

**Joint inspection of services to protect children and
young people in the Shetland Islands Council area**

September 2009

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Introduction

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

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

¹ *'How well are children and young people protected and their needs met?'*. Self-evaluation using quality indicators, HM Inspectorate of Education 2005.

1. Background

The inspection of services to protect children² in the Shetland Islands Council area took place between February and March 2009. It covered the range of services and staff working in the area who had a role in protecting children. These included services provided by health, the police, the local authority and the Scottish Children's Reporter Administration (SCRA), as well as those provided by voluntary and independent organisations.

As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services who work to protect children living in the area. Some of the children and families in the sample met and talked to inspectors about the services they had received.

Inspectors visited services that provided help to children and families, and met users of these services. They talked to staff with responsibilities for protecting children across all the key services. This included staff with leadership and operational management responsibilities as well as those working directly with children and families. Inspectors also sampled work that was being done in the area to protect children, by attending meetings and reviews.

As the findings in this report are based on a sample of children and families, inspectors cannot assure the quality of service received by every single child in the area who might need help.

Shetland is the most northerly of local authorities in Scotland, with the second smallest population. It includes some of the most isolated communities in Scotland. The island group stretches for 161 kilometres north to south and comprises 100 islands, of which 15 are inhabited. Around 7,000 of a total population of 22,000 live in the main administrative centre of Lerwick. Health services are provided by NHS Shetland, with specialist health services commissioned from Aberdeen. Northern Constabulary's headquarters are in Inverness.

The age profile of Shetland's population is relatively young. Nearly 20% is aged less than 16 years, compared with a national average of 17.8%. Both employment rates and average earnings are above the national average. However, the cost of living is high when contrasted with the Scottish mainland. In the year ending March 2008, the names of 14 children were on the Child Protection Register (CPR), which, at 3.2 per thousand, was more than the national average (2.7). Like most of Shetland's comparator's authorities³, the number of children referred to services because of concerns about their welfare has increased steadily over the last five years.

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

³ Comparator authorities include Orkney Islands Council, The Moray Council, The Highland, Scottish Borders Council and Angus Council.

2. Key strengths

Inspectors found the following key strengths in how well children were protected and their needs met in the Shetland Islands Council area.

- Trusting and supportive relationships between staff and children.
- Effective joint working by staff across services to ensure children were aware of dangers and knew how to keep themselves safe.
- Successful promotion of public awareness of child protection.
- Involvement of children and young people in reviewing and developing services.
- Safe recruitment of staff and volunteers in all services and community groups.
- Vision and commitment to improve children's lives, demonstrated and promoted by elected members, Chief Officers and senior managers.

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

Children benefitted from supportive relationships with staff who knew them well. Staff developed individual packages of support to meet the needs of children and families effectively. They ensured children and young people were aware of dangers and knew how to keep themselves safe. Staff were alert to risks to children and responded promptly to protect them when concerns were raised. Services responded well to children's short-term needs, but success in meeting their long-term needs was more variable.

Being listened to and respected

Communication between children, their families and staff was very good. Staff knew children well and built helpful relationships with them. As a result, many families trusted staff enough to be open and honest about their difficulties. Most staff maintained regular contact with families. In a few cases, children and families did not receive support from an alternative member of staff when their social worker was absent, for example due to sickness. Staff took the opportunity to see older children on their own and carefully observed younger children to note any changes in their behaviour, mood or physical appearance. They used a variety of methods effectively to overcome communication difficulties. Staff used specially prepared booklets outlining a child's particular likes, dislikes and characteristics to help carers for children with disabilities understand their needs well. Some health visitors did not have enough contact with families to get to know them well.

Communication with children and families at formal meetings was clear and effective. Education and social care staff, in particular, discussed difficult issues sensitively and paid attention to ensuring they understood children's and families' views. Children's and parents' views were sought routinely about matters that affected them and these were presented clearly by staff in formal meetings. In some cases, staff helped children to complete *Having Your Say* or *My Meeting* forms to express their views to meetings. However, these forms were not used consistently, for all children. Some staff in education services used a helpful guide to involve children in decision-making. Children's panel members gave older children the opportunity to speak to them on their own and communicated very well with children and parents during hearings. They listened to parents' and children's views and wishes and took appropriate account of these when making decisions.

