Child protection and welfare inspection report

Health Information and Quality Authority Regulation Directorate monitoring inspection report on child protection and welfare services under the *National Standards for the Protection and Welfare of Children*, and Section 8(1)(c) of the Health Act 2007

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of Service Area:	Sligo/Leitrim/West Cavan	
Dates of inspection:	23 – 25 February 2016 & 1 – 3 March 2016	
Number of fieldwork days:	6	
Lead inspector:	Grace Lynam	
Support inspector(s):	Bronagh Gibson Niamh Greevy Ruadhan Hogan Sharron Austin	
Type of inspection:	☒ **Announced** ☐ **Unannounced** ☒ **Full** ☐ **Themed**	
Inspection ID:	**753**	

About monitoring of child protection and welfare services

The Health Information and Quality Authority (HIQA) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

HIQA is authorised by the Minister for Children and Youth Affairs under section 8(1)(c) of the Health Act 2007, to monitor the quality of service provided by the Child and Family Agency to protect children and to promote the welfare of children.

HIQA monitors the performance of the Child and Family Agency against the National Standards for the Protection and Welfare of Children and advises the Minister for Children and Youth Affairs and the Child and Family Agency.

In order to promote quality and improve safety in the provision of child protection and welfare services, HIQA carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of HIQA's findings.

HIQA inspects services to see if the National Standards are met. Inspections can be announced or unannounced.

This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child-centred Services	☒
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☒
Theme 4: Use of Resources	☒
Theme 5: Workforce	☒
Theme 6: Use of Information	☒

1. Inspection methodology

As part of this inspection, inspectors met with children, parents and or guardians, other agencies and professionals. Inspectors observed practices and reviewed documentation such as child protection plans, policies and procedures, children's files and staff files.

The aim of on-site inspection fieldwork is to gather further evidence of performance against the *National Standards for the Protection and Welfare of Children*.

During this part of the inspection, the inspectors evaluated the:

- timeliness and management of referrals
- effectiveness of assessment and risk management processes
- provision of immediate help where required
- effectiveness of inter-agency and multidisciplinary work
- outcomes for children.

The key activities of this inspection involved:

- the analysis of data
- the review of local policies and procedures, minutes of various meetings, 25 staff files, audits and service plans
- reviewing/sampling 81 children's files and 29 adult files
- speaking with eight children and 15 parents in person or by telephone
- meetings with the area manager, 16 social workers, four team leaders, three principal social workers (one of whom was the chair of child protection conferences), one family welfare conference co-ordinator, two social care workers, one quality and risk manager, one training officer, one information officer, one home youth liaison worker, three administrators and a regional finance manager
- reviewing responses to questionnaires from 11 external stakeholders
- telephone interviews with seven external professionals including members of An Garda Síochána (the Irish police force), health services and educators
- observing staff in their day-to-day work
- observing practice in three child protection conferences reviews, one family support planning meeting, one multi-agency meeting, one team meeting, one core group meeting, one meeting between duty social worker and An Garda Síochána regarding adults of concern
- Two focus groups with social workers, and social care workers/social care leaders.

Acknowledgements

HIQA wishes to thank the children, parents, staff and managers of the service for their cooperation with this inspection.

2. Profile of the child protection and welfare service

2.1 The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (the Agency), which is overseen by the Department of Children and Youth Affairs. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency has responsibility for a range of services, including:

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- service response to domestic, sexual and gender-based violence.

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions each with a regional manager known as a service director. The service directors report to the chief operations officer, who is a member of the national management team.

Child protection and welfare services are inspected by HIQA in each of the 17 areas.

2.2 Sligo/Leitrim/ West Cavan

The Sligo/Leitrim/ West Cavan service area is situated in the West of Ireland. The overall population for Sligo/ Leitrim based on the 2011 Census of Population was 97,191 which included 24,879 children. The unemployment rate for Sligo was just under the national average as was the number of one parent families. Neither Sligo nor Leitrim were characterised by particular extremes with regard to affluence or deprivation. County Sligo was recorded as the 12th most affluent county in the state, (Pobal 2013) and Leitrim was the 13th most deprived local authority area in Ireland. The unemployment rate for Leitrim was just over the national average and it had a lower number of lone parent families than the state average.

The Sligo/ Leitrim /West Cavan service area was under the direction of the service director for the Child and Family Agency West Region.

The child protection and welfare service had three offices located in Sligo, Carrick-on-Shannon and Tubbercurry. There were four social work teams (two based in Sligo) directly line-managed by team leaders who reported to the principal social worker for children and families. A principal social worker chaired child protection conferences and an interim principal social worker managed the prevention, partnership and family

support (PPFS) aspect of the service. Each team had a number of social workers who had mixed caseloads which included welfare cases, child protection cases and children in care. Teams included social care workers, social care leaders, and administration staff. Home youth liaison officers employed by the Home Youth Liaison Service (HYLS) [1] were assigned to the social work teams. The area manager managed the service through the principal social workers.

