collaborative work had resulted in 'tailor-made packages of support, mentors who understood their needs, and financial assistance enabled care leavers to succeed in further education.'

We saw a few good examples of programmes to support the employability and development of care experienced young people. In Aberdeen City, there was a good example of a creative approach to supporting the employability of care leavers.

Good practice example: Aberdeen City

Five children's rights development assistants had been employed by the Aberdeen City partnerships on a part-time basis, using Life Changes Trust funding, to support the children's rights service. Not only did this provide these young people with employment opportunities, it also enabled them to become more involved in the development of services and planning.

The children's rights development assistants told us that the experience of carrying out paid work helped give them confidence and develop new skills. They were involved in chairing the champions board, carrying out training and awareness-raising, co-ordinating social media for care experienced young people and assisting children's rights officers in involving looked after or care experienced young people.

Continuing care options and choices implemented

Since the findings of the joint inspections in 2012 – 2017, most partnerships had developed a growing awareness of their corporate parenting responsibilities in relation to continuing care, the **Staying Put** Scotland guidance and many had committed to supporting the **Scottish Care Leavers Covenant**.

Although the effectiveness of supporting continuing care varied, we saw commitment to this across most partnerships and steps had been taken to support and enact the legislation. These included the variation in registration of care services such as children's houses and fostering services to support a continuation of these placements for young people who wished to continue their placement.

There were, however, challenges across partnerships in fully supporting the continuing care agenda. In some areas, senior leaders acknowledged that enabling young people to remain in their children's house was a very positive experience for

the young people in terms of supporting the stability of care. Leaders stated, however, that this had implications for the availability of placements and it impacted on how well and quickly partnerships were able to bring young people back into the area from out of area placements. We did see evidence that many partnerships were trying to address this, for example, by undertaking regular recruitment drives for foster and kinship carers to strengthen capacity within these placements.

In one partnership area, however, a few staff held the view that continuing care was conditional on a young person's good behaviour, rather than a legal entitlement.

Supporting improvements in wellbeing and living independently

In our review of case records for children and young people who were looked after or care experienced, we saw differences in improvements in wellbeing across different care groups. We saw that children and young people in foster care were most likely to show improvements in wellbeing from the support they received from services, while young people eligible for aftercare services were least likely to show this.

We saw variability in the implementation and quality of pathways plans for older young people**.** In our surveys for staff across all eight inspections, only one third of staff agreed that plans for care leavers supported their transitions to adulthood at a time and pace that was right for them.

Young people who responded to our survey for those 16 and over reflected mixed experiences when it came to their care or pathways plans. While half of those who responded told us the things they wanted were always in their care plans and that they had been involved in agreeing these plans, one fifth of respondents said this only happened 'sometimes'. A few young people either said this did not happen or said they did not know what a care or pathways plan was.

In our review of case records, we noted that plans to address need and risk were not always in place for care leavers and, where they were, the quality of these was variable. There were plans in place to address risk for care leavers in just over half of cases. Of these, just over half again were evaluated as 'good' or better[17].

In some partnerships we saw strong evidence of the positive impact of throughcare and aftercare teams in supporting young people to move on to independent living and increase young people's resilience in times of crisis. In these areas, most young people spoke positively of their experiences with these staff. However, in other partnerships, where throughcare and aftercare teams or services were less

[17] Across the records read for **all** children and young people in need of care and protection, plans to address risk and need were in place in most case records and, of these, two thirds were evaluated as good or better.

embedded or not present, we saw evidence of the highly varied experiences of care leavers and, on many occasions, care leavers told us they experienced an inconsistent service.

Corporate parenting partners delivering on responsibilities

While corporate parenting commitments were embedded in strategic plans across partnerships, and most had committed to enact the Scottish Care Leavers Covenant, the extent to which partnerships met these commitments varied. In our surveys of staff across all eight inspections, just under two thirds of staff felt that local leaders had a clear vision for the delivery and improvement of services for looked after children and young people and those who were care experienced. When asked if they had confidence that local leaders ensured there was the necessary capacity to meet the needs of this group of children and young people, only just over a third of staff agreed there was.

Using data to support outcomes-based practice

Across most inspections, we commented on the lack of effectiveness of partnership approaches to systematically monitoring the outcomes for care leavers. While we saw some examples of how this had begun or was being implemented in part, no partnership was making full use of a comprehensive analysis of data to be able to understand patterns and trends in relation to care leavers. This meant that all partnerships needed to do more to be able to fully identify their care leaver population, in order to tailor services to meet their specific needs.