Being helped to keep safe

The support given to children and families to help keep safe was good. A range of services provided individual, flexible packages of support to families. This support helped to reduce risks to children and assisted families to care for their own children. Health visitors provided a range of postnatal support groups which were accessible to all families with infants. Midwives offered intensive support to vulnerable parents who required extra help preparing for their baby. Staff from the Bruce Family Centre worked effectively alongside health visitors to support vulnerable families with young children, offering helpful parenting programmes and one-to-one support. Family support workers provided parenting support to parents who did not want to join a group. Social workers and family support workers offered valuable support to

vulnerable families out-of-hours. Where children had additional support needs, families were helped by the home-school link teacher, pre-five teacher, pre-five nursery nurse and support workers. *Mellow Parenting* courses had been provided for particularly vulnerable families in the past, but no courses had been provided for a considerable time. Parenting support was not well coordinated. A parenting strategy was being developed by the Childcare Partnership, but no timescale was identified for its completion.

School staff worked jointly with social workers, school nurses and police officers to deliver personal and social development programmes in a flexible and accessible way. Children had easy access to clubs where youth workers helped them take part in activities safely. Some children had their needs met through out-of-school care and breakfast clubs provided by the Bruce Family Centre. Young people benefited from health advice at drop-in services at four secondary schools. This was provided by school nurses working alongside Shetland Youth Information Service (SYIS). Social workers and support teachers worked creatively with individual children to ensure they knew how to keep themselves safe. The home-school link teacher monitored all children educated at home very well. Procedures were followed appropriately when a child was missing from education. Staff in the Schools Service were very committed to maintaining children in school. As a result, few children were excluded.

Children had a good understanding of how to keep themselves safe. They felt safe in their schools and most felt safe in their communities. They knew how to safely use the Internet and were aware of the dangers of misusing drugs and alcohol. Younger children were aware of road safety and the dangers of talking to strangers. Children were confident that they could speak to someone about matters that concerned them. Most children were aware of child protection posters in school which provided local and national help lines. They knew how to contact national helplines such as ChildLine.

Some examples of what children said about keeping themselves safe.

"I would avoid someone I did not like the look of, or phone my Dad for advice."

"It is easy to talk to the headteacher as she knows me well."

"It is everybody's business to keep me safe."

"The headteacher would be discrete if you told her about being bullied."

Immediate response to concerns

The immediate response to concerns about children and young people was good. Staff across all services listened well to children and young people. They took effective action in responding to signs that children and young people may be at risk. Managers supported social workers to respond to immediate concerns. Police officers responded promptly to protect children affected by domestic abuse. Midwives took effective action in responding to concerns about unborn or newly born babies. Accident and Emergency (A & E) staff referred concerns about young people at risk of substance misuse to social work staff. Social workers and police officers investigated concerns promptly and took appropriate steps to protect children from harm. In many cases, children and their families were given helpful support and information during investigations of reported concerns. When children were unable to remain at home, staff found suitable accommodation for them, without undue delay. Staff sought advice and used appropriate legal measures to ensure that children were protected from harm or neglect. However, in a few cases, responses were based on incomplete information. Staff were unable to make appropriate assessments and decisions. As a result, these children did not always get the immediate help they needed.

Meeting needs

Meeting children's needs was good. Staff supported vulnerable children and families effectively, whether or not children were on the child protection register (CPR). They worked well together across services to keep children safe and meet their needs. Staff developed imaginative packages of care, with support targeted effectively at meeting identified needs. Children's short-term needs were identified effectively and supported well but some children did not have their longer term needs met. In a few cases, staff gave too much attention to supporting adults, while overlooking the needs of children. The lives of these children were not significantly improved by the support provided.

Staff from different services helpfully shared responsibilities and resources to meet the needs of vulnerable children living in remote areas. Financial support was provided to allow children to access services. Skilful pupil support teachers and staff from the Additional Support Base helped vulnerable children at school, linking educational and social support. The Bridges Project helped older children moving from education to employment. Children with complex health difficulties had their needs met by specialist health staff. Children with a disability were supported well by Laburnum Respite Unit and Outreach Service. Babies born to mothers who misused substances were given appropriate care to meet their particular needs. Looked after children received high quality care in foster placements or the local residential unit but there were insufficient foster carers to meet the needs of all children unable to return home. Most relatives received support to provide long-term care for children but this was not provided to all carers who required it.