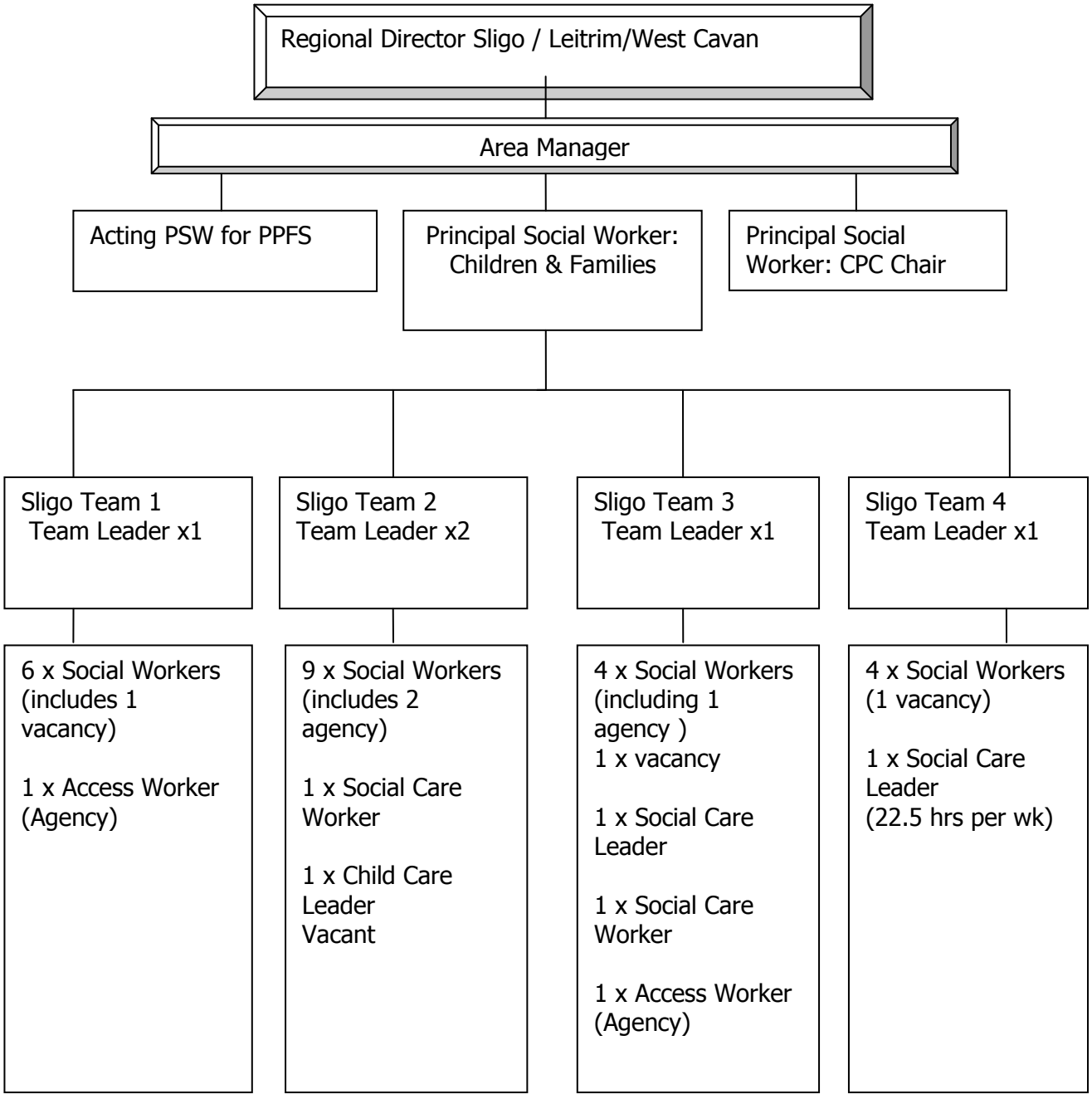
The area had received 1,069 referrals in the 12 months before the inspection and there were 576 cases open at the time the data was returned to HIQA. Of the 1069 referrals 294 referrals required initial assessments. One-hundred-and-nineteen of these were classified as child protection referrals and 156 were classified as welfare referrals. The area had 43 children on the Child Protection Notification System (CPNS) at the time of the inspection.

The organisational chart in Figure 1 describes the management and team structure of the child protection and welfare service, as provided by the Service Area.

[1] The HYLS is a not-for-profit organisation set up in the region in 1989 to provide a service to young people who were dropping out of school and not availing of training opportunities.

Figure 1: Organisational structure of the Child Protection and Welfare Service, Sligo/Leitrim/ West Cavan Area[*]

CPC= Child Protection Conference



[*] Source: The Child and Family Agency

3. Summary of inspection findings

The Child and Family Agency has legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. These children require a proactive service which acts decisively to assess and meet their needs in order to promote their safety and welfare. As much as possible, children and families require a targeted service aimed at supporting families. However, there will always be some children who will need to be protected from the immediate risk of serious harm.

This report reflects the findings of the inspection, which are set out in Section 5. The provider is required to address a number of recommendations in an action plan which is published separately to this report.

In this inspection, HIQA found that of the 27 standards assessed:

- Four standards were met
- Twenty three standards required some improvement

Overall, once children were allocated to a member of staff in the service, the majority of children and their families received a good service. However, children experienced delays in being allocated to a social worker and in their needs being assessed. Children who were identified as being at serious and immediate risk received a timely service and emergency action was instigated when required.

However, the service had not implemented the national service delivery model due to a shortage of staff. This meant that social workers were not organised into teams which focused on particular areas of social work such as intake and duty, child protection and welfare, family support and alternative care. Social workers were carrying mixed caseloads and therefore divided their time between the various social work services provided.

Social work interventions improved children's lives. Families and children reported that their experiences of the service were positive and beneficial. Overall, rights were respected and valued. There were some areas of practice which required improvement such as the promotion of the right to access information, raising awareness in the community about child protection issues and services, risk identification and management and consistent application of thresholds.

The area had a clear management structure and there were some effective management systems in place but others required improvement. Staff were aware of their responsibilities and there were clear lines of accountability at individual, team and service level. However, the quality of the leadership and oversight was mixed. There

were some systems in place to ensure the service was delivered in a planned and well resourced manner but risk management systems required improvement as not all risks within the service had been identified.

Staff vacancies were impacting on the ability of the area to provide timely services to all who required them. Recruitment of staff was an issue in the area and contingency plans for staff shortfalls had not been effective.

The information system in place ensured that necessary information was available and analysed by the service. Generally, the records kept on children and families were of a good standard but were not always up-to-date.

Whilst no significant risks were found, over the course of the fieldwork, inspectors brought three cases to the attention of the principal social worker for children and families. Written assurances were requested on one of these cases and the principal social worker provided assurances that risks had been addressed.

4. Summary of judgments under each standard

During the inspection, inspectors made judgments against the National Standards. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

National Standards for the Protection and Welfare of Children	**Judgment**
Theme 1: Child-centred Services	
Standard 1:1 Children's rights and diversity are respected and promoted.	Requires improvement
Standard 1:2 Children are listened to and their concerns and complaints are responded to openly and effectively.	Requires improvement
Standard 1:3 Children are communicated with effectively and are provided with information in an accessible format.	Requires improvement
Theme 2: Safe and Effective Services	
Standard 2:1 Children are protected and their welfare is promoted through the consistent implementation of Children First (2011).	Requires improvement
Standard 2:2 All concerns in relation to children are screened and directed to the appropriate service.	Requires improvement
Standard 2:3 Timely and effective actions are taken to protect children.	Requires improvement
Standard 2:4	Requires improvement

National Standards for the Protection and Welfare of Children	**Judgment**
Children and families have timely access to child protection and welfare services that support the family and protect the child.	
Standard 2:5 All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence.	Requires improvement
Standard 2:6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	Meets standard
Standard 2:7 Child protection plans and interventions are reviewed in line with requirements in Children First (2011).	Meets Standard
Standard 2:8 Child protection and welfare interventions achieve the best outcomes for the child.	Requires improvement
Standard 2:9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.	Meets Standard
Standard 2:10 Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.	Requires improvement
Standard 2:11 Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels.	Requires improvement
Standard 2:12 The specific circumstances and needs of children subjected to organisational and or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.	Requires improvement