5. How good is collaborative leadership?

Key messages

1. Collaborative leadership of child protection was well embedded across most partnerships, with robust governance being evidenced through child protection committees and chief officers' groups which functioned well.

2. The collaborative leadership of child protection was much more robust and embedded than that for corporate parenting. There must be equity in the governance arrangements for both aspects of practice to enable all children and young people in need of care and protection to achieve their potential.

3. Leaders need to work collaboratively better and more effectively to ensure that service provision and prioritisation are based on a comprehensive assessment of need. For this to be robust, partnerships require to pay further attention to effective joint strategic needs assessments which would give greater understanding of needs both now and in future. This needs to be complemented by the understanding generated by **joint self-evaluation,** in order to focus on continuous improvement. From this, effective **joint commissioning** practices would ensure a holistic approach to service delivery.

4. Performance measures were, in the main, focussed on organisational activity and processes. This meant partnerships were at a disadvantage in being able to demonstrate tangible differences which services made to the lives of children, young people and their families.

5. We saw an improvement in the implementation of high-quality support and supervision for staff. Leaders had worked hard to create a learning culture in which staff felt valued, respected and listened to.

In these joint inspections, inspectors evaluated how well leaders worked collaboratively across both the child protection and corporate parenting spheres. We reviewed the leadership of each separately, then together, to assess the effectiveness of collaborative leadership for services for all children and young people in need of care and protection.

Across most partnership areas, we saw that collaborative leadership of child protection was more embedded and more effective in relation to child protection than it was in relation to all corporate parenting responsibilities. Across the eight partnership areas, the highest evaluation we gave for this suite of quality indicators was 'good'. This reflected the fact that, where we very often saw important strengths in one area of practice, we saw areas for improvement in others which were required in order to maximise the wellbeing, experiences and outcomes for all children and

young people in need of care and protection. In most of these partnerships, where we saw strengths in the effectiveness of leadership of child protection, the leadership of corporate parenting across all corporate parenting responsibilities was less effective. In these cases, leaders were more sighted on certain groups of children and young people, for instance, those in residential care, than others, such as care leavers.

Leadership of vision, values and aims

In most partnership areas, we saw that shared vision, values and aims were explicit and embedded across strategic planning for services for children and young people in need of care and protection. For example, in the Argyll and Bute joint inspection report we commented, 'the vision, values and aims in relation to children and young people in need of care and protection were clearly stated and commonly held.'

However, across partnerships, we saw variability in how staff demonstrated trust in, and understood, the vision for services. On average, less than half of staff told us that local leaders had a clear vision for the delivery and improvement of child protection services. This ranged considerably across partnership areas, however, with just over a quarter of staff stating this in one area and the majority of staff stating this in another.

Similarly, on average, just under two thirds of staff told us that local leaders had a clear vision for the delivery and improvement of services for looked after children and care experienced young people. This also ranged across partnership areas from just over one third in one area, to the majority in another.

Leaders across partnerships worked well together, in the main, demonstrating an open and collaborative culture in which leaders were willing to learn from each other. Just over half of staff, however, felt that leaders were visible and communicated regularly with staff at all levels.

In summary, while partnerships had committed to shared visions for services for children and young people in need of care and protection, there were significant variations in how engaged staff felt in these.

Leadership of strategy and direction

Across the eight partnership areas, we saw good evidence of effective governance in relation to child protection in most areas. Most child protection committees, reporting to chief officers' groups, were demonstrating regular audits of practice, some joint self-evaluation, and evidence of learning from practice, including from significant case reviews and from wider local and national learning reviews. For example, in the Fife joint inspection report we commented that 'Leaders were modelling a culture of learning through joint self-evaluation and reviews, facilitated by the well performing child protection committee.'

While we saw strong commitment to corporate parenting across partnerships, the extent to which this supported both the delivery of effective services for children and young people and supported their improving outcomes varied. Less than half of staff, on average, had confidence that local leaders had ensured there was the necessary capacity to meet the needs of children and young people in need of protection and looked after children and care experienced young people. Staff agreeing or strongly agreeing to this ranged from just over a quarter in one partnership area to just over a half of staff in another.