Women's Aid supported children affected by domestic violence through sensitive individual counselling. Educational psychologists worked skilfully with children to reduce the effects of trauma and neglect. The services of an experienced consultant psychologist were commissioned for a small number of children who had

experienced sexual abuse. Staff from Child and Adolescent Mental Health Services (CAMHS) supported children with mental health or complex emotional needs effectively. CAMHS prioritised referrals and urgent cases were seen quickly but some children had to wait to get the help they needed. Clinical psychological support had been unavailable to children for a more than a year because of staff sickness.

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

Promotion of public awareness of child protection was very good. Staff used a range of effective approaches to engage with the local community. These approaches included an informative website and helpful public meetings. Public awareness of child protection was high and as a result, children and young people felt safe in their communities.

The promotion of public awareness about keeping children safe was very good. Staff used a wide range of effective approaches to communicate well with the local community. All households in Shetland had received a leaflet with useful information about child protection. A series of informative road shows throughout the Council area had provided valuable advice to volunteers and local community. The local media was used very effectively to promote public awareness of child protection. Together with *Youth Voice*, the CPC produced a range of very helpful leaflets and pocket-sized cards which effectively helped to raise public awareness about child safety. Leaflets, posters and cards giving valuable information and advice about child protection were displayed in almost all public reception areas in Council, police and NHS premises. The *Child Safe Shetland* website provided a range of helpful advice for community groups to help keep children safe. There was no dedicated website for the CPC.

Members of the public showed high levels of awareness of how and where to report any concerns they had about children's welfare. Referrals were received from a variety of sources and to a range of services. These concerns, including those from anonymous sources, were taken seriously and acted on promptly. Most referrers received oral feedback on action taken in response to their concerns but appropriate written feedback was not always provided so that referrers were assured their concerns were taken seriously. Out-of-hours contact numbers were well-publicised and used appropriately. Staff receiving concerns about children out-of-hours through the hospital switchboard passed these to duty social workers without delay. Support was provided by duty social work managers to ensure there was effective 24-hour cover to respond to concerns. They had access at all times to relevant information held centrally to enable them to take appropriate action.

5. How good is the delivery of key processes?

Staff across services involved parents in decision-making effectively. Children were not always given enough support to participate in formal meetings. Staff understood when to share information to protect children. At times, information-sharing depended too heavily on staff maintaining good professional relationships. Staff did not always record contacts with children or the work they were doing. Action to protect children was based on effective initial assessments of risk. The quality of child protection plans was improving. Some plans to meet children's long-term needs were not based on comprehensive assessments. Coordination of support for children not on the Child Protection Register (CPR) was inconsistent.

Involving children and their families

Arrangements for involving children and families in key processes were good. Parents were routinely involved in child protection case conferences, core groups, children's reviews and Children's Hearings. Staff working with families provided very effective support to encourage parental attendance and participation at all meetings. In most cases, staff shared reports with families prior to attendance at meetings. Minutes detailing decisions made were generally distributed on time. Parents understood what they needed to do to improve their circumstances. In some cases, they signed an agreement of actions to be taken. Staff had produced leaflets for children, explaining the purpose of meetings and what to expect. Although these had been used with a small number of families, they were still to be implemented more widely. Children and young people did not always attend case conferences and core groups. Those who did attend were supported well. Some older children attended key meetings, such as reviews, to express their views but not all children were encouraged and supported to be fully involved in meetings. Some social care, education and health staff had provided effective support to allow children to express their views. However, practice was inconsistent. Almost half of the children attending Children's Hearings completed *Having Your Say* forms. The Children's Reporter monitored how many forms were returned and had carried out an evaluation to identify improvements in their use. Panel members encouraged families to be full participants in Children's Hearings and parents were encouraged to find solutions as part of the decision-making process. The role of advocacy and the benefits it could bring for children and families was not well understood across services. There was a limited range of advocacy services available locally and none specifically developed for children. Some children in residential care had been supported by a children's rights worker and the Children and Young People's Rights, Information and Support Service. This service was under review at the time of the inspection and was not available fully to children.