National Standards for the Protection and Welfare of Children	**Judgment**
Theme 3: Leadership, Governance and Management	
Standard 3:1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Requires improvement
Standard 3:2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.	Requires improvement
Standard 3:3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.	Requires improvement
Standard 3:4 Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy standards.	Standard met
Theme 4: Use of Resources	
Standard 4:1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.	Requires improvement
Theme 5: Workforce	
Standard 5:1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.	Requires improvement
Standard 5:2 Staff have the required skills and experience to manage and deliver effective services to children.	Requires improvement

National Standards for the Protection and Welfare of Children	**Judgment**
Standard 5:3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	Requires improvement
Standard 5:4 Child protection and welfare training is provided to staff working in the service to improve outcomes for children.	Requires improvement
Theme 6: Use of Information	
Standard 6:1 All relevant information is used to plan and deliver effective child protection and welfare services.	Requires improvement
Standard 6:2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	Requires improvement
Standard 6:3 Secure record-keeping and file management systems are in place to manage child protection and welfare concerns.	Requires improvement

5. Findings and judgments

Theme 1: Child-centred Services

Services for children are centred on the individual child, their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use the services.

Summary of inspection findings under Theme 1

The social work service promoted children's rights and supported children to participate in decision-making. The staff valued the views of children and their families and consulted with them. Communication with families was good. The team did not raise awareness within the wider community about child protection and welfare issues and the social work service.

Children's rights

Children's rights were respected and promoted. Children were aware of their rights and were treated with dignity and respect. Social workers promoted children's rights such as their right to education, their right to participate in decision making, their right to live with their own families and their right to develop their own cultural identities.

External agencies reported that the social work service took a child centred approach, promoted and protected children's rights and that the child was the focus of social work reports. The United Nations Convention on rights was prominent in social work offices and social workers told inspectors this underpinned their approach to their work. One local team had a written declaration of what they stood for which outlined the values of the team and their aspiration to protect children. Parents told inspectors that social workers were "all about the children".

There was evidence on files of efforts made to promote children's right to education and maintain them in school. Children were seen alone by social workers and children told inspectors they could talk to their social workers. This ensured their right to be heard. Parents told inspectors they received information in writing following their attendance at meetings. Parental consent to share their information was sought when families were referred to support services. This practice promoted families right to privacy. Social workers and social care leaders acted as advocates for children: inspectors heard them discuss the need for children's homework to be supervised and the need for children to celebrate special events and saw evidence of their efforts to

ensure children had educational assessments carried out. Parents were supported to exercise their rights.

However, the right to access personal information was not consistently promoted and there was no evidence that children and families received written information about their rights including their right to make a complaint. Children were not sure what records were held on them or that they had the right to access their information.

Diversity

The service met children's needs in relation to diversity, disability and communication. Diversity was valued and the service was inclusive of families and children from diverse cultural and ethnic backgrounds. There was evidence of promotion of diversity: ethnicity and cultural background were recorded on children's files which also reflected cultural differences in parenting. Assessments reviewed by inspectors demonstrated identification of issues unique to particular ethnicities. Training in cultural diversity was included in the 2016 training plan.

Where children had special needs social workers made sure they were fully informed of the child's specific needs in order to consider them when planning for the child. For example, one social worker liaised with an autism therapist to find out about the particular needs of a child to ensure these were considered and included in the assessment of the child's needs.

The diverse needs of children were identified and met. Social workers considered children and young people's medical, gender, and cultural needs when undertaking assessments. Children's files contained accounts of the efforts made by social workers to support parents to ensure children's particular needs were met.

However**,** there were no communications systems available within the service in order to assist children with sensory disabilities.

Communication

Overall, communication with children and families was effective. The views of children were sought in relation to decisions being made about their lives and this was evident in files read by inspectors. Parents told inspectors that the service had been explained to them and they understood why social workers were involved with their family.

Children and parents were supported to express their views. Children had recently begun to participate in child protection conferences. Inspectors observed that social workers and the chair of the child protection conference supported and encouraged parents and children to express their opinions at meetings. Parents and children's views were well represented on their files and, where appropriate, social workers completed forms with children and young people in preparation for child protection conferences. One external agency observed that social work reports skilfully interpreted life from the child's perspective and inspectors saw evidence that social workers had spoken to

children about their daily routines. Parents spoken with told inspectors that communication was good and they were given information about the service. Others said that social workers were good at returning calls and that when they contacted them they were "straight on it" and very helpful.

There was evidence that where English was not the first language of families interpreters were used to facilitate clear communication and reports were translated into other languages as required.

Social workers made efforts to ensure parents understood the concerns the Agency had about their children. Inspectors found evidence of social workers meeting with families after case conferences to ensure parents were clear about what was required of them.

Social workers went to lengths to ensure they could communicate with all children. Inspectors read accounts in children's files about how social workers picked up tips from the speech and language therapist to assist them in communicating with children with learning difficulties. External professionals told inspectors that social workers went the extra mile to ensure children's needs were met.

Complaints

Complaints were well managed but recording of complaints required improvement.

The area was implementing the national complaints policy "Your Service, Your Say" and complaints were investigated and outcomes reached. The principal social worker for children and families was the complaints manager. Thirteen complaints had been made about the child protection and welfare service, though none of these complaints had been made by children. These included complaints about communication, information about the outcome, and access to services. Inspectors found that complaints were fully investigated and a decision was made in a timely manner. However, the complaints register did not always reflect if complaints had been resolved to the satisfaction of the complainant. There were also some completion dates missing from records and one in which the outcome was not recorded.

Some parents told inspectors they had been told how to make complaint about the service but they had not done so. Whilst complaints forms were generally available to the public inspectors did not see evidence of conversations with children about their right to make a complaint or how to do so. Children spoken with told inspectors they knew they could make a complaint about the service.

Complaints were analysed for learning. Complaints made in 2015 had been reviewed by the principal social worker for children and families to identify what could be learned from them to improve the service. Inspectors saw a document produced where the complaints had been grouped into categories such as access to services and information about the outcome of the complaint investigation. Actions were identified to address the

issues which included the re-structuring of the service into dedicated duty teams. This would address the issue about access to services. The actions identified were shared with team leaders at management meetings so that they would learn from them.

Raising awareness in the community

There had been efforts made to inform external professionals, such as general practitioners, about changes that were taking place in the service in relation to the criteria (thresholds) for acceptance of referrals.

The area manager and the principal social worker for children and families had given presentations at training events for professionals and community and voluntary groups. These presentations included information on how to make a referral and the different thresholds of need that determined whether or not a referral would be accepted by the social work department. Professionals told inspectors they could telephone the social work department for advice and guidance when they had concerns about children and that this was helpful and supportive.

