care inspectorate

Report of a joint inspection of services for children and young people at risk of harm in North Ayrshire

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

7 June 2022

Education Scotland Foghlam Alba

Healthcare Improvement Scotland

HMICS Improving Policing Across Scotland

HAPPY TO TRANSLATE

Contents

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 North Ayrshire council, NHS Ayrshire and Arran, Scottish Children's Reporter Administration (SCRA), 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 North Ayrshire.

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.

The inspection of services for children at risk of harm in the North Ayrshire community planning partnership area took place between August 2021 and April 2022. Due to constraints presented by the ongoing Covid-19 pandemic, we did not undertake the engagement phase with North Ayrshire that was planned for January 2022. 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 August 2021 and April 2022 to gather the evidence reflected in this report were:

- we carried out a staff survey and received 892 responses from staff working in a range of services
- we reviewed five survey responses from children and young people and nine 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, 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 senior leaders from the partnership on three occasions throughout the inspection, which included discussions on how to conclude the inspection
- in April 2022, we reviewed additional evidence and met with partnership representatives.

We judged from this activity that 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: 134,250 people

Proportion of children:
In 2020 16.6% of the population were under the age of 16, similar to the national average of 16.8%

On 30 June 2020, the population of North Ayrshire was 134,250. This is a decrease of 0.4% from 134,740 in 2019. Over the same period, the population of Scotland increased by 0.0%.

52 (28%) of North Ayrshire's 186 data zones are in the 15% most deprived in Scotland. It is estimated over 6,200 children (27.9%) age 0-16 could be living in poverty in North Ayrshire in 2019/20.

North Ayrshire had 168 incidents per 10,000 population, of domestic violence recorded by Police Scotland in 2020/21. This was higher than the national average of 119.

In 2020/21, North Ayrshire had a rate of 5.2 for number of children on the child protection register (per 1,000 of the 0 –15yr population), higher than the Scottish average of 2.3.

The rate of child protection investigations (per 1,000 of the 0 –15yr population) was 20.4, this was higher than the Scottish average of 12.8.

Key messages

Strengths

1. Recognition and initial response to risk and concern to children was a strength. Staff took timely and appropriate action to keep children safe.
2. Overall, key processes for assessing and managing risk for children at risk of harm were well established and working effectively.
3. Effective oversight and scrutiny of child protection performance was provided by the chief officers group and child protection committee.
4. Partners had a well-established approach to gathering and using performance data to inform and support improvement activity.

Areas for improvement

1. The partnership should further develop its review of outcome data to demonstrate the difference services are making in keeping children safe.
2. Continued attention was needed to ensure all children and young people are meaningfully involved in decisions about their lives and in the development of future service provision.

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

Key messages

1. Recognition and response to initial concerns for the safety of children and young people was effective in most cases.
2. Effective multi-agency working was helping to protect children and young people and staff shared any concerns about them without delay.
3. Staff took immediate action to protect children and young people when concerns had been raised about their safety.
4. Staff were well supported through a comprehensive range of guidance, procedures and training opportunities.
5. Partners were gathering and analysing key performance data to inform their understanding of child protection services and direct further improvement activity.

Recognition of risk and concerns

Recognition of risk and concerns about children was a strength. Our review of records evaluated the quality of multi-agency responses to concerns about immediate risk of significant harm to children as good or very good in most cases. Concerns were shared timeously with social work or police in almost all cases and clear decisions were made to keep children safe in all the records we read.

Partners immediately prioritised children and young people at risk of harm in response to new and unprecedented challenges brought by the Covid-19 pandemic. Recognising the increased risks caused by isolation, partners swiftly launched a child protection awareness campaign on social media which resulted in an increase in calls to children's services regarding children's welfare. Staff continued to have contact with children and young people in the most vulnerable situations as the pandemic progressed. We talk more about this in Statement 2.