All services had written policies and procedures for dealing with complaints. Helpful leaflets on making complaints were on display in a range of public buildings. There were very few complaints leaflets designed for children. Managers worked hard to resolve disputes at a local level. Complex complaints were thoroughly investigated, but sometimes this led to lengthy delays in resolving them. Complaints relating to child protection were analysed on an annual basis and actions taken as appropriate.

Overall, policies on allegations against staff took appropriate account of the links between child protection, alleged abuse, complaints and disciplinary procedures.

Sharing and recording information

Sharing and recording information was satisfactory. Staff understood when to share information with colleagues in their own and other services. This was supported by a helpful inter-agency agreement and by managers who promoted close joint working. Staff shared relevant information verbally and in writing, on a day-to-day basis and at formal meetings such as case conferences. In some cases, information-sharing depended too heavily on individual staff deciding what information to share and with whom. As a result, in a few cases, relevant staff were unaware of information they needed to respond to a child appropriately. The standard of recording was variable in health, education and social work services.

Particular features of information-sharing included the following:

- staff discussed concerns about children at an early stage with the Children's Reporter and social work service;
- police used child concern reports well to alert others to concerns and share relevant background information;
- General Practitioners (GPs) alerted midwives to vulnerable pregnant women promptly and continued to share information throughout the pregnancy;
- police advised victims of domestic abuse and other services about perpetrators' whereabouts and the legal restraints placed on them, to protect victims and children;
- there was effective recording of decisions taken at strategy meetings to plan joint investigations;
- information recorded by social workers and managers responding to concerns out-of-hours was not always transferred to children's records;
- the school nursing service was not always included when information was shared about vulnerable children; and
- significant events in the lives of children on the CPR were not gathered together to give a full picture across services.

The quality of recording was variable. Police officers recorded relevant information routinely. Senior police officers checked records to ensure actions had been completed. Scottish Children's Reporter Administration (SCRA) files were in good order, with decisions clearly documented. Most social work and education files were well-structured but in some cases, key information had not been recorded. This included important information about when children were seen by staff. Practice in filing confidential material in school records was inconsistent. Staff in the Schools Service did not always record information they shared or received, or the support

they provided to children. Some health records contained little information about contacts with children and families or with other services.

The *Shetland Personal Information Sharing Protocol* provided helpful guidance to staff about the importance of gaining consent before sharing information and of recording whether consent was given. Staff across services understood clearly when they needed to obtain consent from children and families to share information. They also knew when to share information without consent to protect children from harm. In most cases, health and social care staff ensured that consent was recorded appropriately. Reasons for not obtaining consent were not always clearly described in records.

Information about registered sex offenders was shared within well-established Multi-Agency Public Protection Arrangements (MAPPA), by representatives of all relevant services. Police officers submitted information about these offenders to the Scottish Intelligence Database (SID). Police officers and staff in the Criminal Justice Service (CJS) updated the Violent and Sex Offender Register (ViSOR) regularly to ensure the most accurate and recent information was available at all times. CJS staff and police officers carried out appropriate assessments of sex offenders jointly. Risk management plans were strengthened by health staff contributing information about sex offenders with medical needs.

Recognising and assessing risks and needs

Overall, recognising and assessing risks and needs was satisfactory. Staff across services recognised when a child needed help or was at risk. They referred their concerns to social workers or police officers promptly. Midwives routinely asked about domestic abuse and substance misuse as part of their pre-birth assessment process. A & E staff assessed risks to children appropriately when they attended for treatment. Health visitors were at an early stage of assessing and recording the needs of, and risks to, children. When a child protection concern was raised, a joint strategy meeting took place, where social workers and police officers planned effectively what action to take. This involved gathering information already known about the child and family from social work, health, education and police services. Following joint interviews, review meetings were held to discuss whether the actions taken successfully protected the child and what further action was needed. Health staff were not routinely involved when planning investigations. Managers had agreed to implement a new procedure where health staff would be consulted at all future joint strategy meetings.

