care inspectorate

Interim report on phases 1 and 2 of a joint inspection of services for children and young people at risk of harm in West Dunbartonshire

Prepared by the Care Inspectorate in partnership with Education Scotland, Healthcare Improvement Scotland and Her Majesty's Inspectorate of Constabulary in Scotland

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Education Scotland Foghlam Alba

Healthcare Improvement Scotland

HMICS Improving Policing Across Scotland

HAPPY TO TRANSLATE

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Introduction

Our remit

At the request of Scottish Ministers, the Care Inspectorate is leading joint inspections of services for children and young people at risk of harm. As a result of the Covid-19 pandemic, the programme of joint inspections of services for children was paused between March 2020 and June 2021 and recommenced in July 2021. The remit of these joint inspections is to consider the effectiveness of services for children and young people up to the age of 18 at risk of harm. The inspections look at the differences community planning partnerships are making to the lives of children and young people at risk of harm and their families.

Joint inspections aim to provide assurance on the extent to which services, working together, can demonstrate that:

1. Children and young people are safer because risks have been identified early and responded to effectively
2. Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm
3. Children and young people and families are meaningfully and appropriately involved in decisions about their lives. They influence service planning, delivery and improvement
4. Collaborative strategic leadership, planning and operational management ensure high standards of service delivery.

The inspections also aim to consider the impact of the Covid-19 pandemic and the continuation of practice to keep children and young people safe.

The terms that we use in this report

- When we say **children at risk of harm**, we mean children up to the age of 18 years who need urgent support due to being at risk of harm from abuse and/or neglect. We include in this term children who need urgent support due to being a significant risk to themselves and/or others or are at significant risk in the community.

- When we say **young people**, we mean children aged 13-18 to distinguish between this age group and younger children.

- When we say **parents** and **carers**, we mean those with parental responsibilities and rights and those who have day to day care of the child, including kinship carers and foster carers.

- When we say **partners**, we mean leaders of services who contribute to community planning. This includes representatives from West Dunbartonshire Council, Greater Glasgow and Clyde NHS, Police Scotland and third sector organisations.

- When we say **staff**, we mean any combination of people employed to work with children, young people and families in West Dunbartonshire.

Appendix 1 contains definitions of some other key terms that we use.

Our approach

Inspection teams include inspectors from the Care Inspectorate, Healthcare Improvement Scotland, Her Majesty's Inspectorate of Constabulary in Scotland and Education Scotland. Teams also include young inspection volunteers, who are young people with direct experience of care or child protection services. Young inspection volunteers receive training and support and contribute to joint inspections using their knowledge and experience to help us evaluate the quality and impact of partners' work.

We take a consistent approach to inspections by using the quality framework for children and young people in need of care and protection, published in August 2019. Inspectors collect and review evidence against all 22 quality indicators in the framework to examine the four inspection statements.

How we conducted this inspection

Our joint inspection process normally consists of three phases:

- Surveys and record reading
- Analysis of publicly available information, partnership position statement and evidence
- Engagement with children, young people and families and focus groups with staff.

The inspection of services for children at risk of harm in the West Dunbartonshire community planning partnership area took place between October 2021 and March 2022. Due to constraints presented by the ongoing Covid-19 pandemic, we did not undertake the engagement phase with West Dunbartonshire that was planned for February 2022. This meant that we did not meet children, young people and families or conduct focus groups with staff.

We recognised the significant challenges for the partnership in managing the ongoing impact of the pandemic and the resources needed to do so. Moreover, the need to postpone meetings with children and families in the context of another Covid-19 wave meant that a much longer time had elapsed since we read children's records than would usually be the case. For some families, an interview would now be inappropriate. In this context, all four bodies involved in the inspection agreed a different approach to the norm was needed.

The activities the inspection team were able to undertake between October 2021 and March 2022 to gather the evidence reflected in this report were:

- We carried out a staff survey and received 536 responses from staff working in a range of services
- We reviewed 14 survey responses from children and young people and 21 from parents and carers
- We reviewed practice by reading a sample of records held by services for 60 children and young people at risk of harm
- We read a position statement prepared by the partnership and we undertook an analysis of all available evidence and reviewed publicly available information about the partnership
- The young inspection volunteers reviewed the partnership's online resources and social media
- We met with the partnership on three occasions throughout the inspection which included discussions on how to conclude the inspection.

