care inspectorate

Progress review

following a joint inspection of services for children and young people in need of care and protection in Orkney

August 2021

Education Scotland Foghlam Alba

Healthcare Improvement Scotland

HMICS Improving Policing Across Scotland

HAPPY TO TRANSLATE

Contents

1. Background to this progress review

We carried out a joint inspection of services for children and young people in need of care and protection in the Orkney community planning partnership area between August and October 2019. The joint inspection report was published in February 2020.

At that time, we were not confident that the partnership in Orkney would be able to make the necessary improvements highlighted in the inspection report without additional support and expertise. As we noted in the final report, our conclusion was based on:

- the scale of the work needed to: reduce the risks created by inconsistencies in key child protection processes; embed accountability for, and shared ownership of, corporate parenting; modernise approaches to services for children and young people in need of care and protection
- the limited capacity in the community planning partnership and the very small pool of managers available to take forward improvements at pace while also meeting operational demands
- the need to focus on core business as well as seeking fresh ideas and knowledge of what has been successfully implemented elsewhere that could be adapted and tailored to the Orkney context and external challenge
- the lack of previous progress in developing and embedding robust self-evaluation as a mechanism for assurance about quality and effectiveness.

Our report identified five priority areas for improvement (appendix 1) and we asked partners in Orkney to develop a joint action plan in response to these. This was to show how they would make improvements in these areas and how they intended to reduce risks as a matter of urgency. We said that we would support the community planning partnership to build capacity for change and to make improvements. Along with the other bodies taking part in the inspection, we also said that we would monitor progress and report on this in due course.

2. Summary findings

We identified that there were three distinct periods following the inspection, with regard to how progress was taken forward by the partnership. In its initial response, during late 2019 and the first months of 2020, the partnership was slow to develop an effective response to the areas for improvement that had been identified. Early versions of its improvement plan did not take a strategic approach and were subject to frequent change. The partnership's response was also affected by a number of changes in key personnel. In the second period though, from summer 2020, there was a different, more focussed direction. New appointments were made to key positions and a more comprehensive improvement plan was produced that was subject to more thorough oversight and management. Leaders were by then fully appreciating the range of improvements needed and that cultural change was required. In the third period from late 2020, the pace of change was stepped up further. There was a focus on effective staff engagement and on improving governance and accountability. Key policies and procedures were also updated followed by a series of high-profile practice events into spring 2021.

As a result of the changes that were introduced during this latter period, we were able to identify that improvements had been made or were well underway. More effective leadership and planning was now driving change. However, because many of the changes were only introduced relatively recently, we also concluded that it was too early to be sure of their impact. There was also a need to further develop consistency of practice and improve the involvement of children and families in decision making about their lives.

The review found that:

- partners in Orkney were now making encouraging progress in responding to the areas for improvement identified by the previous inspection
- key processes in responding to children in need of protection have been improved and policies and procedures to support practice have been updated
- partners need to maintain momentum in order to sustain the improvements that have been made and the change that has been achieved
- partners still need to be able to evidence the difference that the recent changes they have made are making to improving outcomes for children and families.

3. How we conducted this progress review

Between April and June 2021, a team of inspectors from the Care Inspectorate, Healthcare Improvement Scotland, Her Majesty's Inspectorate of Constabulary for Scotland and Education Scotland carried out a review of the progress made in the Orkney community planning partnership area.

In the face of the challenges to undertaking the progress review during the Covid-19 pandemic, the inspection team acknowledge with gratitude the contribution of all the staff in Orkney who took part. We are particularly grateful to those who facilitated the remote access to information, without which the review could not have been undertaken.

The focus of our review

The aim of this review was to assess and report on progress made in planning and implementing action to address the priority areas for improvement identified during the joint inspection**.** Because four of the five priority areas were about children in need of protection, this review focussed on the recognition of and response to initial concerns that they faced. It also considered the way that leaders within Orkney were overseeing arrangements to protect children and young people, including in the way that they were managing the change process following the inspection. The partnership's response to the inspection's findings in relation to care experienced young people has been monitored through the support provided to Orkney by the Care Inspectorate and its partners, including the inspection of regulated care services.