Social workers had access to a number of risk assessment tools but generally used the *Department of Health Assessment Framework* or *My World Triangle*. Overall, social workers produced high quality initial assessment reports for child protection case conferences. The Children's Reporter gathered helpful information and made prompt decisions when assessing initial referrals. Staff from children's and adults' services completed few joint assessments when parents were either abusing substances or had mental health or learning difficulties. There was no common approach to assessment across services. The Integrated Assessment Framework (IAF) was piloted in one area but was in very early stages of development. A few very comprehensive non-offending parent assessments had been completed, which

helped staff to make appropriate plans for children. Some social workers produced well-documented and comprehensive assessments for case conferences or Children's Hearings. However, some assessments were too adult-focused when children were living in chronic neglect situations. Not all assessments gave sufficient analysis of longer-term risks and needs for effective plans to be made. A few decisions made by the Children's Reporter were based on telephone calls from social workers rather than written reports. These were based on expectations of future support rather than clear and agreed plans. Expected support was not always put in place.

Appropriately trained social workers and police officers conducted joint interviews effectively and in a sensitive manner. They decided if a medical examination was required, sometimes without medical advice. As a result, in a few cases, children's health needs may have been overlooked. Paediatricians were available in Aberdeen for advice to support local GPs but arrangements for some medical assessments lacked clarity. Children requiring detailed medical examination were taken to Aberdeen for specialist opinions and appropriate treatment.

Community Alcohol and Drugs Services Shetland (CADSS) staff were alert to risks to children when parents were abusing substances. They routinely asked service users about contact with children and what family support they had. CADSS staff contributed information to help case conferences assess risk. The alcohol service nurse assessed child and parent relationships during home visits. Some social workers used a helpful substance misuse checklist to enhance their assessments. Midwives tested women for substance misuse to decide when babies needed to be delivered in Aberdeen. Inter-agency guidance on working with substance misusing parents had yet to be fully implemented across services.

Planning to meet needs

Planning to meet needs was satisfactory. Staff across services met regularly in case conferences and reviews where plans to meet children's needs were agreed. Pre-birth case conferences considered the needs of unborn babies and agreed effective plans to support them after birth. All children on the CPR had a plan in place to help keep them safe. Most plans clearly identified actions to be taken forward and who would be responsible. However, recording of timescales for agreed actions and expected outcomes for children and families was inconsistent. In some cases, staff making plans did not give enough consideration to agreeing alternative actions should the plan fail.

Staff prioritised attendance at case conferences and reviews and were clear about their contributions. Health visitors and school nurses were not involved routinely in all case conferences and pre-birth meetings, although attendance had improved very recently. Staff working with adults were not always invited when they may have had a useful contribution to make. Minutes of case conferences were usually distributed within agreed timescales. Case conferences and looked after children's reviews were skilfully and sensitively chaired. However, chairs lacked sufficient authority to challenge staff practices across services. Overall, reports submitted to case conferences were comprehensive but some did not give sufficient analysis of risk and need. The quality of child protection plans varied. While some were detailed

and ensured staff and parents knew what actions were expected, too many were vague. They did not specify what needed to change to reduce risk to children and as a result, progress could not be measured easily.

The needs of looked after children were considered well and support plans updated at regular multi-agency review meetings. All children looked after away from home had a helpful individual education plan (IEP). Overall, looked after children benefitted from having well-monitored plans in place. In some cases, there were delays in progressing plans to meet children's longer-term needs. Children with additional support needs had helpful multi-agency support plans, which were reviewed regularly. There had been a delay in implementing the IAF. As a result, there was no clear and consistent structure to help staff jointly plan to meet the needs of vulnerable children who were not looked after or whose names were not on the CPR. Plans submitted to Children's Hearings helped panel members make well-informed decisions about children.

Plans to protect children were monitored by inter-agency core groups. Most staff gave priority to attending. Families' involvement in core groups ensured they played an important role in plans to keep children safe. Overall, core groups were effective at monitoring progress, reviewing new information and adjusting plans when circumstances changed. In a few cases, meetings did not take place regularly or within specified timescales. Some core groups did not focus sufficiently on evaluating the progress of plans and whether risks were reduced. Support to some children and families was not maintained when their names were removed from the CPR because services were not well coordinated.