However, the service was not proactive in raising awareness about child protection and welfare issues in the wider community or about the social work service provided. Whilst there were some leaflets about particular aspects of the service generally available to the public in the social work offices there was no concerted effort by the service to inform the general public about social work services or to raise awareness about child protection and welfare issues.

Theme 2: Safe and Effective Services

Services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect children from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the proper support mechanisms are in place to protect children and promote their welfare. Assessment and planning is central to the identification of children's needs, the risks to which they are exposed and the supports which need to be put in place for each individual child to keep them safe and maintain their wellbeing.

Summary of inspection findings under Theme 2

This inspection found that many elements of this service were delivered in an effective manner. Children at greatest risk were prioritised:child protection plans were in place and children identified as a result of retrospective disclosures were risk assessed and actions were taken to keep them safe. Initial assessments were thorough and interagency co-operation was effective.

However, there were some waiting lists and this meant that not all interventions were timely. Prioritisation and classification systems were not fully embedded into practice and services for supporting families required improvement. Closure of cases was not always prioritised.

Protecting children

When children were allocated to a social worker they were protected and their welfare was promoted through the implementation of Children First: National Guidance for the Protection and Welfare of Children (Children First (2011)).

Staff were aware of their legal responsibilities in relation to protecting children and promoting their welfare and told inspectors they carried out their function in line with Children First (2011) and legislation. There were a number of national guidance documents that ensured that priority was given to keeping children safe and these were available to staff.

However, there were waiting lists for assessments and for retrospective allegations of abuse and the system in place to manage the assessment wait lists was not robust.

Referrals and assessments

Child protection and welfare concerns were screened and assessed in line with national guidance and legislation but were not always timely. Screening is the process whereby referral information was reviewed to determine whether it was an appropriate referral to the social work service. Information provided for the inspection indicated that 1069 referrals had been received by the service in the 12 months prior to inspection. All referrals had been screened and 345 (31%) of these screened within 24 hours in line with the Agency's policy.

Preliminary enquiries were carried out in line with Children First 2011 to clarify the nature of the concern and document relevant information. One-thousand-and six preliminary enquiries were carried out. Once a referral was accepted the case was classified and prioritised and a decision was made on the basis of these whether it would be allocated to a social worker for initial assessment or put on a waiting list.

Not all cases were correctly categorized as welfare or protection. Inspectors reviewed files and found some mis-classification against the Agency's 'Thresholds for Referral to Tusla Social Work Services' guidance document. Social workers were familiar with the threshold guidance document but told inspectors that the thresholds were not fully embedded into practice. The mis-categorisation meant there was potential for some risks or unmet needs to be unidentified as such.

The majority of referrals were correctly prioritised using the Framework for Measuring, Managing and Reporting Social Work Intake, Assessment and Allocation Activity (MTP) document. Inspectors found a small number of cases that had been incorrectly prioritised. When this was identified to team leaders they reviewed and amended the priority rating of these cases.

Initial assessments were comprehensive and of sufficient quality to protect children and promote their welfare but were not all completed within the Agency's timeframes. Referrals were followed up by an initial assessment, carried out by the allocated social worker. This involved visits to the family and contacting other services in order to develop a full picture of the circumstances of the child and their family and in order to reach a conclusion about the risk of harm and to plan an appropriate response. Data provided indicated that 294 referrals required an initial assessment and 275 of these had been completed at the time the data was compiled - 37 of these within the Agency's required timeframe of 20 days. Inspectors found they included information about the child's development and the family's capacity to respond appropriately to the child's needs.

Following initial assessment 181 cases were closed, 96 cases were deemed to require a social work intervention. Of these, 47 required further assessment. While the quality of the assessments was good inspectors found that these assessments were extensive and

may have moved into the remit of a further assessment. The impact of this was that decisions about necessary interventions may have been delayed.

Further assessments were comprehensive and based on consultation with families. A standard framework:The Framework for Assessment of Children in Need and their Family was used to conduct the assessment. Good detailed assessments contained descriptions of children's circumstances and well presented accounts of their expressed wishes. Social workers reported on their observations of family life balancing the strengths of the family and risks to the children and clearly stating what improvements were required.

However, there were waiting lists for carrying out both initial and further assessments. Whilst the children at highest risk (determined by the information available at referral stage) were prioritised, the risks to the children on the waiting lists were unknown. The needs of these children were not assessed in a timely manner and therefore there was potential that these children could be exposed to unnecessary risk or had unmet needs. Team leaders reviewed all referrals at the intake stage to ensure there was no risk to children and that any actions required to keep children safe were taken. One-hundred-and-fifty-nine children were waiting for either an initial or a further assessment at the time the data was submitted to HIQA. Inspectors sampled cases on the waiting lists and did not find evidence of any child at risk awaiting assessment. However, inspectors sought assurances on two cases and received a satisfactory response.

There was a system in place to manage and record notifications from An Garda Síochána. There had been 213 Garda notifications in 2015 and 29 to the date of inspection in 2016. Team leaders had regular liaison meetings with An Garda Síochána to discuss management of cases and share information.

Just over half (51%) of all referrals were about cases known to the social work service. These were either closed or currently open cases. Inspectors sampled re-referrals and found that appropriate actions were taken to ensure children were safe and that their needs were met. These included re-prioritisation of cases, allocation of cases on wait lists, strategy meetings and core group meetings being held.

Planning for children at risk

Children who had been assessed as being at ongoing risk of significant harm were safe.

Children deemed to be at ongoing risk of harm were referred to the child protection conference system in a timely manner. Child protection conferences and reviews observed were well managed, organised and facilitated by a qualified and experienced principal social worker who had completed national training to carry out the role. There was no waiting list for a child protection conference and there had been no emergency child protection conferences. Minutes were circulated to all invitees within a reasonable period of time, usually within three weeks of the meeting taking place. Parents confirmed receiving these minutes. Information provided for the inspection indicated that 53 child protection conferences (relating to 142 children) were held in 2015. Inspectors observed three child protection review conferences and spoke with parents and young people about their experiences at these meetings. One was lengthy, lasting over three hours. At the child protection review conferences inspectors heard parents and young people expressing their views and they were received respectfully. Later, they told inspectors they felt listened to.

There were good child protection plans in place and they were reviewed appropriately. Child protection plans were comprehensive and clear and were reviewed in line with the requirements of Children First (2011). Inspectors sampled child protection plans and found that they were clear and actions were specific to the needs of each child. Plans clearly outlined the actions to be taken and their purpose, and who was responsible for implementing the actions. There was evidence that core groups (sub-group of professionals who attended the CPC meeting) were used to monitor the progress of child protection plans.