In undertaking the review, we acknowledge that the last year has been a difficult one for all front-line services because of the Covid-19 pandemic, and that it has presented challenges for every partnership area and affected the way that services have been delivered to those that use them.

It is within that context that the review sought to address three questions.

- How well has the partnership improved its practice in relation to its recognition of, and response to, children in need of protection?
- How well are agencies now working together to support children who are in need of protection?
- How does the partnership assure itself of the quality of service and decision making in respect of support for children who are in need of protection?

Our approach to the review

We were confident that despite the constraints imposed by the Covid-19 pandemic, the range of information available to us, together with the engagement and participation of partners in Orkney, would give us sufficient insight into the progress made since the joint inspection.

In conducting the review, we:

- took account of the work carried out by the Care Inspectorate strategic link inspector and the Healthcare Improvement Scotland public protection and children's health service lead, to support chief officers and senior managers in improving services
- reviewed supporting evidence from the partnership of the progress made, including two recent significant case reviews (SCRs) undertaken in Orkney
- undertook a staff survey, which was completed by 152 staff working across the range of children's services within Orkney
- held focus groups and interviews virtually, using video meetings, with chief officers, senior managers, elected members of Orkney Islands council, NHS Orkney board members, first-line managers and front-line staff
- reviewed the records of 60 children and young people[1]
- held telephone conversations with parents and carers.

We decided not to meet with children and young people during this progress review. This was because much of the improvement activity was fairly recent and it would be too early for them to be able to tell us about its effect on service delivery or their lives. We also took account of restrictions on travel and contact between members of different households as a result of the pandemic and decided that inspectors would not visit Orkney during the review. Inspectors were also keen to ensure that their activities did not place additional requirements on services. We wanted to ensure that the partnership was able to focus on continuing to support families and on its statutory duties during pandemic restrictions.

[1] : The sample was based on all inter-agency referral discussions (IRDs) in relation to children and young people for whom there were child protection concerns in Orkney between 1 April 2020 and 31 March 2021. The review looked at both the circumstances of the IRD and the subsequent response to them. Consequently, the sample cannot assure the quality of service received by every child in Orkney, particularly those in long-term care, or whose initial involvement with the local authority pre-dated the review's time frame.

4. Progress made

The partnership's approach to improvement

The report of the joint inspection was published in February 2020, three weeks before the start of the first Covid-19 lockdown. However, an initial improvement plan had been developed before the report's publication. This focussed on a limited number of actions rather than taking a more strategic approach. Its style and presentation also made it difficult to determine progress. This first period following the inspection in the first months of 2020 also coincided with several departures of key senior leaders and managers in Orkney. As a result, progress was initially limited.

However, it was evident from summer 2020 onwards that leaders and senior officers, including those appointed into interim positions, were taking the inspection's findings very seriously. With the appointment of a new chair, there were renewed commitments made at the chief officers group (COG) to work more closely together and to support the improvement programme. A further and more comprehensive version of the improvement plan was produced, supported by a project management delivery approach. Even with this effort, senior leaders recognised that improvements were not being achieved as quickly as anticipated. They identified that some of the foundations of good practice, including the provision of guidance for staff, were missing and needed to be rebuilt. They also recognised that there was an entrenched culture of practice in Orkney, particularly around recognition of harm and thresholds for intervention, that would take time, drive, energy and resources to change. Consequently, in this second post-inspection period, during autumn 2020, significant developments were made in relation to updating and improving policies and procedures.