In some partnerships, we saw arrangements in place to strengthen the embedding of corporate parenting to support all staff to recognise their responsibilities. Joint strategic commissioning arrangements in relation to corporate parenting were variable across partnerships and, in some, were in the very early stages. We saw a disconnect between these approaches and those taken to develop a strategic needs assessment. This lack of connectedness in some partnerships meant that leaders were at a disadvantage in knowing and understanding their whole population of looked after and care experienced children and young people. Coupled with differing processes and degrees of success in relation to performance management and oversight of young people's outcomes, most partnerships needed to do more to maximise this aspect of service provision. This finding mirrors that in our 2012-2017 overview report which stated that the better performing partnerships were those in which investment had been made in joint commissioning practices, joint strategic needs assessments and joint self-evaluation, indicating that this is an area which still requires improvement.

Leadership of people and partnerships

In the review of findings of joint inspections 2012 – 2017, we noted a need for better consistency in relation to partnerships supporting staff through ensuring a learning culture. This included enabling staff to experience regular oversight and review of practice, including effective and meaningful supervision, which staff told us was a neglected area of practice. Across the eight joint inspections 2018-2020, we saw significant positive developments in this area. Two thirds of staff responding to our surveys told us they have regular supervision which supported and challenged them to achieve a high standard of practice; most staff felt listened to and respected and felt valued for the work they did. Almost all staff told us that they felt proud of the contribution they made to improving the wellbeing of children, young people and their families. This was a definite improvement from the position in 2012 – 2017 and a noteworthy achievement for leaders.

We saw many areas with positive, enabling and learning cultures which allowed staff to be professionally curious, in order to deliver the best service to a child or young person. The majority of staff also told us that they felt optimistic about their work and ability to overcome barriers to achieving the best outcomes for children and young

people. In the City of Edinburgh joint inspection report, we highlighted a good practice example about its learning culture.

Good practice example: City of Edinburgh

We heard about restorative and case management models which were supported by leaders. These enabled multi-agency case discussions and had a positive benefit for frontline staff and leaders alike. These were instigated primarily by social work staff in the local authority and included a range of agencies from the partnership. This is an example of what we call a learning culture and is seen as good practice.

When it came to visibility of, and communication from senior leaders, across the eight partnerships, staff gave mixed responses. On average, just over half of staff who responded to our surveys reported that their leaders were visible and communicated regularly with staff at all levels, however, in individual areas this ranged from just over one third to almost three quarters.

Almost all staff said they knew what standards of practice were expected of them. However, just under two thirds of staff felt that leaders knew the quality of work they delivered at the front line.

Across most partnerships, we saw that the principles, values and language of the Getting it right for every child approach was supporting staff to work in partnership across different agencies. Most staff told us that this was having a positive impact on the lives of children and young people. Leaders had worked hard to embed this in practice as a means of enabling staff to better support children and young people in need of care and protection.

Leadership of improvement and change

We commented in all joint inspections about partnerships' effectiveness of collating, analysing and using quantitative and qualitative data to drive knowledge about, and improvement in, services for children and young people in need of care and protection. In the Aberdeen City joint inspection report we highlighted that 'the partnership has a clear vision about the purposeful use of data to drive service planning and improvement and the Business Intelligence Unit will provide the strategic and technical expertise in realising this ambition.'

While in some areas, we saw particular strengths in this regard in relation to child protection, in all areas, this was less well embedded in relation to corporate parenting. Half of staff responding to our survey told us they had been involved in the evaluation of the impact of what they did and felt that this had informed the improvement of services for children and young people, however, across the eight partnerships, this ranged from one third of staff to just over half of staff. Less than

half of staff responding to our survey felt that change and developments were managed well and led to tangible improvements for children and young people. Ironically, engaging with staff was viewed by the senior leaders we spoke with as vital in supporting improvement in services.

In our 2012 – 2017 overview report we noted that, 'over the course of the inspection programme, we saw evidence that all partnerships were gathering performance data to a greater or lesser degree, however, not all partnerships were using the data to demonstrate the impact of what they did or to inform future service delivery'. In the review of joint inspections 2018 – 2020, this broadly remained the case.