There was a national 24 hour CPNS in place. It was kept up to date by the chairperson. At the time of the inspection there were 43 children on the child protection notification system all of whom had an allocated social worker. Of the 43 children listed on the CPNS, 11 children's names were listed for a second time. Inspectors sampled these to assess whether children were taken off the system prematurely but found that in each case the decisions made were appropriate to the circumstances of the children. Forty names had been de-listed from the CPNS in the 12 months prior to the inspection. A child would be de-listed when a decision was taken at a child protection review conference that there was no longer ongoing risk of significant harm.

Inspectors found that there was a system in place to ensure that thresholds for listing names on the CPNS were met and that reviews were conducted in line with the timeframes set in Children First (2011). The rationale for decisions made was stated clearly whether this was to list or to de-list names on the CPNS.

Requests for a case transfer from one area to another where a child was listed on the CPNS were identified on the system. This was a way of ensuring that families that

moved from area to area continued to receive social work interventions. Inspectors reviewed one such case and found all appropriate actions had been taken to safeguard the children when the family moved between areas.

There were five children removed from their homes on emergency care orders and nine children temporarily removed under section 12 of the Child Care Act 1991. Inspectors sampled these cases and found that appropriate actions were taken to ensure children's safety. There had been Supervision orders obtained on seven children in 2015.

Welfare services

When families had an allocated social worker the welfare needs of children and families were identified and met and services supported families and protected children. In the cases inspectors reviewed children were appropriately referred between welfare and child protection services.

Services were provided directly by the child protection and welfare team and by external agencies and services. There was also a good system of community support services available to families but this was concentrated in the Sligo area and was only being planned in Leitrim. This meant that people in Leitrim had to travel to Sligo to avail of some support services.

Support services were provided under the Prevention, Partnership and Family Support (PPFS) service, managed by an interim principal social worker. Service allocation meetings took place where the needs of the family were discussed and the appropriate service or services identified to match the family's need. Forty-eight families, representing 93 children, had been referred to family support services in 2015. These services were provided by various organisations which received funding from the Agency and included family resource centres, Sligo social services (Meitheal service), Foroige and the family welfare conference service.

The Meitheal service was available to support families. Meitheal is a welfare service for supporting families and is the national practice early intervention model. The Meitheal Internal Procedures document guided staff in making a referral to the service. Forty five children availed of a Meitheal process in 2015. Inspectors read files and found that Meitheal was not fully utilised as an option when cases were being stepped down from child protection to the welfare category. Referral numbers to the service were low even though it was well developed in the area. This issue had been discussed at a senior management team meeting in January 2016 and a decision made to review the effectiveness of the Meitheal process.

When held, family welfare conferences (FWC) were used to promote the strengths within a family and prevent risk of harm to children. Referrals to the service were low and not consistent across the teams. In 2015, 35 family welfare conferences - relating to 66 children - were convened. There was no waiting list for family welfare

conferences and they were appropriately used at various stages of the child's journey through the system:as part of a child protection plan, as a step down option when a child's name was de-listed from the CPNS or before a child protection conference. Referrals were appropriate and an analysis of the service for 2015 seen by inspectors indicated that service users thought the process had resulted in an improved outcome for the child. Inspectors observed a family welfare conference and found the process was used to good effect. Inspectors sampled family welfare conference minutes and found they reflected positive collaboration with families. Meetings were well attended by family members and professionals and resulted in good, detailed family plans that were compiled by the family and monitored by family members for the benefit and safety of the children. The family welfare co-ordinator provided good oversight of the process and inspectors found evidence of good work undertaken with families in preparation for the conference.

Few families had written family support plans in place and the area did not have an internal family support service. The data provided for the inspection indicated that there were 250 family support cases but only 15 of these had written family support plans. Inspectors reviewed a sample of family support plans and found they were good, appropriate to the needs of the family as assessed by the social worker and they were appropriately reviewed. However, some of the family support plans on children's files were not fully completed. Inspectors observed a family support planning meeting and found that it was well attended and included the full participation of the family. A support plan was developed in collaboration with the parents and communication was supportive and respectful. Inspectors found that where families did not have written family support plans in place they were either receiving some social work services and support from external agencies or they were on waiting lists for services.

Families were further supported through direct work carried out by social care staff and the home youth liaison officers. Inspectors read accounts of some of this work and found evidence of good quality interventions that helped children and young people process difficult experiences. Parents told inspectors that staff supported their family, and regularly met with their children. They said this benefitted their children and also helped them as parents.

Support and specialist services

Children for whom an assessment had been carried out had timely access to supports and specialist services.

The area manager told inspectors that the area had the resources to provide bespoke services for families and there was evidence that families that had an allocated social worker were receiving the services they required. Inspectors did not find any evidence of children awaiting specialist assessments or services. Where children had special needs or medical requirements inspectors found good evidence that children received the services they needed and their families were supported in accessing them. These included assessments for speech and language therapy, occupational therapy assessments and autism services.

The social work team required further training in order to be competent in validating child sexual abuse referrals. The area did not have a specialist team for this work but the social work team worked collaboratively with An Garda Síochána on these cases. Inspectors sampled child sexual abuse cases and found evidence of good co-working with An Garda Síochána, thorough assessments of children's needs and behaviours and a focus on ensuring the safety of all children. Whilst some social workers had received training in this specialist area of practice others had not and further training was required to ensure there were always members of the team who were competent in the specialist interviewing of children. Further training in this specialist area was included in the 2016 training plan.

Case planning and management

Caseloads were monitored to ensure they were manageable but closure of cases was not consistently prioritised so that cases on the waiting list could be allocated more quickly.

Team leaders used a national caseload management tool:Guidance for Caseload Management, Framework for Measuring, Managing and Reporting Social Work Intake, Assessment and Allocation Activity to establish the workloads of social workers. However, inspectors found that closure of cases was not prioritised. Inspectors found a number of cases that should have been closed and were not. The implication of this was that social workers may have had capacity to take on more cases and this would not be correctly reflected in the caseload management process if they were carrying cases that should have been closed. The supervision process had identified that these cases should be closed but the work had not been done to affect the closure. At the time of inspection there were 262 unallocated cases, 28 of which were high priority.

Systems for managing waiting lists were poor. There was no policy in place to manage waitlists and there was no proactive management of the waiting lists on a day to day basis. Team leaders told inspectors that if further information was received about a

case on the waiting list they would review the case in light of the new information and decide whether or not it warranted a change in priority. Inspectors found one case on a list that had been awaiting allocation for eight months at the time the list was compiled.

In 2015, a review had been carried out of cases awaiting allocation for more than three months where a previous referral existed, the findings of which had been shared with the management team in September 2015 but there was no action plan to address the findings of the audit of re-referrals. Whilst high priority cases awaiting more than three months were identified on the risk register, the only control identified was to examine re-referrals and implement recommendations from a service review. It was not clear to inspectors how this would address the deficit.