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

An appropriate range of policies and procedures was in place to guide staff in their work to keep children safe. Shared plans for the delivery of children's services, including child protection services, promoted positive outcomes for children. However, there was insufficient monitoring and support for their implementation. Staff across services involved children in reviewing and developing services very effectively. Systems to ensure safe recruitment of staff and volunteers were robust. Most staff were helped in their work by appropriate training and support from their managers.

Aspect	Comments
Policies and procedures	Policies and procedures were good. All services had policies and procedures in place which provided staff with clear guidance for protecting children. These linked clearly to the shared vision for keeping children safe. Northern Constabulary was in the process of updating its guidance documents to ensure staff understood the implications of changes in the police force structure. Inter-agency child protection guidelines were followed consistently by staff across services. At times, insufficient attention was given to ensuring all staff fully understood and implemented new procedures. A helpful system was in place to update policies but the impact of some key policies had not yet been evaluated.
Operational planning	Operational planning was satisfactory. The multi-agency Integrated Children and Young People's Plan (ICYPP) was clear, informed by public consultation and linked appropriately to national policies. The CPC's business plan integrated well with the ICYPP and set out targets for improvement in appropriate areas. Both outlined high aspirations for all children and focused clearly on positive outcomes. Staff at all levels across services recognised the plans' objectives. However, both had too many action points for staff to implement them all. The ICYPP lacked clear implementation timescales and details of required resources. Some actions had been progressed but implementation had not been appropriately monitored. Staff responsible for progressing actions were not always given enough direction. Some services had established systems for reporting on performance but these did not all link directly to the ICYPP. The CPC's Quality Assurance Sub-committee was improving performance monitoring across services. However, not enough management information was yet collected and analysed.

Aspect	Comments
Participation of children, their families and other relevant people in policy development	The participation of children, their families and other relevant people in policy development was very good. Children and families were asked regularly for their views about the services they received. This was largely supported by the network of youth service provision, <i>Youth Voice</i> , which covered all communities. <i>Youth Voice</i> was well established and given financial and staffing support. The involvement of elected members through the Youth Cabinet helped inform the Council of important issues for children. Youth Services staff were extremely effective in ensuring almost all children were successfully included in developing local services and policies.
Recruitment and retention of staff	Arrangements for recruitment and retention were very good. There was robust practice on safe recruitment, which took account of legislation and national guidance. The Council ensured all community groups recruited staff and volunteers in a safe manner and supported them to do so. Innovative approaches by the Council and NHS to recruitment and retention had reduced vacancies and retained existing staff. Some services shared resources to make the best use of a limited number of staff. Staff absences had a significant impact on the delivery of specialist services. Procedures to monitor the impact of staff absence on key service areas were being developed.
Development of staff	The development of staff was good. Staff received relevant and helpful child protection training, which they could access without undue delay. Specialist training had been undertaken by staff who needed this to carry out their work. All NHS staff had personal development plans and Council staff regularly discussed their training needs. A number of courses were run on a multi-agency basis, effectively promoting joint working. Training for staff on substance misuse had been provided recently but not all staff who would benefit had attended. Health visitors, school nurses and some social workers did not receive supervision and support on a regular basis to help them in their work.

7. How good is individual and collective leadership?

Chief Officers and the Child Protection Committee (CPC) were strongly committed to improving outcomes for children. They ensured that the needs of vulnerable children were considered when planning and developing services. They encouraged and supported joint working across services. As a result, staff worked together effectively to protect children and meet their needs. There had been significant delays in implementing an integrated assessment framework. Managers promoted a strong culture of continuous improvement. Self-evaluation had influenced shared development priorities appropriately. The effectiveness of quality assurance processes varied across services.

Vision, values and aims

The impact of vision, values and aims was very good. The shared vision in the ICYPP outlined high aspirations for children and set the context for services' individual and collective work with young people. Respect for social diversity was seen in policies, public information, training and in the attitudes of staff and officers across all services.