We judged that from this activity we had sufficient evidence to reach confident conclusions about key strengths and areas for development. Given that we did not meet with children, young people, parents and carers whose records we had read, we were not able to evaluate quality indicator 2.1 - Impact on children and young people.

Key facts

Total population:
88,340 people

Proportion of children:
In 2020 17.5% of the population were under the age of 16, slightly above the national average of 16.8%

On 30 June 2020, the population of West Dunbartonshire was 88,340. This is a decrease of 0.7% from 88,930 in 2019.

The proportion of datazones (40%) in West Dunbartonshire within the 20% most deprived SIMD datazones in Scotland is amongst the highest across the country. By contrast, it has one of the lowest proportions of datazones (6%) within the 20% least deprived datazones.

West Dunbartonshire had the second highest prevalence of domestic violence incidents recorded by Police Scotland in 2020/21, at 168 incidents per 10,000 population, compared to the national average of 119.

In 2020/21, West Dunbartonshire had a rate of 15.1 child protection investigations (per 1,000 of the 0 – 15yr population), higher than the Scottish average of 12.8.

Key Messages

- The partnership was responding effectively when concerns about children and young people were first identified
- Children and young people said they had an opportunity to develop a relationship with a key member of staff
- There are discrepancies between how staff saw their practice and what we saw in children and young people's records.
- Following the initial identification of harm, the quality of key processes was inconsistent
- From reading records, there was little evidence of children's views being solicited or taken into account when decisions were made that affected them
- There was little follow up analysis of the impact of services to improve outcomes for children and young people at risk of harm
- To be more impactful, the child protection committee's oversight and scrutiny of data and quality assurance activity required development
- Strategic leaders needed to work collaboratively to understand their activity and its impact on children and young people at risk of harm.

Statement 1: Children and young people are safer because risks have been identified early and responded to effectively.

Key messages

- The partnership maintained child protection services and tried to reduce the impact of the Covid-19 pandemic on the operational delivery of services to children and families
- There was a marked contrast between the confidence expressed by staff in their abilities and what we saw in records
- When concerns about children were first identified, the partnership responded promptly
- There were delays in inter-agency referral discussions taking place and they had not taken place for a third of the children whose records we read
- Improvement is needed in both the response to follow up concerns and the effectiveness of reducing risk for children and young people.

Response during the Covid-19 pandemic

Despite experiencing high levels of infection as the Covid-19 pandemic progressed, the West Dunbartonshire partnership were successful in maintaining services to, and contact with, children at risk of harm and their families. They continued to deliver essential child protection services alongside providing families with much needed practical support. Weekly contact with children and young people subject to child protection registration was maintained. The majority of children and young people and most parents and carers who responded to our survey felt that they had sufficient contact with a member of staff during the pandemic.

Identification of concerns

When concerns about children were first identified, these were shared with the police and social work without delay and they responded promptly. The named person was informed in every record we read. Immediate action was taken at this stage to keep children safe which was enabled by clear initial decision making between partners.

Staff who completed our survey reported that they felt confident in their knowledge, skills and their ability to identify, report and assess risks and concerns. They felt supported and challenged by their managers to achieve a high standard of practice and staff from all agencies said they received regular supervision. However, although most staff felt confident that local child protection arrangements were effective and took place in a timely way, this was not for the most part supported by our record reading findings after the initial concern was identified and reported.

Effectiveness of response

An Inter-Agency Referral Discussion (IRD) should be held to ensure all the relevant information is shared between the key agencies so that decisions and actions are well informed and coordinated. No IRD had taken place in just over a third of our sample of records. Police and social work were involved in all IRDs, when they occurred, with health also in attendance at almost all of these. Education, additionally, were involved in the majority of IRDs.