Of all the joint inspections 2018 - 2020, the highest evaluation of the quality indicator in relation to leadership and direction was 'good', and this applied to six out of the eight partnerships. One of the issues raised in the evaluation of this quality indicator and commented on in reports was the need to strengthen approaches to the systematic use of data, particularly in regard to corporate parenting. In our reports, we noted that the effective collection, analysis and use of data would support partnerships to better understand and deliver on their corporate parenting responsibilities across all care groups, in particular, care leavers.

We found, across all partnerships, that there was scope for partners to maximise the use of data and resources to better understand their care leaver population and fully deliver on corporate parenting responsibilities to address their needs.

Performance data, in the main, focussed on collecting information about organisational activity rather than the difference this activity had made to the lives of children and young people and their families. We saw opportunities for partnerships to further embed the ways they collect evidence of improvement, thereby creating greater capacity to report on outcomes. In particular, across all partnerships, we noted the need to better analyse and use the information and comments gained from children, young people and families to improve service planning at an individual and strategic level.

In some partnerships we saw evidence of regular and ongoing consultations to listen to the voices of care experienced young people, for instance through champions boards, regular consultation events and ongoing feedback opportunities. In other areas, engaging with children and young people for the purpose of seeking their views with a view to contributing to service development was not consistent. Overall, we commented in several reports, and in earlier chapters of this report, the need for partnerships to further maximise the opportunities they had to listen to the voices of children and young people and use their views to inform the strategic planning of services for children and families.

Conclusion

We have gained a significant weight of knowledge in relation to how these eight partnerships are meeting the needs of children and young people in need of care and protection.

For children and young people involved in the child protection system, in particular, partnerships were better able to demonstrate improvements made as a result of the intervention of services working collaboratively. On the whole, partnerships were effective at responding to concerns about risk of harm, although more needed to be done to address cumulative harm. Responses were appropriate, timeous and generally resulted in better outcomes for these children, young people and their families.

The governance and oversight arrangements for services to support children and young people in need of protection were much more embedded and robust than those for corporate parenting and more needed to be done to ensure effective and equitable governance was in place for all children and young people in need of care and protection.

While most partnerships were able to show some improvements in specific areas, such as positive destinations, not all care experienced young people were supported to achieve positive health and wellbeing outcomes. In particular, the outcomes for care leavers were poorest.

Partnerships had worked hard to develop systems for collating, analysing and reporting on performance data. However, we saw an over emphasis on quantitative data and information on outputs or actions, rather than a balance between quantitative data and qualitative data which could inform services about the differences these outputs and actions were making to the lives of children and young people.

We encourage partnerships to review these findings and apply the learning to their individual areas with a view to supporting continuous improvement across services for children and young people in need of care and protection.

We recognise that the impact of the coronavirus pandemic has been significant on partnerships, services and, importantly, on children, young people and their families. The learning from these findings, although dating from before the pandemic, remains relevant as partnerships implement their recovery plans going forward and consider their responses to the independent care review.

In our future scrutiny and assurance work, while continuing to undertake our duties to provide public assurance of the safety, quality and effectiveness of care services

for children and young people, we will undertake to place the learning from the independent care review and the five foundation statements at the heart of our inspections. We remain committed to providing assurance that Scotland's children and young people grow up loved, safe and respected so that they realise their full potential.

Appendix 1: Glossary

Adverse childhood experiences (ACEs) are stressful events occurring in childhood including:

- domestic violence
- parental abandonment through separation or divorce
- a parent with a mental health condition
- being the victim of abuse (physical, sexual and/or emotional)
- being the victim of neglect (physical and emotional)
- a member of the household being in prison
- growing up in a household in which there are adults experiencing alcohol and drug use problems.

Care experienced refers to a child, young person or adult who is, or who has been, looked after at some point in their childhood. We recognise that this term is not defined in law but is increasingly used in Scotland.

Care leaver is a legal term used to refer to any young person who was looked after at the time of their 16th birthday and is no longer looked after. All looked after children may become care leavers including children looked after at home.

Champions boards are groups which allow young people to have direct influence within their local area and hold their corporate parents to account. They also ensure that services are tailored and responsive to the needs of care experienced young people and are sensitive to the kinds of vulnerabilities they may have as a result of their experiences before, during and after care. Young peoples' views, opinions and aspirations are at the forefront in this forum and are paramount to its success. Champions Boards build the capacity of young people to influence change, empower them by showing confidence in their abilities and potential, and give them the platform to flourish and grow.