- Elected members and senior officers of the Council gave a positive lead about the vision and values influencing services for children in Shetland. They ensured that children had equal access to high quality services to meet their needs, no matter how remote the area. Staff understood this clearly.
- The Chief Executive of NHS Shetland and senior managers prioritised child protection and the delivery of services for the most vulnerable children in Shetland. They continuously promoted and supported joint work with partners to meet children's needs. The Director of Public Health had a strong child protection focus and led several key improvements.
- The Chief Constable and the Divisional Commander ensured child protection was given high priority. They encouraged and supported the Area Commander in his role as CPC chair. The Area Commander ensured priority for protecting children was reflected in local policing plans. Police officers consistently demonstrated high levels of care and concern for children's welfare.

The Chief Officers and elected members ensured that the needs of vulnerable children were central in all plans for children's services. Staff across services showed a clear understanding of the values stated in the ICYPP and CPC business plan and incorporated them into their day-to-day work with children and young people.

Leadership and direction

Leadership and direction was good. Elected members, Chief Officers and senior managers understood the national context for child protection and were very clear about their individual and collective responsibilities to keep children safe. They ensured that staff in all services regarded child protection as high priority and acted accordingly. Staff in the health visiting and school nursing services lacked clear expectations from managers about the focus of their work to support children and families. As yet, no strategy had been agreed to direct joint work to improve the lives of children affected by parental substance misuse.

The CPC had appropriate representation from all services, including a diverse voluntary sector. It successfully ensured that all voluntary groups across the islands gave child protection high priority. The CPC's chair, vice-chair and lead officer provided effective leadership and support to help partners achieve the outcomes set out in the CPC business plan. The CPC was aware of the risk of overload on a small number of staff, and had begun to make appropriate use of subgroups and time-limited task groups to progress agreed actions. The quality assurance sub-committee had made an encouraging start in collating and analysing management information and leading improvements at a local level.

The CPC had sufficient resources to undertake its work effectively, through a budget to which all partners contributed. Council structures supported joint working to meet the needs of children and families effectively. Northern Constabulary was revising its structure, to ensure local resources for child protection were enhanced by support from the centre, when needed. Child protection was reflected appropriately in all strategic and operational plans. Chief Officers ensured resources were made available for vulnerable children and families, where needs were identified. Services pooled resources to develop specialised packages of care, ensuring that children with the most complex needs were able to remain in their own community.

Leadership of people and partnerships

Individual and collective leadership of people and partnerships was good. There were many examples of effective multi-agency working which demonstrated confident and trusting inter-agency relationships. A commitment to collective responsibility in protecting children was demonstrated by sharing key roles in the CPC across different services and willingness of all services to take a lead in progressing agreed actions. Structures and remits within the Council and NHS promoted a culture of working together across traditional boundaries. Managers were accessible and supportive.

Staff across services worked closely together to deliver safety programmes to young people in schools and in the community. Managers encouraged strong partnership working across services to provide effective support to the most vulnerable children and families. There had been delays in implementing the IAF which would require staff to plan together to meet children's needs. Despite considerable resources and attention from managers, the pilot had involved only a small number of families and the benefits for children were unclear. No clear plan had been agreed for wider implementation.

Managers made the best use of available resources by supporting staff to work flexibly and share tasks, where appropriate. There was close collaboration between CPC partners and the many small voluntary organisations and community groups. The Executive Officer of Shetland Council of Social Services (SCSS) shared information effectively across the voluntary sector, in her role as CPC member. Services worked well at a strategic level on Shetland Alcohol and Drugs Action Team (SADAT) but its action plan was not well connected to CPC planning. Relationships between front line staff in statutory services and CADSS had improved but there was no shared approach to the provision of addiction services.

Leadership of change and improvement

The leadership of change and improvement was good. Staff and managers were focused clearly on improving outcomes for children. Services had worked well together to complete an evaluation of their joint work. Two multi-agency case reviews had been conducted. Afterwards, learning was shared at an inter-agency seminar, with plans for this to become an annual event. Staff did not always have enough support to ensure changes were fully understood and established as part of their everyday work. The appointment of a Children's Services Improvement Officer was helping to bring about improvements to the consistency of planning to meet children's needs.

The CPC was very keen to learn from others and regularly sought examples of best practice from outside Shetland. For example, findings of child protection inspection reports from elsewhere had influenced the strengthening of arrangements locally to involve health staff in investigating concerns about children. Improving information systems within the Council were beginning to help managers monitor key areas of work with children and families. However, performance monitoring within social work and education services was not yet robust enough to ensure consistently high standards in important areas, such as case recording, information-sharing, and the effectiveness of core groups.