These were followed up by implementation launch events into spring 2021. To reinforce the change that was required, these were led prominently by leaders and key individuals from both within the partnership and external agencies. The focus of this third period since the inspection, from the end of 2020, was on effective staff engagement, as partners recognised the need to gain their support if they were to embed and sustain improvements. Governance and reporting arrangements between strategic groups were also strengthened, although some uncertainty remained about their specific roles. Accountability was more clearly identified and the project management approach, which partners adopted, enabled them to begin to evidence progress on the improvements they needed to make. The pace of change picked up significantly and there was a renewed approach to ensuring greater transparency and accessibility surrounding the plan. Partners now fully recognise the scale of improvement required to achieve their aspirations for children and young people in need of protection in Orkney. They have also accepted that cultural change will take time to achieve and have committed to this.

How well has the partnership improved its practice in relation to its recognition of, and response to, children in need of protection?

Partners had undertaken to review or replace single and multi-agency policies, procedures and guidance relating to child protection. Changes introduced over the

six to ten months prior to our review had provided greater clarity about key processes, as well as roles and responsibilities of both agencies and individuals. Staff were consulted throughout the process of change and felt empowered by having contributed to the implementation of the new procedures. Those we spoke to welcomed their accessibility, such as through shortcut links on their computers. The training that had supported their introduction had also been well received. Most staff reported that training and learning had increased their confidence and skills in working with children and young people in need of protection. Although the restricted period of the pandemic meant that most training was provided virtually, this had increased opportunities for staff based on outer islands to attend. However, as with other areas of Scotland where learning had been limited to online training, it had also meant that opportunities to share ideas and consolidate learning in the same physical space had been lost.

Almost all respondents to our survey reported that they had the knowledge, skills and confidence to recognise and report signs of child abuse, neglect and exploitation. A majority were also confident that effective intervention processes existed to reduce their incidence. Initial discussions with a trusted colleague or manager where child protection concerns were suspected had become more likely. NHS Orkney had appointed a lead public protection nurse who was available for health staff to consult with as well as being involved in wider training and improvement work.

Partners had created a multi-agency approach to child exploitation, including child sexual exploitation (CSE), led by a group of both front-line staff and senior managers, although the consequence of this was not yet evident. Police Scotland had established a new post of divisional CSE co-ordinator to better share information and intelligence and focus on prevention, intervention, protection and detection.

In contrast to the impetus around child exploitation, staff raised concerns through focus groups and the survey about the partnership's approach to neglect, particularly in relation to younger children. They described inconsistencies in the recognition of neglect and thresholds for intervention as a longstanding cultural issue that required a multi-agency response to address its consequences. This was a key message in the inspection report, and we saw evidence in our record reading of the continuing failure to recognise the effect of cumulative harm and neglect. The partnership's own audit of inter-agency referral discussions (IRD) also raised questions about neglect being potentially overlooked. Although the use of neglect toolkits from other areas was being explored, staff were requesting further multi-agency training to improve their confidence in dealing with the implications of longer-term cumulative harm. It is pertinent to note the findings of the recent triennial review of initial case reviews and significant case reviews, published by the Care Inspectorate, that neglect remained the main non-fatal category of significant harm nationally, and that reviews repeatedly identified missed opportunities to intervene or to recognise its signs early enough.

The joint inspection in 2019 noted that there had been a number of changes to the IRD process that year and that the recording of IRDs was not of an acceptable standard. It also noted a lack of associated guidance or training, or oversight by the public protection committee (PPC). In response, a further IRD process was launched in December 2020. The associated procedures included a clear process for resolving disagreements, although it was not evident that all staff were aware of this. Almost all the IRD records that we read during the review, including those completed

before the most recent process was introduced, had gathered relevant information and considered risks and immediate safety needs, including the need for medical examinations and joint investigative interviews. In most cases, the overall quality was rated as good or better, and most were completed within expected timescales. Although not usually part of the approach to undertaking IRDs involving health, police and social work, education staff were being consulted and took part when they had important knowledge about the child. This had improved collaborative working. Partners had recognised the need to provide feedback to those who had made child protection referrals, both staff and public, although we were told that this was not yet fully implemented.