Collaborative working

Effective multi-agency working played a key role in identifying risk and protecting children and young people. Practitioners understood the principles of **Getting it right for every child (GIRFEC)** and were confident the GIRFEC approach was having a positive impact on the lives of children and young people at risk of harm. This approach supported early identification of children and young people in need of protection and subsequent multi-agency responses. In all the records we reviewed, information about concerns was shared appropriately with the named professional acting as the professional point of contact in universal services. The strengths in collaborative practice were also evident for children living in island communities. Creative responses were helping to keep children safe, while responding to the unique challenges of living off the mainland.

The partnership had established processes to track unborn babies when mothers were living in vulnerable situations. This supported health and social work staff to identify and respond to concerns about babies pre-birth. The trauma-informed contact and care approach was being rolled out by police and education to enhance timely responses to children affected by domestic abuse. Although it was too early to measure impact, this was a promising initiative with the aim of ensuring that adults who worked closely with children had the necessary information to respond to children's needs at the right time.

Effectiveness of response to concerns

Following notification of a child protection concern, **inter-agency referral discussions (IRDs)** should be convened to co-ordinate decision making and agree the immediate action required to ensure the safety of children. Our review of records found that when IRDs took place they were effectively supporting staff make joint decisions in response to concerns raised. Practice in these cases followed **national child protection guidance** and on almost all occasions, clear IRD records reflected the involvement of social work, health and police colleagues. The quality of IRDs was supported by routine IRD audits and of cases not meeting the threshold for discussion. In reviewing records, we found some did not contain the expected IRD paperwork. In response to our findings, the partnership immediately undertook additional work to better understand why their own audit activity had not supported consistency in practice in this area. They found a number of IRDs had not been fully completed on their electronic system and corrective action was required. The partnership implemented a plan to enhance IRD processes, with monitoring arrangements in place through the IRD oversight group.

When an **initial multi-agency meeting** was held, staff made a collective assessment of risk and developed a multi-disciplinary child protection plan. In most of the records we read, we evaluated the overall quality of practice as good or very good with clear decisions being made in all applicable cases.

In response to concerns about the safety of children and young people, staff acted timeously to keep them safe. Almost all investigations included measures to ensure the immediate and interim safety of children and young people. The need for a medical examination, legal measures or a joint investigative interview was considered in almost all cases.

The partnership had undertaken development work alongside Missing People, a specialist organisation supporting missing people and their families. This had assisted staff to identify strengths and areas for improvement in supporting young people with frequent missing episodes. Partners subsequently launched multi-agency missing person guidance in 2021. The partnership should continue with its plan to monitor implementation to provide assurance that risks to young people are reduced.

Staff competence and confidence

Most respondents to our staff survey were confident in recognising and reporting concerns related to risk of abuse, neglect and exploitation. They were supported in their practice by the child protection committee and individual agency's learning and development activity and local guidance. Partners had taken a flexible and creative approach to the challenge of providing face-to-face training, with opportunities moving primarily online and arrangements to prioritise 'unseen children'. Bespoke child protection training was also provided to staff who were redeployed as part of the pandemic response. Almost all respondents to our staff survey understood the standards of practice that were expected of them and most believed that learning and development opportunities positively impacted on their skills in working with children and young people at risk of harm. Practice reflection and improvement short modules (PRISMS) had been implemented across the partnership and provided learning and development opportunities for operational staff that focused on learning from audit and case review activity. The learning and development subgroup of the child protection committee was also helpfully driving forward mandatory training opportunities across agencies.

Performance management and quality assurance

The partnership had a well-established framework for analysing data and audit activity to effectively inform and support improvements in the quality of child protection practice. The child protection committee had embedded the national **child protection minimum data set** to track a range of factors concerning child protection referrals, investigations and child planning meetings. Partners were also making use of data about vulnerable young people and from the out of hours social work service to enhance their understanding of risk and demand in relation to young people at risk of harm. Reporting and oversight arrangements were in place, with the child protection committee's management information group tracking, analysing and reporting to the child protection committee. We look more at how partners used this information to support improvements in practice in Statement 2.