Once the partnership had decided to proceed to an initial multi-agency meeting, the quality of the response in some cases was evaluated as good or better but the majority were evaluated as adequate. There was appropriate representation from agencies and clear decisions were again made in almost all cases. Most meetings took place within timescales and almost all had a written record. However, we considered that risks and needs had been partially considered in just under half of the records we read. Children and young people who were of an age to have had their views and experiences considered, had not contributed to the initial multi-agency meeting. The contribution of parents and carers was better in most cases.

Results from the staff survey highlighted that the majority of social work and social care staff agreed children at risk of harm were living in the right environment to keep them safe. However, some staff groups in other agencies disagreed with the statement. The majority of respondents agreed or strongly agreed that children and young people are being supported to recover from their experiences of harm. Responses from health and police staff do highlight variations with some disagreeing with the statement. It would benefit the partnership to use the survey results themselves to identify gaps and understand these discrepancies.

The partnership had identified improvements that needed to be made to ensure that IRDs focused on the immediate needs of the child. However, these had not yet impacted on practice and the partnership agreed that improving IRDs is a priority area of focus.

The partnership was addressing specific issues of concern for children and families in the area. These included children and young people's mental health, online harm and domestic abuse. Domestic abuse was an enduring concern and a significant factor for families of children whose names were on the child protection register. The Violence Against Women and Girls Partnership had supported the introduction of Multi-Agency Risk Assessment Conferences (MARAC) in 2020 and the No Home for Domestic Abuse Policy. This promotes a zero tolerance approach to domestic abuse within local authority properties. These were promising steps but it was too early for the partnership to know about the direct impact on children and young people.

Staff competence and confidence

The difference between the quality of practice we saw in records and the responses from staff to some of the survey questions was a concern for us. Survey results showed a workforce who said they were confident of their knowledge, skills and abilities. The majority of staff agreed that children were being protected from harm with some variance in responses from individual agencies. Most staff told us they were confident that child protection processes were effective. However, this was not supported by all aspects of the record reading findings. The results we saw for the quality of assessments, plans and chronologies in particular were in marked contrast to the perception of staff. The discrepancy in these two sources of evidence raised important questions regarding what led to this level of confidence and how managers were assuring themselves of the standards and quality of practice.

Almost all staff stated they were receiving supervision or had opportunities to speak to a line manager in a way that challenged them to achieve a high standard of practice. We had limited additional information on how staff were supported to reflect and improve their skills or received feedback. As a result, we were less confident about how staff were being supported to maintain the level of confidence they conveyed in their responses.

Almost all staff said they knew what standards of practice were expected of them. The majority of respondents agreed or strongly agreed that participation in regular multi-agency training and development opportunities had strengthened their contribution to joint working. Most practitioners who completed our survey were satisfied that training had increased their personal confidence and skills in working with children at risk of harm. The ongoing impact of the Covid-19 pandemic had reduced the partnership's capacity to provide training and the child protection committee had a recovery plan in place to address this.

Performance management and quality assurance

The partnership was undertaking some quality assurance activity. However, their efforts were not being well used to inform any changes in practice. There was a lack of clarity about how the learning was informing the partnership about its performance. There was limited evidence about how the partnership was using feedback, data and quality assurance activity consistently to understand the effectiveness of the work undertaken to keep children and young people safe. An overarching framework for quality assurance would provide the partnership with a structure and agreed approach to better realise the impact of their work.

During our inspection we saw examples of how data could have been better used to help the partnership further understand its strengths and areas for development. These included the number and age profile of children on the child protection register; the use of child protection orders; the application of initial child protection processes and the scale or complexity of presenting risks.

It was encouraging that the partnership had realised the need to develop its oversight of quality assurance and had established posts to support the child protection committee in this activity.

Statement 2: Children and young people's lives improve with high quality planning and support, ensuring they experience sustained loving and nurturing relationships to keep them safe from further harm.

Key messages

- The majority of children, young people, parents or carers who responded to our survey said they were happy with the level of contact they had with their worker during the Covid-19 pandemic.
- Assessments, chronologies and plans had been completed by staff but the quality of these needed to improve.
- The majority of children's plans were being reviewed within timescales, however, the quality of most reviews was rated as adequate.
- The partnership highlighted a range of activities intended to support children and young people at risk of harm. We could not always see the impact of these or how they related to an overarching plan for service delivery.
- There was limited evidence that learning from audit or scrutiny activity was being used to influence practice development or improvement.