Despite the most recent improvements to the IRD process and procedures, some issues remained. For example, it was evident from the records we read for this review that agencies did not always share a common understanding of the threshold for an IRD. Indeed, the partnership's own audit observed that even with the latest procedures, there were still different opinions between health, police and social work about both the purpose of an IRD and when one should be initiated. There were also inconsistencies in how an IRD was recorded. We saw examples of multiple children being recorded on the same IRD form for the same incident, even when they were not related. We also saw different children, including siblings, being recorded on separate IRD forms again for the same incident. Reports of the number of IRDs having been completed over the period that we were reviewing also varied. Inconsistency in the completion of IRD records made it more difficult for partners to assure themselves of the quality of this work. We also observed that health information was not always available to inform IRD decision making as the lack of an overall electronic patient recording system within NHS Orkney compromised the ability to provide it quickly. On some occasions, concerns about information sharing were also limiting access to health information, including that from GPs.

The geography and scale of Orkney presented challenges, including travel, weather and staff capacity, to the delivery of children's services. At times, statutory services found creative and positive solutions to responding to children's needs. For example, by providing emergency transport to reach outer islands, or through the use of trusted professionals on outer islands for safeguarding children, including accommodating them on a temporary basis. The out-of-hours service had limited expertise to undertake joint investigative interviews, and there were also issues about how referrals it received were recorded. Concerns highlighted in the earlier inspection and other reports around children having to travel to Aberdeen for forensic medical examinations remained unresolved despite the efforts of senior leaders in Orkney. The inspection team recognised that this was an issue that will require a co-ordinated national solution.

We heard from staff, and saw evidence in the records we read, about increasing incidences of children, young people and parents with mental health and wellbeing issues. Fewer than half of respondents to our survey were confident that mental health outcomes were improving for children and young people. The child and adolescent mental health service (CAMHS) lacked sufficient capacity to deal with the rise in both the increased demand and the need for more intensive support. There was a reliance on the third sector, the school counselling service, school nurses and community psychiatric nurses to provide both early intervention and continuing support. However, although support for mental health and wellbeing for children in

need of protection was an under-developed area, we learnt of the forthcoming redesign and development of this service that may provide an opportunity to resolve this.

Around half of respondents to the staff survey reported that independent advocacy was routinely available to children and young people in need of protection. Nevertheless, in the children's records that we read we saw no evidence of it having been provided. It was apparent that although a service exists for looked after children in Orkney there is no such provision for children in need of protection. In our discussions it was evident that there was a lack of clarity about the role of independent advocacy as a whole. Staff appeared to understand that they were able to provide such advocacy and speak on behalf of the child. There was little recognition of the right of the child to be represented by someone independent of the decision-making process.

Technological solutions, influenced in part by the pandemic and the requirement for staff to work from home, had driven improvements such as remote access to records for social workers and the provision of mobile phones. Staff, including the out-of-hours service, were generally able to access the information they required when they needed it in responding to child protection concerns. The social work records system's functionality had been enhanced and staff were being supported through weekly meetings to help improve its efficiency.

How well are agencies now working together to support children who are in need of protection?

The partnership's Getting it Right (GIRFEC) approach was refreshed in April 2021 and was well received by staff. A clear vision was presented that encompassed both the post-inspection improvements and the aspirations of The Promise[2]. Two-thirds of respondents to our survey believed that the GIRFEC approach was effectively supporting children and young people. Associated processes were encouraging improved collaborative working between staff from different agencies. For example, staff we spoke with reported that there was more regular discussion between professionals in advance of formalising their concerns as child protection referrals. Regular multi-agency training and development opportunities had strengthened joint working to support children and young people in need of protection. Some families felt that there could have been better communication between professionals at the outset. However, most were happy with the way that those supporting them were working together to keep their children safe. Our record reading showed that even during the pandemic, the collaborative working that most children had received was rated as good or better, as was the continuity of protective processes.