The identification and management of long term neglect cases was not consistent. Inspectors reviewed a sample of files and found that whilst patterns of neglect were considered during assessments and identified through re-referral rates and analysis of parental engagement chronologies were not routinely kept on files. This was evidenced in a number of files read by inspectors. Inspectors found that there was no system in place to track children that were listed, de-listed and re-listed on the CPNS. This meant the area could not easily identify the children for whom being at ongoing risk of significant harm was becoming a pattern.

Inspectors sampled complex cases and found they were well managed through the range of interventions provided by the social work team. These included applications to court for legal proceedings, provision of support and welfare services, strategy meetings, core group meetings, the child protection conference and CPNS system. A practice support group had recently been established and one of its terms of reference was to discuss and maked decisions about cases identified as complex.

Transfer of cases was carried out in line with Children First 2011. Inspectors noted from file reviews that when families moved to another area the appropriate follow up action and liaison was carried out. The national CPNS system also identified whether children whose names were listed required transfer and this was a further safeguard for children at risk of ongoing risk of significant harm.

Caseload reviews by inspectors identified that social workers had manageable caseloads and social workers told inspectors they were well supported by their team leaders.

Interagency cooperation

Interagency working was effective. External agencies and professionals worked well with social work teams in the best interests of children and their families. There was evidence in files of good interagency working. Professionals attended meetings to discuss children and families and there was good sharing of information.

Social work teams reported good working relationships with An Garda Síochána which the Gardai confirmed. Team leaders told inspectors they had regular meetings with An Garda Síochána. Inspectors sampled the minutes of these meetings and found they were held four times a year. There was good exchange of information about cases, thresholds and new services, for example, the national out of hours service and how it could be accessed and adults that posed a risk. Questionnaires completed by members of An Garda Síochána reflected that their requests for information were dealt with promptly and professionally and that notifications were responded to appropriately.

There was ample evidence of good communication with external agencies and professionals such as teachers, general practitioners and support services for families. There was good sharing of information to protect children, meet their needs and support families. External professionals confirmed this. Where children had special needs and were involved with professionals in psychology and autism services they were included in the planning for these children. There was evidence of their participation in meetings about children and families and of contact with social workers. Inspectors spoke with school principals who confirmed that social workers linked closely with them. External agencies returned questionnaires to HIQA in which they described good working relationships with the social work department. They described information sharing and consultation as "excellent". They reported that there were sufficient opportunities to share information to keep children safe and that the service was accessible.

Learning

Serious incidents had been reported in a timely manner but there had been no local review and national reviews had not been brought to a conclusion. Managers acknowledged the importance of learning from serious incidents and reviews by the National review Panel (NRP) but were in the early stages of developing practice in this area. The practice support group was identified as the forum but the terms of reference for the group did not include this. There was some evidence that learning from serious incidents was disseminated but it was not clear how the learning was implemented in order to improve practice.

There had been one completed serious incident review in the area but the report was not available.

Organisational and institutional abuse

There had been no referrals of organised and institutional abuse in the 24 months prior to the inspection. The Child and Family Agency had a guidance note on the Protection of Children In Ireland From Organised and Institutional Abuse which had been circulated to social work teams.

All referrals were screened through the duty system. There was a national draft document guiding practice in the management of retrospective disclosures. There had been 96 retrospective disclosures made in the past 12 months. These were initially investigated in line with Children First (2011) to establish whether there was any current risk to children in contact with the alleged abuser. Inspectors reviewed a sample of cases and found that where children were identified appropriate actions were taken to ensure their safety. Three cases were brought to the attention of the principal social worker as there was insufficient information recorded around the actions that had been taken.

Forty-nine (51%) retrospective cases were on a waiting list for full assessment. The area manager told inspectors that of these 49 adult cases some work had been done on 16 of them. Inspectors noted when sampling retrospective cases that some could not be progressed for legal reasons or because the alleged abused was not identified sufficiently for investigation to commence. The area manager told inspectors that he had received approval for two additional posts to process these retrospective allegations and although a plan had been discussed to fill these from the current complement of staff and recruit new staff into the resulting vacancies, this had not been effected at the time of the inspection.

Team leaders kept and maintained lists of adults of concern. Inspectors sampled cases of retrospective disclosures and found evidence of information gathering and liaison with An Garda Síochána. All these cases had been audited and categorised and the associated risks were monitored through liaison meetings with An Garda Síochána.

Theme 3: Leadership, Governance and Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed and the system is subject to a rigorous quality assurance system. Services provided on behalf of the area are robustly monitored.

Summary of inspection findings under Theme 3

Some aspects of the management structure were effective but others were not. Whilst there were clear structures in place and the majority of staff were aware of their responsibilities management oversight and the quality of leadership varied and the level of individual accountability required improvement.

There were some systems in place to ensure that a safe, good quality service was delivered. Services provided on behalf of the Agency were well monitored. However, while risk was well managed the identification and reporting of all risk required improvement. Quality assurance systems were in place but required further development to ensure they were effective in improving service delivery.

Statement of purpose

The area subscribed to the national statement of purpose and function for the Child and Family Agency but did not have a local statement of purpose which reflected local needs. The service performed its function in accordance with legislation and national policies within the limits of available resources.

Management structures and systems

There were structures in place which identified clear lines of authority and accountability and staff were aware of their roles and responsibilities. However, the quality of accountability and leadership varied. The area manager was accountable for the service provided and the principal social workers reported to him. Parents who spoke with inspectors did not know who was in charge of the service.

The structure of the service was not in line with the national plan for service delivery which identified three functions: family support, child protection and children in care. The child and family social work team did not function in a standardised way. Each

team provided a duty and intake service which processed new referrals but there were inconsistencies in how the service was delivered and managed. Social workers carried mixed caseloads and this meant that they were sharing and prioritising their time across the three functions.

The quality of leadership varied in the service. Social workers told inspectors that team leaders were accessible and available and demonstrated good leadership. Inspectors observed the availability of managers to their teams for formal and informal consultation. Senior managers worked with the staff team on a number of issues relating to service and practice development. However, inspectors found that while the four teams were providing the one child protection and welfare service they did not present as a unified team.

There were some effective management systems in place but others required improvement. The service area had a number of national policies, procedures and guidance documents that guided their work. There was no system in place to ensure the full implementation of all these policies. Staff could access policies through a hub and some staff had copies of particular policies to hand. However, managers were unable to confirm that all policies were fully implemented.