Benchmarking local data indicates higher than average national rates of child protection activity in the area. This includes overall child protection registration and de-registration rates, rates of **compulsory supervision orders** and a continued increase in the number of **child protection orders** over the past five years. Data for out of hours social work services also show higher levels of demand than neighbouring partnership areas. We were assured that the partnership was aware of these trends and was undertaking regular demand analysis of local management information with other areas as part of their performance management and quality assurance 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

1. Collaborative work to address abuse and neglect was positively impacting on the lives of the majority of children and young people at risk of harm.
2. Assessments, plans and chronologies were routinely completed for children and young people at risk of harm. The quality of key processes was good in the majority of records we reviewed.
3. Although it is too early to see the impact of efforts, the partnership had prioritised a range of supports and initiatives with the aim of supporting improvements in the mental health and emotional wellbeing of children and young people.
4. A range of supports were provided to children and families with the aim of reducing risk of harm and improving wellbeing outcomes. The partnership was limited in its ability to fully demonstrate the difference services were making to children and young people's lives.
5. The partnership's work to reduce risks to children and young people arising in the community, or from children harming themselves or others, was less effective than work to address abuse and neglect.

Assessment and planning to reduce risk

Overall, key processes for assessment and care planning were well established and working effectively to support practitioners to understand and respond to risk of harm for children and young people. Assessments, plans and chronologies were routinely completed for children and young people at risk of harm. Staff survey respondents were confident in their ability to assess and analyse risks and needs, as well as being able to complete plans within timescales. This was supported by our review of records where we found the quality of assessments and plans to be good or very good in the majority of cases. Reviews were taking place in line with national guidance, including as the pandemic progressed. We found the quality of reviews to be good or very good in the majority of records.

While we found chronologies in most of the cases we reviewed, we evaluated just under half as adequate and two records as weak. We were reassured to find development of chronology practice was a key priority within the child protection committee's business plan, as continued attention to this area should enable staff to further improve their practice in recognising accumulating concerns.

Over 40% of assessments and plans in our record sample were evaluated as adequate, highlighting that the partnership had more to do to achieve a consistently high quality of practice. However, the **child protection committee** had taken action to improve consistency in the standards of these key processes. The child

protection committee had prioritised improvement activity around assessing risk, SMART (specific, measurable, achievable, realistic, timely) planning and reviews.

Support for children and young people at risk of harm

A range of support services were available to children and young people with the aim of reducing risk of harm and improving wellbeing outcomes. Examples included the Rosemount crisis intervention service, the Notre Dame service to support children at risk of sexual abuse or exploitation and the Aberlour Sustain service. These operated at varying times, including evenings, weekends and holiday periods. Collaborative work to address abuse and neglect was positively impacting on the lives of the majority of children and young people at risk of harm. Support to children at risk of harm and their families continued as the Covid-19 pandemic progressed. Local hub arrangements were established quickly, and individual face-to-face contact continued to keep children safer. Senior leaders provided oversight and sought assurance through their use of local and national data, which included specific information on children at risk of harm being seen throughout the pandemic. We found the majority of children and young people had been protected from harm and had their wellbeing needs met during the restricted period to a good or very good standard.

Some services had evaluated the impact of their work on the lives of the children and families they supported. For example, the Rosemount crisis intervention service gathered feedback directly from families who used the service. A recent evaluation showed almost all children successfully remained at home following intervention.

The partnership's work to reduce risks of abuse and neglect was effective in the majority of cases. However, the effectiveness of work to reduce risks to children and young people arising in the community, or from the child harming themselves or others was less effective. The partnership was taking action to address risks to these groups of young people. The focus of this included establishing a young people suicide taskforce and the young person's suicide prevention pathway to reduce risk, support for missing young people and **contextual safeguarding approaches.** As a result of this work, the partnership was well placed to be able to demonstrate improvement in these areas.