Of the records we read where an initial multi-agency meeting was held, all risks and needs were addressed and in most cases, clear decisions were made and recorded. Social work staff had attended all such meetings, and each of the other key agencies were represented in around two-thirds of them. Where there was a subsequent

[2] : The Promise is the main report of Scotland's independent care review published in 2020. It reflects the views of over 5,500 care experienced children and adults, families and the paid and unpaid workforce. It described what Scotland must do to make sure that its most vulnerable children feel loved and have the childhood they deserve. https://www.celcis.org/files/9915/8092/1878/Independent_Care_Review_The-Promise.pdf

multi-agency assessment, almost all included a written plan and most of these were evaluated as good or better.

At the time of the review, partners had only recently introduced a revised standardised child's plan which was being tested. Nevertheless, in most records we read we judged the multi-agency team as good or better at effectively ensuring the immediate safety of the child when subject to a multi-agency plan. However, some staff were slightly less confident about preparing an outcome-focused child's plan than they were about assessing and analysing risks and needs. Families we spoke with had been able to contribute to their plans, although not always from the outset. None of the families we spoke with reported that health staff had contributed to plans to keep their children safe.

A new multi-agency chronology template, supported by guidance materials, had recently been introduced. From the records we read during this review, it was too early to see the effect of this. Although practice had improved from the earlier inspection, the quality of chronologies to support effective decision making, assessment and planning remained inconsistent. Of the chronologies we read, we judged just over half to be adequate or weak. We continued to see examples of different formats being used, standalone single-agency chronologies not being brought together, and chronologies that only started with the most recent concern. Even though staff described how shared chronologies helped them identify patterns of concern, partners acknowledged that more needed to be done to improve their overall quality. For example, the partnership's own file reading report identified chronologies as an area for improvement and one of the recent SCRs had stressed the need for chronologies to be used to identify themes and patterns.

There was inconsistent practice in engaging and involving children and young people and parents and carers in assessment and planning processes. Our record reading showed that parents' or carers' views were more likely to be sought than those of their children. Even though our record reading highlighted that parents were also more likely to attend planning meetings, families said that they were not always involved in meetings about their children. They also told us that when reports were made available to them, they were not always helped to understand them, or given enough time before a meeting to do so. By contrast, very few children were directly involved in the process, with a staff member often representing their views instead. Both recent SCRs found that children's views were not heard, whereas parents' or carers' views had been, even where they conflicted with the child's interests.

Staff were benefitting from regular supervision and single and multi-agency learning and development opportunities. They were involved in many of these developments and their feedback had contributed to more iterative learning. Most survey respondents said they received either regular supervision, or opportunities to speak with a line manager, that supported and challenged their practice. A similar proportion said they felt supported to be professionally curious with the aim of keeping children and young people safe. NHS Orkney had developed new child protection case supervision for health visitors and school nurses with support from a NHS Shetland senior nurse.

Although improvements had been made to processes and practices to support children and young people in need of protection, it was too early to evaluate the difference that these had made. Despite a majority of survey respondents recognising that there was a clear vision for improving services, some were

concerned about the sustainability of the changes. For example, only around half were confident that outcomes for children in need of protection were improving. Fewer than half felt that there was sufficient capacity to meet the needs of such children, particularly in areas such as emotional health and wellbeing.

Recruitment and retention of staff remained challenging. Although it was encouraging that some efforts were being made to overcome this, for example through financial incentives and mentoring those in existing roles, accommodation was repeatedly identified as the biggest obstacle to attracting new staff. Through focus groups and the staff survey, we learned of the effect of short-term appointments on continuity of support, particularly from social work staff. We spoke with staff from other agencies and families who told us they had experienced a high turnover of social workers. Families also described difficulties in building trusting relationships when key workers changed regularly, and how some young people were reluctant to have to tell their story again and engage with new workers.