The quality of communication varied throughout the service. Staff and managers communicated through a range of management and team meetings, emails, formal and informal supervision. Where meetings occurred regularly they were found to be an effective means of communication. Inspectors read minutes of meetings and found, in general, that there was good attendance, standing agendas, actions were identified and they were followed through at the next meeting. The main focus of meetings was improving services, discussing practice issues and policies, dissemination of learning, and required training. However, one team had not been meeting regularly and were not as up-to-date about changes.

Staff were aware of the scope of their decision-making powers and appropriately requested approval for additional funding from senior management. Whilst there was some evidence in case notes read by inspectors that decisions and the rationale for them were recorded this was not always clear.

Planning the service

There was no local 2016 service plan in place. The local 2015 service plan outlined strategic objectives and some of these had been achieved. There had been some informal discussions around the 2016 plan and the area manager identified that the 2016 plan would be informed by the Children and Young People's Plan for 2015-2017(developed by the Child and Young People Services Committee), findings from audits, the Child and Family Agency's corporate plan for 2015-2017 and business plan for 2016. There had also been a staff consultation process completed in preparation for the furure restructuring of the service.

However, there was no proactive management of waiting lists on a day-to-day basis. In difference to other areas who had utilised 'blitz' and other strategies to reduce waitlists, the area manager was relying on the recruitment of additional staff and the hiring of a private company to carry out all outstanding initial assessments prior to the re-structuring of the teams.

Risk management

Risk management systems required improvement. There was an Agency integrated risk management policy which guided the identification and management of risk. The area manager was responsible for managing risk within the service. The service area had a risk register but not all risks were identified on the register and not all identified controls were effective. For example the register did not identify the lack of access to a specialised trained team for validating child sexual abuse, and did not identify good rigorous oversight of waitlists as a control.

Not all risks were reported. There were a number of risk reporting methods used including local risk assessments, serious incident reporting forms and national templates for reporting case risks such as the Need To Know reporting mechanism. However, whilst staff told inspectors they should report risk to their team leader such as personal safety issues and risks related to cases these were not all reported. Team leaders were not able to tell inspectors how to identify or report service risks. One team leader had no training in risk management and a team leader told inspectors that they were supposed to report risks associated with unallocated high priority cases but that this was not done.

Quality assurance and monitoring

Quality assurance and monitoring processes were evolving within the area. The quality and compliance section of the national office had implemented a number of audits in November and December 2015 to review the areas adherence to internal processes and national standards. Inspectors viewed audit reports of adult retrospective abuse cases,

and closed cases, and a recently concluded CPNS and open cases audit. The audits, highlighted some good practice but also raised deficits.

The local area had conducted a number of audits to identify where service improvements were required, for example, high priority cases awaiting allocation for more than three months, and a sample of child protection and welfare cases. While issues identified through audits on particular cases were noted on the the information system not all of these had been actioned. In addition, while a lot of audits had been undertaken the managers did not have a clear strategy on how they would implement required improvements. Inspectors found that some audits had informed training requirements and an action plan was developed for others, but it was not consistent. In addition some action plans did not address all of the issues identified, for example mis-classification of cases.

Monitoring of service provision through service level agreements was rigorous. Service level agreements with voluntary agencies were in place and inspectors saw evidence of regular meetings that took place with all funded agencies providing services on behalf of the Agency. Inspectors read minutes of a sample of these meetings which showed that finances and the level of service provision being provided were discussed. In this way the agencies were held to account for the grants they received. Inspectors viewed a summary table of all these agencies which recorded all the relevant information relating to the service level agreements. This included levels of grant funding, whether a service level agreement was in place and the dates the agreement was signed by both parties, whether audited accounts had been received and a site visit conducted. However, inspectors found that three service level agreements were not signed by the area manager.

Theme 4: Use of Resources

The effective management and use of available financial and human resources is fundamental to delivering child-centred safe and effective services and supports that meet the needs of children.

Summary of inspection findings under Theme 4

Available resources were planned, deployed and managed but this needed to be tightened up. The service was under-resourced due to staff shortages and this had an impact on service provision. The allocation of resources was based on prioritised needs but this meant that some service needs were unmet. Financial resources were well governed. There were issues with unsuitable and insufficient accommodation.

Resources

Resources in the area were planned and managed to meet prioritised needs. Staff vacancies affected service delivery. Staff were, in the main, deployed to meet prioritised needs except when they were on duty. The area had five permanent vacancies for social workers and four additional posts approved. The area manager told inspectors that the plans to restructure the social work teams would help with the resourcing issue. When social workers were on extended periods of leave they were not replaced.

Staff resources for duty and intake could have been better deployed. For example, the social worker on duty each day did not spend all day doing duty and if there were no new referrals received they engaged in their own casework. Also, there were no efforts to proactively work the waiting lists if there were no new referrals to duty or to make opportunities to blitz (intensively work) waiting lists in order to progress them through the system.

Some resources were deployed to identified needs. In line with the national framework document Better Outcomes, Brighter Futures the government's agenda and priorities for children and young people from 2014-2020, there was a children's and young people services committee which was chaired by the area manager. A socio-demographic profile of the region and a local needs analysis had been conducted and this contributed to the development of the Children and Young People's Plan 2015-2017. This plan helped in ensuring that resources were deployed to the areas that required them most. Community resources were not accessible throughout the area's geographic catchment but this was being developed.

Office accommodation required improvement. The Carrick-on-Shannon offices were not fit for purpose but there were plans in place to re-locate. Inspectors attended one meeting in a room in Manorhamilton and observed that attendees kept their coats on

for the duration of the meeting due to the low temperature of the room. Other interviewing rooms in the Sligo office were located off public spaces which impacted on service users confidentiality.

Financial performance reviews took place on a regular basis. The area manager was required to work within existing budget allocation.There was regular finance meetings between the area manager and the regional finance manager to discuss expenditure and review the budget.

Theme 5: Workforce

Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children's services recruit and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.

Summary of inspection findings under Theme 5

The service was provided by a qualified staff team who had varying levels of experience. They were enthusiastic and committed to providing a safe service that was child-centred and effective. Induction procedures were good. Training provision was good and based on identified needs. However, staff vacancies were significantly impacting on the ability of the area to provide timely services to all who required them.

Recruitment

The majority of staff were recruited in accordance with legislation, standards and policies, but not all staff files were up to date. Inspectors reviewed 25 staff files, some of which were paper files, over two locations. The majority of the files sampled had appropriate references, qualifications, job descriptions and an Garda Síochána vetting. However, there was evidence of a probation process on one file only and there were no job descriptions on file for social care workers and child care leaders. The staff files at one location held very little evidence of professional registration and ongoing professional development. Therefore, it was unclear how the service ensured that all social work staff had up-to-date professional registration, which was required in order to work as a social worker.