The partnership had prioritised a range of supports and initiatives with the aim of supporting improvements in the mental health and emotional wellbeing of children and young people. It had taken account of increasing levels of need as the pandemic progressed. A pan-Ayrshire approach had been taken in response to the Scottish Government's mental health strategy, and additional funding had been used to develop **child and adolescent mental health service (CAMHS)** extreme teams. These focused on holistic care and more timely access to local services and support. The Kilwinning wellness model had seen a significant drop in average CAMHS waiting times compared to other localities and using learning from this pilot, the model was being rolled out to other localities. Staff survey responses were mixed about the effectiveness of mental health and emotional support. Over one third of respondents disagreed that mental health outcomes were improving. Comments from staff noted difficulties in accessing mental health services for children and

young people. Responses indicated however, that trauma informed, and nurturing approaches were making a positive impact. Continued attention by partners will be required to establish the extent to which recent developments support improved mental health outcomes for children and young people.

Quality improvement leading to improvement outcomes

As noted in Statement 1, the partnership was routinely and systematically gathering and using performance data to ensure improvement activities were informed by local intelligence. This helped to ensure attention was focused on the areas where it was most needed. Examples included the action taken in response to an increase in the number of children being re-registered on the child protection register within two years. Scrutiny of data had led partners to undertake a multi-agency audit of a sample of case records. They had used the findings of this to inform improvement actions, including targeted learning and development for frontline staff.

A key element of this statement is understanding the extent to which children and young people experience sustained, loving and nurturing relationships and how they have experienced services. There was a clear commitment and a range of activity to support staff to develop positive relationships with children and young people. Further attention on impact measures will strengthen the ability of the partnership to understand the differences services are making. We say more about this in the section about Statement 4.

Statement 3: Children, young people and families are meaningfully and appropriately involved in decisions about their lives. They 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

1. In our review of records, almost all children and young people at risk of harm had the opportunity to develop relationships with key members of staff. Staff had maintained contact with children and young people at risk of harm as the Covid-19 pandemic progressed.
2. Most parents and carers had opportunities to develop relationships with key members of staff and good quality contact continued as the pandemic progressed.
3. Independent advocacy was available for children and young people at risk of harm. This was helping children and young people to actively participate in decisions about their lives.
4. The partnership needed to strengthen approaches to ensure all children and young people are meaningfully and consistently involved in their own plans and have further opportunities to inform service development.

Ensuring the contribution of all children, young people, parents and carers

Almost all children and young people at risk of harm had the opportunity to develop relationships with key members of staff. We also found that staff had maintained contact with children and young people as the Covid-19 pandemic progressed.

Inspectors looked for evidence that staff were encouraging and enabling children and young people to express their views and that they took these into account when making decisions that affected them. The proportion of staff who agreed that children and young people at risk of harm were able to participate meaningfully in decisions that affected their lives was 54%. While there was some good practice evident, there was a need for improvement in a significant minority of cases.

Most parents and carers of children at risk of harm also had opportunities to develop relationships with key members of staff and, in the majority of records, a good quality of contact continued through restricted periods. Overall, our record sample found parents and carers were more likely to have been listened to and included than children and young people.

The partnership's own multi-agency audit identified similar findings and the child protection committee had subsequently taken action to improve the involvement of children in child protection processes and to support staff to adopt a more child centred approach. The role of independent reviewing officers had been enhanced and changes had been made to key processes and paperwork to support this. Performance data was collected by the management information group and there had been improvements in the recording of children's views during child protection

investigations over the past two years. The attention being given by the child protection committee gave us confidence that partners were well placed to make improvements in the quality of practice to ensure all children, young people and their families contribute meaningfully and appropriately to decisions about their lives.

Independent advocacy

Independent advocacy was available for children and young people at risk of harm through the commissioned Barnardo's Hear4U service and there had been increasing numbers of referrals to the service over the past two years. The service monitored impact by gathering and reporting on feedback from children and young people who had received a service. Most recent reports highlighted the positive impact, including feeling more able to contribute to decision making and report safety concerns. The partnership's audit activity on child protection case conferences identified some points for learning around the availability of the advocacy service. Improvement action was being monitored through the evaluation and improvement subgroup of the child protection committee.