Staff told us that although the culture of practice in Orkney had improved, not everyone shared the same understanding of thresholds for intervention or definitions of concern. Staff based on outer islands experienced challenges in living and working in the same communities as those using services. Practical and logistical challenges also affected collaborative working for them. However, a recent SCR had demonstrated the need to reflect on the cultural factors which affected the recognition of and prompt response to child protection concerns across the whole of Orkney. A recent joint meeting of the public protection committee and the chief officers group had considered if the improvement plan was a 'sufficient driver of change' in this context or, if not, what more needed to be done. It had acknowledged that cultural change is complex and not accomplished quickly; a point also emphasised by the recent triennial review.

How does the partnership assure itself of the quality of service and decision making in respect of support for children who are in need of protection?

Following the inspection in 2019, there had been insufficient impetus to planning the required improvements. Some staff described an initial period of denial in response to the inspection's findings and leaders acknowledged that improvements were not being made quickly enough during the first half of 2020. The initial improvement plan was overly complex and reactive and was subject to frequent changes. Quality assurance systems were not in place from the outset to assess the progress that was being made. Subsequent changes of senior managers, the time taken to establish governance arrangements and the need to identify additional resources to support the improvement process had also affected the pace of change.

It was clear that a number of interim senior and operational appointments were crucial to driving the progress that was subsequently made. An improvement delivery group, or leadership team, was established with representatives from across all agencies. It became responsible for overseeing a clearer and more comprehensive improvement plan. A project management approach was adopted which provided an effective delivery model. Clear records of completed actions were maintained, such as the development and implementation of up-to-date single and multi-agency child protection procedures. Nevertheless, given that a number of the appointments that were key to what was subsequently achieved are in place until the

middle of 2022, how improvement will be sustained in the longer term is more difficult to assess.

The emphasis on the improvement plan had made the relationship between it and other key plans, such as the children's services plan or the public protection committee business plan, complex, and the paramountcy between them unclear. For example, instead of the public protection committee being responsible for the actions resulting from the SCRs within its business plan, these were added to the improvement plan, which was anticipated would evolve into the partnership's single 'continuous improvement plan'. However, this approach meant that despite partners working more collaboratively on major policy areas such as the refreshed Getting it Right approach, there was a tendency to focus largely on short-term priorities. Whereas many of these were still appropriate, the energies and effort that they required meant there was a risk that wider children's services planning and commissioning, including work begun in August 2019 on a strategic needs assessment, could be overlooked.

Nevertheless, accountability arrangements between the chief officers group and key groups such as the improvement delivery group and the public protection committee, and in turn between the chief officers group and the wider partnership, were in place for oversight of the plan and child protection matters. For example, the chief officers group received an annual report from the public protection committee and reported on this to the Orkney partnership, itself responsible for a number of community plans. Although individual agencies maintained their own risk registers, chief officers were clear about their shared responsibility for risk in relation to public protection. Even so, the purpose of these various groups or the relationship between them was not always clear. For example, we heard of staff presenting the same reports to different meetings, often containing similar membership, as they were uncertain which group's remit covered their report. Although it was improving, effective scrutiny of the progress being made had been slow to develop. Elected members and board members relied on officers providing them with accurate information. This was described as having been at times confusing and superficial and consequently, they had not always been able to provide sufficient challenge. However, there were noticeable improvements and the clearer accountability and improved plan meant that members were now more aware of their responsibilities. Elected members must continue to provide robust and rigorous scrutiny and seek additional evidence where required, to assure themselves of the effectiveness of service delivery and that improvements are being embedded.