Staff survey feedback

Responses to the staff survey indicated that most staff who were supporting children at risk of harm considered that they were working well together. They reported that the Getting it Right for Every Child approach was having a positive impact on the lives of children at risk of harm. Most said they felt proud of the contribution they were making to improve the wellbeing of children at risk of harm and their families. Staff survey responses suggested that joint training and access to child protection training were working well and staff were benefitting from the opportunities. Social work staff were less positive. Most staff felt that learning and training had increased their skills and confidence.

Assessing risk and need and planning

Staff had completed assessments, chronologies and plans that considered needs, concerns and risks for children in all of the records we sampled. However, their quality was not of a sufficiently high standard; the majority of assessments, chronologies and plans were rated as adequate, and a few were unsatisfactory. There was limited evidence that chronologies were used to identify patterns of significant events and experiences. The majority of plans were reviewed within timescales, but the quality of reviewing was mostly rated as adequate or below. This meant we did not have confidence that the partnership was developing plans to provide timely interventions to meet needs and reduce risk, maximise safety and improve wellbeing. Furthermore, the child's voice was not always present in the records we read, with the result that there was limited evidence that their views were being acted on in the planning process.

Support for children and young people at risk of harm

Services continued to work together during the Covid-19 pandemic restrictions and physical and virtual contact was maintained with children and young people during the lockdown periods. Practical support, including food and shelter, was also made available. Some care leavers were enabled to stay in touch digitally. Children and young people, as well as parents and carers, were generally content with the level of support that they had received.

The effectiveness of work to reduce risks of abuse or neglect from parents or carers, or from within the community, was assessed as good in less than half the sample we read. In most instances, in the small number of cases where there were risks of the child harming themselves or others, practice to reduce those risks needed to be more effective.

The partnership had introduced an adult services parenting capacity assessment and a strengths-based approach to supporting parents with alcohol and drug issues. There was limited evidence of their impact. Improving the lives of children through specific parenting interventions was a strategic outcome within the integrated children's service plan but aspects of this work were in need of a refresh. While our record reading found that most children and young people were impacted by parental behaviour, we could not see evidence of collaborative working between children and adult services.

It was difficult to establish whether mental health outcomes were improving for children and young people. Half of the respondents to the staff survey disagreed or strongly disagreed that mental health outcomes for children and young people were improving. Several new initiatives and services had been launched in response to meeting young people's mental health and wellbeing needs. For example, 'Young People In Mind' was promoting the mental health and wellbeing of looked after and accommodated children and young people. It would have been helpful to have seen evaluations or audits of these supports in order to assess their effect, or the longer term consequences for vulnerable young people. Steps had been taken across the Greater Glasgow Health Board Child and Adolescent Mental Health Service

(CAMHS) which had positively impacted in reducing waiting times in West Dunbartonshire.

Quality improvement leading to better outcomes

While there is good intention and a willingness to encourage new initiatives, performance measurement and evaluation had not been sufficiently developed to help the partnership understand where to best concentrate their efforts to support improved outcomes for children and families. There was agreement about some key areas for improvement but there were no corresponding targets and no clear line to actions intended to achieve objectives.

Evidence of scrutiny and analysis of data relating to performance measures and quality assurance was limited, although the partnership was developing a self-evaluation framework. It was not always clear how learning from audit activity was leading to change. Self-evaluation had shown that performance in meeting key child protection timescales was inconsistent but improvement targets had yet to be set. There was little indication that information gathered was being used to improve either the quality or timeliness of child protection processes. For example, an increase in the number of referrals to the Scottish Children's Reporter Administration (SCRA) and a decrease in the number resulting in compulsory measures, had not apparently been explored. A commitment had been made to the Wave Trust's campaign to reduce child abuse by 70% by 2030. It was unclear though, how the campaign's implementation would be measured, or how, in 2030, the council would know if its commitment had achieved the desired aim.