Strategic influence of children, young people and their families

Partners had made promising developments in their approach to including the voices of children and young people in strategy and service development. Local authority partners had established approaches to engagement and listening to children and young people more widely and across children's services. This strategic approach included action to include the views of 'seldom heard voices'. Young people's views were also being represented by the involvement of young people with experience of care services in both the multi-agency **Promise** oversight board and the operational group. The next steps for the child protection committee could usefully include a more systematic approach to gathering perceptual feedback from children, young people, and parents and carers, to direct and inform **self-evaluation** and improvement work. At the time of writing this report, the partnership had already engaged with the Care Inspectorate's link inspector to progress this.

There was a strong multi-agency commitment to raising public awareness of protection issues, including targeting communication at children and young people. The public information and engagement subgroup of the child protection committee was raising the profile of the child protection committee in local communities, including groups which have been harder to reach. Work to ensure the voices of children and young people influence the committee's strategic priorities and strategic planning was an area for further improvement.

Our young inspection volunteers reported they found it challenging to access online information about child protection, keeping safe and services in the partnership area. They also noted the lack of availability of child-friendly versions of strategies and documents and that websites were not accessible or informative for children and young people.

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

Key messages

1. Leaders shared a coherent vision for protecting children and young people. They worked together to support a timely and pro-active response to new and unprecedented challenges.
2. The chief officer group and child protection committee provided effective oversight and scrutiny of child protection performance and set the strategic direction for child protection services.
3. Local children's services and child protection planning reflected national and local priorities to reduce inequalities. The partnership had developed a clear framework to deliver strategic priorities aligned with the local vision.
4. The well-established framework for self-evaluation and quality assurance supported improvements in important areas of practice.
5. The partnership was not yet sufficiently measuring the impact of its work on achieving improved outcomes for children and young people.

Vision, values and aims

Leaders in North Ayrshire were driving forward a coherent, shared vision, 'North Ayrshire – a Better Life'. This was underpinned by the following key priorities: a working North Ayrshire, a thriving North Ayrshire – children and young people, a healthier North Ayrshire and a safer North Ayrshire. This provided the strategic direction for improving the lives of people in local communities and protecting children and young people. Partners had an acute understanding of the persistent inequalities that existed in the area and had a purposeful focus on improving outcomes for children living in poverty. The majority of staff survey respondents agreed that leaders had a clear vision for the delivery and improvement of services they provide for children and young people at risk of harm.

Leadership of strategy and direction

Leaders had established a collaborative approach to directing and implementing services which continued as the Covid-19 pandemic progressed. As new and unprecedented challenges arose, leaders swiftly took action to ensure that the protection of children at risk of harm remained a priority for services. Leaders remained focused on realising their ambitions for local communities and were proactive in response to the impact of poverty on children and families, which had been exacerbated by the pandemic.

Effective oversight and scrutiny of child protection was in place through North Ayrshire's child and public protection chief officers group. **Chief officers** understood the need to provide clear direction and leadership as new challenges arose. Pre-existing arrangements for chief officer and child protection committee meetings were enhanced at the onset of the Covid-19 pandemic with the aim of providing swift,

collaborative, strategic responses to protect children and young people. The increased frequency of reporting arrangements meant leaders maintained a consistent focus on emerging risks and responded to these.

The child protection committee effectively monitored and prioritised activities across the partnership with the aim of protecting children and young people. As stated earlier, the committee had developed its understanding of how well services performed though regular audits and self-evaluation activity. The multi-agency assessment screening hub (MAASH) dashboard, child protection minimum data set reports and the vulnerable children monitoring data set, provided a range of key performance measures that had helpfully informed and prioritised development activity. The management information, and evaluation and improvement subgroups between them led on performance management, self-evaluation and a rolling programme of audits which effectively supported improvements in the quality of key processes.