The partnership's self-evaluation and continuous improvement approach was published in January 2021. This was closely aligned to the Care Inspectorate's own quality improvement framework and was an important development towards the partnership's goal of continual improvement. However, it did not take into account other approaches to self-evaluation, such as 'How good is our school?' used within education. At the time of our review, not all of the elements associated with the approach had been introduced and partners were not yet able to provide the evidence of the difference that improvements were making. Despite this, there was evidence of good practice emerging. NHS Orkney had produced a comprehensive children's health services self-evaluation report in April 2021 and the partnership's first annual IRD audit, which looked at performance, benchmarking opportunities and areas for improvement, had recently been completed. Further quarterly reviews of IRD practice were planned involving the police, social work, health and education.

Although it required further development, partners had made progress in introducing a quarterly quality assurance programme through the examination of children's records. This had so far been completed on two occasions and others were planned. The learning from these initial exercises was set to influence the way that the programme was being developed and the results were used to influence practice. Dissemination of the learning from the two recently completed SCRs was also being arranged.

Although there were a few examples where data was being appropriately considered or explored, its routine analysis to inform decision making about strategic planning was under developed. Evidence was still required to show that the improvements that had been made to operational practice, were making a difference. The national minimum dataset for child protection was still to be implemented despite a decision to do so in November 2019. Even though inter-authority benchmarking of data and practice was outlined as an ambition within the self-evaluation and continual improvement approach, there was as yet no discernible evidence of its contribution to strategic planning.

However, evidence from data did show that there was an increase in the number of children being supported from the second half of 2020 onwards, including the number being accommodated away from home. Although all areas of Scotland saw an increase in the numbers of children being supported following the end of the first Covid-19 lockdown, in Orkney the increase also appears to have reflected changed priorities in responding to children's circumstances and changes in management. In the records we read, we saw examples of strong decision making and robust planning for children and young people linked to their needs rather than the availability of resources. In addition, not only were case conferences being independently chaired but senior managers were also more closely involved in reviewing complex cases.

Senior managers also became very prominent in multi-agency events, such as the launch of the revised procedures, from late 2020 onwards. This was helpful given the recognised importance of effective leadership in planning, implementing and sustaining change. However, it was evident from the survey that, compared to other groups, health respondents were less likely to see their leaders as visible, or to feel that those same leaders were aware of the quality of the work delivered at the front-line. We learned through focus groups and the survey that, although welcomed, the number of recent launch events in a relatively short period of time had left some staff feeling overwhelmed. Although these were wholly relevant and had given staff encouragement, some were concerned by the potential overload of training and guidance that they had received. They suggested that there needed to be a period of consolidation if the culture of practice in Orkney was to be successfully changed.

5. Conclusion

Despite the initial delay where opportunity for change and improvement was potentially lost, we are confident that partners have subsequently taken the findings of the joint inspection of services for children and young people in need of care and protection in Orkney, published in February 2020, very seriously. Chief officers have prioritised necessary change and improvement alongside responding to the demands of the Covid-19 pandemic. There was evidence of progress, much of which was quite recent, in relation to the four priority areas for improvement from the inspection that our review focussed on. This included a new IRD process, improved collaborative working through the relaunch of GIRFEC and better support to staff through training and supervision.

Partners recognised that they need to maintain the current momentum if improvement and change is going to be sustained. This is a particular challenge for Orkney given the limited number of senior officers, many of whom are still in interim positions, and the competing demands that they face. The visibility of senior leaders, especially those within health, is key to the impetus being maintained. Their profile is crucial to not only successfully driving the improvements that are still required, but also sustaining the changes that have been made. There is scope for partners to further refine and strengthen their strategic planning arrangements, supported by their self-evaluation approach and commitment to introduce effective quality assurance systems. For example, evidence is still required to show that the improvements intended to provide more effective support and intervention for children in need of protection, are in turn making a difference for them. Children's rights and participation, for those who are not looked after by the local authority, is an under-developed area, and a multi-agency approach to the recognition of and response to neglect requires further investment. There is also opportunity to further improve practice, such as in relation to the use of chronologies and the preparation of outcome-focussed plans. Recruitment and retention of staff, particularly social workers, continues to present challenges to operational practice, especially in the development of sustained relationships with children and families.