Statement 3: Children and young people and families are meaningfully and appropriately involved in decisions about their lives and influence service planning, delivery and improvement.

As we did not undertake the engagement phase of this inspection, we had limited evidence to address this statement.

Key Messages

- Children and young people who were of an age to have had their views and experiences considered, had not contributed to the initial multi-agency meeting.
- The majority of children, young people, parents and carers in the sample had opportunities to develop a relationship with a key member of staff.
- We rated the quality of how well children had been listened to, heard and included by staff as adequate or below in records.
- There was little evidence to suggest that children and young people are given opportunities for involvement in development activities, service planning and review.

The majority of children and young people in the record reading sample had the opportunity to develop a relationship with a key member of staff. Based on the small sample of children, young people, parents and carers who responded to our survey, most children and young people agreed that their worker listened to their views and opinions. Most also agreed that their worker spent time with them and gave them the help that they needed all, or most, of the time. Children and families were mostly satisfied with the help they were receiving to maintain supportive relationships with the people they cared about.

It was unclear how the wishes and expectations of children and young people were sought, listened to and considered. The majority of respondents to the staff survey felt that children and young people participated meaningfully in decisions that affected their lives and had their views respected. How children were listened to, heard and included by professionals was rated as less than good in the majority of records we read. We saw very few examples of children and young people's views being recorded in meetings which had taken place about them.

Parents and carers had slightly more opportunities to be involved in discussions and planning than children or young people. A majority of staff were confident that families and all relevant agencies actively contributed to effective plans for children and young people. We evaluated how well children, young people and families were listened to in just over half the records as good or better. However, all parents and kinship carers agreed that staff communicated well and helped them to understand what needed to change to keep children safe.

The availability of independent advocacy for both parents and carers and children and young people was inconsistent. In our survey, less than half of parents and carers said that they had an opportunity to speak with an independent advocate. This was in line with our staff survey with fewer than half of staff agreeing that advocacy was made available.

Statement 4: Collaborative strategic leadership, planning and operational management ensure high standards of service delivery.

Key messages

- Key plans across the partnership were not well aligned to an overarching vision for childen's services
- The approach leaders and managers were taking to monitoring practice standards and quality assurance was under developed
- To be more impactful, the child protection committee's oversight and scrutiny of data requires development.

Impact of leaders on staff

Survey results indicated that staff felt well supported and confident in their standards of practice. This varied between agencies but indicated that the overall level of confidence in recognising and reporting signs of abuse was high. What was less certain was the extent to which managers and leaders were monitoring and driving up standards.

The records we read indicated that staff were working collaboratively when they had identified and responded to immediate risk. While this was borne out in record reading, we did not see any direct ways in which this had been influenced by leadership. We saw little evidence of supervision or quality assurance activity in records or how learning from the child protection committee was used to influence practice. Although staff felt that leaders had a clear vision for the delivery and improvement of services provided to children at risk of harm, a significant percentage did not experience that as clearly.

Governance arrangements

The partnership had appropriate governance arrangements and we saw that different corporate visions were in place. While these individually had value, key plans were not well enough connected to an overall vision. Furthermore, it was unclear how plans and leadership of strategy, improvement and change were communicated to and understood by staff, children, young people and families. We did not see opportunities for children and young people to be involved in shaping the partnership's visions and values.

We are not yet confident that collective leadership across the partnership is as strong and effective as it needs to be. With significant work ahead to embed the Promise, implement the National Child Protection Guidelines 2021 and new Joint Investigative Interview process, this raised some questions about whether the partnership recognised the collaborative approach required to effectively progress these priorities.

The Child Protection Committee

Although there were appropriate governance structures across organisations, we were less confident following the activity we completed about how effectively the public protection chief officers group was overseeing the work of the child protection committee. We were not assured the child protection committee was maximising its oversight of practice or influencing improvement. Actions were appropriately assigned to a lead officer to take forward but how the progress of actions was jointly monitored was not evident from the minutes of subsequent committee meetings. A data subgroup of the child protection committee had been convened but consistent analytical systems were not yet in place to effectively make use of audit and other data to inform strategic planning, service development and resourcing.