The partnership was not adequately measuring the impact of its work on achieving improved outcomes for children and young people. A greater focus on measuring the quality of work and the impact on children and young people should provide a better understanding of the effectiveness of services and inform future priorities.

Children's service planning arrangements, including child protection business planning, reflected local and national priorities to reduce inequalities and support improved outcomes for children and young people at risk of harm. A clear multi-agency structure ensured strategic priorities were progressed and reviewed and the children's services strategic group had responsibility for linking strategy with operational practice. Clear arrangements were established to support communication between the child protection committee and other strategic planning groups.

Leadership of improvement and change

The response taken by partners to the pandemic was well informed by local data, self-evaluation activity and feedback from children, young people and families. Children's services planning arrangements in North Ayrshire were updated to reflect the challenges faced by services and communities as a result of the Covid-19 pandemic.

Despite the challenges over the past two years, leaders had supported several new policies and service developments in line with the partnership's vision to improve outcomes for children and young people at risk of harm. These were also informed by self-evaluation activity and analysis of data. Promising examples included the taskforce to address suicide among young people, the roll out of the child sexual abuse strategy and the trauma informed contact and care approach. The partnership was at the early stages of implementing the **Safe and Together model** as their preferred multi-agency approach to preventing and addressing violence against women and girls.

The partnership had an agreed, collaborative approach to transformational change. This included more creative use of budgets, the roll out of a community improvement model and work to keep the Promise. While the impact of the pandemic curtailed our ability to evaluate the impact of service developments more extensively, we have confidence in the capacity of leaders and their ongoing approach to adapt to challenge and drive improvements.

Conclusion

The Care Inspectorate and its **scrutiny partners** are confident that the partnership in North Ayrshire has the capacity to continue to improve and to address the points highlighted in this report. This judgement is based on:

- the strength of scrutiny and oversight of child protection practice
- the partnership's proactive response to risks emerging from the impact of the Covid-19 pandemic
- the partnership's performance to date in key protection processes and multi-agency practice
- the partnership's approach to risk based and intelligence informed continuous improvement.

The partnership will need to maintain its strong focus on developing its systematic use of data, quality assurance and joint self-evaluation to help understand what differences services are making and what needs to change. Partners should continue with their improvement plans to ensure all children and young people are meaningfully involved in decisions about their lives and in the development of future service provision.

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 instead to gather further evidence in key areas to provide the assurance we required to complete this inspection. This work has now concluded and is reflected in this report. Based on our confidence in the partnership's strengths and commitment to continuous improvement, this joint inspection is now concluded.

The Care Inspectorate will ask North Ayrshire community planning partners for evidence that the areas for improvement identified in this report are included in appropriate action plans. Actions should clearly detail how the partnership will make improvements in the key areas identified. The Care Inspectorate will monitor the partnership's progress and will continue to offer improvement support through their link inspector arrangements and coordinate further support from scrutiny partners as necessary.

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.

Chief officers are the chief constable and chief executives of health boards and local authorities who are responsible for ensuring that their agencies, individually and collectively, work to protect children and young people as effectively as possible.

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.

Child protection order is an order granted by a sheriff when they believe that a child is being ill-treated or neglected in a way that is causing or is at risk of causing significant harm and needs to be moved to prevent this risk.

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.

Compulsory supervision order is a legal document that means that the local authority is responsible for looking after and helping a child or young person.

Contextual safeguarding approach is an approach that recognises that as young people grow and develop, they are influenced by a whole range of environments and people outside of their family.

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.

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.

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.

National child protection guidelines https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021/

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 describes what Scotland must do to make sure that its most vulnerable children feel loved and have the childhood they deserve.

Safe and Together model is a suite of tools and interventions designed to help childcare professionals become domestic-violence informed.

Scottish Children's Reporter Administration (SCRA) is a national body that 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 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.

Self-evaluation is when services taking a close look at what they have done and evaluating themselves and their progress against a prescribed set of standards.

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