Whereas changes to key processes had made the agreed approaches clearer and easier to follow though, most of the changes had only been introduced relatively recently over the previous six months and were still being embedded. Although there were encouraging signs, it was therefore too early to see conclusive evidence of their effect either on multi-agency practice, or on outcomes for children in need of protection.

6. What happens next?

The Care Inspectorate and its scrutiny partners will continue to monitor progress and to offer support for improvement to community planning partners in Orkney. Over the next year, we would expect to see the changes that have been made being consolidated and added to so that they can be sustained over time. We would also anticipate that the positive effect of these changes on the lives of children in need of protection in Orkney will become evident and will lead to demonstrably better outcomes for them.

To provide evidence of this, we will explore opportunities with partners in Orkney to gain the views of children, young people and their families as part of our ongoing monitoring work. This will be key to a second progress review that will include a focus on their lived experience. In the meantime, we will continue to offer support as required and monitor progress through existing link inspector arrangements.

Appendix 1: Areas for improvement arising from the 2019 joint inspection of services for children and young people in need of care and protection in Orkney community planning partnership area

- Ensuring key child protection processes including inter-agency referral discussions, risk assessments, case conferences and core groups work effectively to protect children at risk of harm.
- Publishing comprehensive up-to-date inter-agency child protection procedures and training staff on these to clarify roles and responsibilities, and to help staff to be confident in their work.
- Bringing about a step change in the impact of corporate parenting by delivering tangible improvements in the wellbeing and life chances of looked after children, young people and care leavers.
- Strengthening key child protection processes, fully implementing the Getting it right for every child (GIRFEC) approach, and commissioning services to meet priority areas of need including therapeutic and family support services.
- Improving the effectiveness and oversight of the public protection committee in carrying out core functions to protect children and young people.

Appendix 2: Staff survey and record reading analysis terms

Where we have reported on results from the staff survey and record reading, we have standardised the terms of quantity so that:

- ‘few’ means up to 14%,
- ‘fewer than half’ means between 15% and 49%,
- ‘the majority’ means between 50% and 74%,
- ‘most’ means between 75% and 89%, and,
- ‘almost all’ means more than 90%.

Appendix 3: The terms we use in this report

Child and adolescent mental health service

NHS Scotland child and adolescent mental health services (CAMHS) are multi-disciplinary teams that provide (i) assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems, and (ii) training, consultation, advice and support to professionals working with children, young people and their families.

Chief officers groups

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

Child sexual exploitation

Child sexual exploitation (CSE) is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Getting it right for every child

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.

Initial case review

Following the death or significant harm of a child in Scotland, the local child protection committee will be notified, and an initial case review (ICR) carried out. If the case raises serious concerns about professional or service involvement the committee may decide to proceed to a significant case review.

Inter-agency referral discussion

An inter-agency referral discussion or IRD (note that in some areas of Scotland, the initials IRD refer to an initial referral discussion) 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.

Public protection committee

In Orkney, as in a number of other areas across Scotland, child protection and adult support and protection committees have been combined into single public protection committees (PPC). From a child protection perspective, these committees are the key local bodies for developing, implementing and improving child protection strategy across and between agencies, bodies and the local community. They are expected to perform a number of crucial functions in order to jointly identify and manage risk to children and young people, monitor and improve performance and promote the ethos that "It's everyone's job to make sure I'm alright".

Significant case review

A significant case review (SCR) is carried out where a child has died, or has been significantly harmed, or where they have been at risk of harm. SCRs aim to find out if anything could have been done to prevent harm, and what could be done to stop a similar event happening in the future.

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

Website: www.careinspectorate.com
Email: enquiries@careinspectorate.gov.scot
Care Inspectorate Enquiries: 0345 600 9527

@careinspect careinspectorate