Close monitoring by the Child Health Child Protection Group and prompt action by managers had improved information-sharing between A & E and social work services. There had been little improvement in standards of recording within children's core health records, despite two case file audits. Quality assurance within SCRA and Northern Constabulary was strong. SCRA was introducing a peer review system for the Children's Reporter, to enhance scrutiny of work and provide opportunities for wider learning. Police officers from the Family Protection Unit routinely sampled child protection cases and provided feedback to the Area Commander on good practice and areas for improvement.

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

Summary

Inspectors were confident that vulnerable children were known to services and that staff took prompt action to ensure their safety when concerns were raised. Most families received appropriate support at an early stage to help them care for their children. Children were aware of how to keep themselves safe and they were listened to by staff who knew them well. Actions to protect children were based on effective initial assessments of risk. The longer-term needs of some children were not always thoroughly assessed, reviewed and met.

The Chief Officers and the CPC have a clear focus on improving services and have effective structures in place to take forward this work. In doing so they should take account of the need to:

- provide consistency in recording and ongoing assessment of risks and needs;
- improve arrangements for medical examinations to meet the needs of all children about whom there are concerns;
- improve planning to meet children's needs, including children whose names are not on the Child Protection Register;
- implement plans to monitor and review the impact of the Integrated Children and Young People's Plan; and
- agree a joint strategy to improve support for children affected by substance misuse.

9. What happens next?

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

**Helen Happer
Inspector
September 2009**

Appendix 1 Quality indicators

The following quality indicators have been used in the inspection process to evaluate the overall effectiveness of services to protect children and meet their needs.

How effective is the help children get when they need it?	
Children are listened to, understood and respected	Very good
Children benefit from strategies to minimise harm	Good
Children are helped by the actions taken in immediate response to concerns	Good
Children's needs are met	Good
How well do services promote public awareness of child protection?	
Public awareness of the safety and protection of children	Very good
How good is the delivery of key processes?	
Involving children and their families in key processes	Good
Information-sharing and recording	Satisfactory
Recognising and assessing risks and needs	Satisfactory
Effectiveness of planning to meet needs	Satisfactory
How good is operational management in protecting children and meeting their needs?	
Policies and procedures	Good
Operational planning	Satisfactory
Participation of children, families and other relevant people in policy development	Very good
Recruitment and retention of staff	Very good
Development of staff	Good
How good is individual and collective leadership?	
Vision, values and aims	Very good
Leadership and direction	Good
Leadership of people and partnerships	Good
Leadership of change and improvement	Good

This report uses the following word scale to make clear the evaluations made by inspectors:

Excellent	Outstanding, sector leading
Very good	Major strengths
Good	Important strengths with areas for improvement
Satisfactory	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

Appendix 2 Examples of good practice

The following good practice example demonstrated how services can work together effectively to improve the life chances of children and families at risk of abuse and neglect.

Child Safe Shetland

The Child Protection Committee (CPC) recognised that keeping children safe was not the responsibility of services or professional staff alone. All community groups and organisations required to ensure that staff and volunteers were suitable to work with children and that they had the knowledge and guidance they needed to keep children safe.

Child Safe Shetland was set up with funding from the Community Safety Partnership. Staff from a number of services provided training for local voluntary and community groups, to help them understand their responsibilities to protect children. This training was supported by an easy to use information pack, which included copies of all the forms and documents which groups needed. *Child Safe Shetland* met the costs of carrying out background checks on all staff and volunteers. Training was provided for staff and volunteers across the islands, to increase their confidence in recognising signs that a child needs help and to ensure they knew how to report any concerns. A dedicated website provided useful contacts, updates and links to other relevant websites. *Child Safe Shetland* and the work of the CPC was publicised widely in the local media.

Child Safe Shetland received widespread public support. Children have benefitted from a higher level of awareness about their safety. A recent public survey showed most people knew how to get help if they were concerned about a child's welfare. Staff and volunteers in community groups have increased their understanding of child protection and are better equipped to meet children's needs.

How can you contact us?

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