It was difficult to establish to what extent strategic leaders were working collaboratively as a partnership and whether accountability for leading and directing work to keep children safe was representing the full range of relevant partners.

Conclusion

While the partnership's initial response to identifying and reporting concerns was good, the effectiveness of services in improving children's lives was unclear. Our record reading results raised concern about how children and families are supported to sustain safe and positive changes in their lives. We were concerned about the disparity between staff's own views about how effective their work is, and our assessment of performance, from what we read in records. This led us to question whether managers need to be more realistic in their assessment of performance and more challenging of themselves and each other.

We were struck by the number of initiatives and activities that partners were involved in. It was clear to us that there was little follow-up or analysis of the impact of proposed actions, particularly by the child protection committee. Actions were not reviewed under a cohesive framework, the use of which could subsequently influence service improvement and help target resources. This lack of cohesion was reflected at a strategic leadership level where we saw little evidence of improvement in outcomes which leads us to question how much the partnership understands it's activity and impact.

What happens next?

The Care Inspectorate and scrutiny partners agreed not to undertake a full engagement week based on reasons outlined in the introduction of this report. We decided that the most appropriate course of action would be to support the partnership to undertake improvements in the areas we have identified. While we are more confident the partnership now know where changes need to be made, we do not think they would be able to take all the actions necessary without external support and challenge. The partnership has agreed with this approach and has recognised the need for improvement.

We asked the leadership team in West Dunbartonshire to provide an improvement plan which they have done and it includes areas highlighted in this inspection. The partnership has established governance arrangements to oversee its improvement action planning which will be chaired by the chief social work officer.

Along with scrutiny partners, the Care Inspectorate will lead a series of improvement sessions to support the partnership with the key areas for development. During late May and June 2022, we will facilitate nine sessions with a range of staff to help focus the direction of improvement activity. Thereafter we will monitor and evaluate the partnership's progress for an agreed period of time and report on the improvements it has made.

Appendix 1: Key Terms

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

Child protection committees are the locally-based, inter-agency strategic partnerships responsible for child protection policy and practice across the public, private and third sectors. Working on behalf of chief officers, their role is to provide individual and collective leadership and direction for the management of child protection services in their area.

A **Children's Service Plan** is a strategic plan prepared by local authorities and relevant health boards. It sets out the provision of children's services and related services in a local authority area.

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

An **initial multi-agency meeting** is the first formal occasion in which the chair and attendees consider whether child protection registration, vulnerable young person's or care and risk management planning is necessary. Examples include initial child protection planning meetings or case conferences; and initial care and risk management multi-agency meetings or equivalent.

An **inter-agency referral discussion (IRD)** is the start of the formal process of information sharing, assessment, analysis and decision-making following reported concern about abuse or neglect of a child or young person up to the age of 18 years, in relation to familial and non-familial concerns, and of siblings or other children within the same context. This includes an unborn baby that may be exposed to current or future risk.

Multi Agency Risk Assessment Conferences (MARAC) MARACs are regular, local meetings where information about domestic abuse victims at risk of the most serious levels of harm is shared between representatives from a range of local agencies to inform a co-ordinated action plan to increase the safety of the victim and their children.

Named persons are a core component of the GIRFEC approach, and are a professional point of contact within universal services, if a child, young person or their parents need information, advice or help. Local arrangements and the term used to describe this role or function may vary from area to area.

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.

The **Scottish Children's Reporter Administration (SCRA)** is a national body which focuses on children most at risk. Its role is to decide when a child needs to go to a Children's Hearing, help children and families to take part in hearings and provide accommodation for hearings.

Scrutiny partners represent the scrutiny bodies that take part in joint inspections. This includes the Care Inspectorate, Education Scotland, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Constabulary for Scotland.

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. This term was in common usage until 2021 when it was replaced by the term 'learning review' in the updated national guidance.

Young Inspection Volunteers are young people (aged 18 - 26) with experience of care services who are specifically trained to support the Care Inspectorate with our inspections. They are part of the inspection team.

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