Chief officers groups provide strategic oversight of key partnership functions in the protection of children and young people across partnership areas.

Child and adolescent mental health services (CAMHS) are the NHS services that assess and treat children and young people with mental health difficulties. CAMHS includes psychological, psychiatric and specialist social work support, addressing a range of serious mental health issues.

Child protection committees are local groups which bring together all the organisations involved in protecting children in local areas. Their purpose is to make sure local services work together to protect children from abuse and keep them safe.

Community planning partnerships are local community planning fora for local authority areas. They are formed from representatives from key agencies and organisations from the public, community, voluntary and private sector. Each partnership works together to plan and deliver services across the local authority area.

Continuing care is a legal term used to mean that a care leaver is enabled to remain in the placement that they were in when they were looked after away from home (for instance, in foster care, kinship care or residential care, but not secure care).

Corporate parents are organisations listed as corporate parents in the Children and Young People (Scotland) Act 2014. Corporate parents have duties to uphold the rights and secure the wellbeing of looked after children and care leavers.

Getting it right for every child (GIRFEC) is a national policy designed to make sure that all children and young people get the help that they need when they need it.

Independent care review refers to the independent review of the care system in Scotland between 2017 and 2020 which looked at the underpinning legislation, practices, cultures and ethos. The review prioritised listening and heard over 5,500 experiences. The Care Review published seven reports in February 2020.

Independent advocacy refers to situations where a person providing advocacy is not involved in providing the services to the individual, or in any decision-making processes regarding their care.

Initial referral discussions, interagency referral discussions or **initial referral tripartite discussions (IRD)** is the process of joint information sharing, assessment and decision-making about child protection concerns. The IRD is not a single event but takes the form of a process or series of discussions.

Kinship care is a legal term that refers to the care arrangements for a child living away from their parents with an adult who has a pre-existing relationship with the child (i.e. is a family member or friend).

Looked after is a legal term used to refer to a child who falls into one of the following categories:

- living at home and subject to a compulsory supervision order (looked after at home).
- living in kinship care, foster care or a residential setting and subject to a compulsory supervision order (looked after away from home).
- accommodated by a local authority by a voluntary agreement (under S.25 of the Children (Scotland) Act 1995). This includes children and young people who receive a series of short-term overnight breaks only.
- subject to a permanence order granted by a court.
- subject to an order, authorisation or warrant made by the relevant authorities under chapters 2, 3 or 4 of Part II of the Children (Scotland) Act 1995.

Multi agency risk assessment conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.

Permanence and Care Excellence (PACE) is a programme delivered by the Centre for excellence for Children's Care and Protection (CELCIS) which supports local authorities and their partners to enable more looked after children to experience permanence. This means providing them with stability, including secure and nurturing relationships, in a setting that continues to adulthood.

Scottish Care Leavers Covenant is a committed promise to young people who have experience of the care system which supports Scotland's corporate parents, carers, practitioners, managers and decision makers in fulfilling their duties to improve the life chances of all of Scotland's care leavers.

Self-directed support (SDS) refers to the provision of social care support that empowers individuals and carers to have informed choice about how support is provided. The aim of self-directed support is to promote independence, informed choice and flexibility.

Self-evaluation is a term that is used to describe the process of services taking a close look at what they have done and evaluating themselves and their progress against a prescribed set of standards. It is important because it helps services to see clearly what they are doing well and where they need to make improvements.

Seven-minute briefing refers to an approach based on research which suggests that seven minutes is an ideal time span to concentrate and learn. Most local safeguarding boards in England and Wales have embedded this approach to deliver short briefings to staff on key topics and are used to support reflective discussion.

Staying Put represents a philosophy of care. The central elements being the importance of relationship-based practice and extended and graduated transitions. Care planning decisions should be based on the needs of individual care leavers.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

Team around the child is a single planning process around the child's plan with all relevant professionals involved.

Trauma informed practice is a strengths-based framework in children's services grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for everyone, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

Appendix 2

Table of evaluations for quality indicators 2.1 and 2.2

	QI 2.1 Impact on children and young people	QI 2.2 Impact on families
Argyll and Bute	Good	Good
Fife	Good	Good
Edinburgh	Very Good	Good
Aberdeen	Good	Good
Stirling	Good	Very Good
Orkney	Weak	Adequate
South Lanarkshire	Adequate	Good
Midlothian	Good	Good

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