Newly appointed staff received good induction. There was a national induction policy dated 2011 that was being implemented. The induction process was comprehensive and covered all relevant information for new staff including policies, legislation and guidance. Team leaders ensured all the information was covered with the new member of staff. There were checklists of relevant information and tasks to be completed to ensure induction was thorough. These were signed off by the team leader as they were completed. Inspectors spoke to newly appointed staff members who said they had been well inducted into their post.

Sufficient staff and skill mix

The area did not have sufficient numbers of qualified, competent and skilled staff to meet the needs of children and to ensure timely delivery of services. The staff providing the child protection and welfare service were appropriately qualified and had varying

levels of experience. They included social workers, social work team leaders, principal social workers, social care workers, social care workers and home youth liaison officers. There were some agency staff employed in the area and these had recently been offered and accepted permanent positions. However, other social work positions remained vacant and this impacted on the timeliness of service delivery.

Inspectors spoke with a number of staff at various levels of the service and all were committed to providing a good quality, child centred service. Inspectors observed staff carrying out their duties and dealing with the public and they were found to be professional and competent.

The administration team had recently been restructured and this had had a positive impact on the service. There was one administration support staff allocated to each of the four teams. There was also a dedicated administration staff member to support the child protection conference process. This improved the timely organisation of child protection conferences and the issuing of minutes following meetings.

Contingency plans for staff shortfalls were ineffective. Recruitment of staff was an issue in the area and national campaigns and panels had been unsuccessful. The area manager told inspectors that a local recruitment campaign had been run in an attempt to fill some of the vacancies and there had been a good response. However, at the time of the inspection, this campaign had not resulted in extra staff and he was struggling to fill vacancies.

Support and supervision

Supervision was timely but the quality of supervision varied and how it was managed and recorded was not consistent. There was a national supervision policy and staff, in general were supervised in line with the identified timelines. Team leaders had been trained in the provision of supervision.

Staff were supervised and supported both formally and informally. Newly appointed social workers, initially, had more regular supervision, in line with the policy. Inspectors reviewed a sample of all staff supervision records and found that although supervision was generally timely the quality of the supervision and the records was inconsistent. Some supervision records were detailed: they contained contracts and supervision schedules, a standard pro forma was used to record the session, decision-making was clearly recorded, actions were monitored to ensure progress and they contained and evidence of personal development planning. However, others did not. Training needs were not always discussed and files did not contain evidence of continuous professional development. Persons responsible for actions and timelines for achieving them were not always identified.

Social workers told inspector they felt supported: that both formal and informal supervision were positive and provided good support and clear guidance. Staff said that

team leaders were approachable and were available for informal consultation outside of scheduled supervision.

However, some supervision did not sufficiently challenge performance or monitor implementation of agreed actions. For example the roll out of the personal development plans for staff, agreed in March 2015 had not been implemented at the time of the inspection.

Training

Training was planned and available in the area. There was a regional training schedule for 2016 which was based on a training needs analysis for 2016-2019. This had been completed from information provided by managers regarding the training needs of the staff. The training schedule was aligned with the strategic objectives identified in the 2016 corporate plan. The training schedule was based on the national training plan facilitated but was also inclusive of local training needs. Inspectors saw training records which showed that training in interviewing children had been identified as a local need and had been provided in the area recently.

There was a specific training plan for newly appointed social workers. Inspectors reviewed the practice development training plan for newly appointed social workers and found that all workers names were on the planned attendance list for the session commencing in March 2016 and modules included multidisciplinary working, reflective practice and conducting home visits.

Attendance at planned training was not prioritised. Staff told inspectors that while training had been planned and they had been assigned to attend, they were not always in a position to attend due to workloads. Inspectors did not find that this had been addressed through supervision or management of caseloads.

Training provided in 2015 included court work, making the most of supervision, domestic violence, workflows, safe talk and interviewing children. Data provided for the inspection indicated that 91% of staff had received multi-disciplinary training in Children First 2011. Inspectors viewed training records which reflected that not all staff had attended all the training sessions provided.

Theme 6: Use of Information

Quality information and effective information systems are central to improving the quality of services for children. Quality information, which is accurate, complete, legible, relevant, reliable, timely and valid, is an important resource for providers in planning, managing, delivering and monitoring children's services. An information governance framework enables services to ensure all information including personal information is handled securely, efficiently, effectively and in line with legislation. This supports the delivery of child-centred, safe and effective care to children.

Summary of inspection findings under Theme 6

The information system in place ensured that necessary information was available and analysed by the service. This meant that managers could make informed decisions when planning and managing the service. However, the system was not robust and the level to which the available information was used differed at various levels of the service.

The information system

There was an integrated information system in place to support the delivery of child protection and welfare services. The information system was secure with differing levels of access based on your role within the organisation. The four teams used the same form for gathering the initial information about a new referral and this was used by administration staff to set up a computerised file on the case. Once the referral was on the system the information this provided a unique identifier to each child and the information could be accessed by the team. This meant that relevant data was available for any social worker following up on the case.

The information officer told inspectors there was good governance in relation to data and there had been no data breaches or information losses in the past 12 months.

The CPNS information system was a positive development. The availability of the national CPNS information system to relevant professionals on a 24 hour basis was identified as an improvement. Authority to access the national system was limited to certain users as it contained information about all the names listed on the CPNS nationally.

The service area was awaiting the implementation of the National Child Care Information System.

Collection and analysis of information

The information system assisted the management team to have access to good information to assist with planning, managing, delivering and monitoring children's services. The area manager told inspectors that there was lots of good information available to the social work team. Inspectors viewed a number of reports that were accessible from the system, including the numbers of open, allocated and unallocated cases, and numbers of referrals per area within the region and data collated for reporting to the national office. The information officer told inspectors that the system was used to generate reports for the area manager such as identifying areas where there were high numbers of re-referrals to assist with the re-structuring of the teams and deploying resources to meet identified need. While inspectors could see the value of gathering this data they were unclear how the information was used to improve the quality and safety of the service.

The information available to the social work team was not always used to best effect. The principal social worker for children and families did not collate statistics for the social work team as a whole so that, for example, she would know the priorities of all the cases on the waiting lists. Some of the data provided for the inspection was not specific to the child protection and welfare service as requested, had been collected separately for the four teams and had not been validated prior to submission to HIQA.

Practice in relation to sharing of information with families was inconsistent. There was a national policy on the provision of information to a parents or guardians. Inspectors found that staff were not familiar with this document or the guidance contained therein. A parent told inspectors they had requested their file under Freedom of Information legislation and had received a copy of it. The principal social worker for children and families told inspectors she had given a client a copy of their file when requested. However, some staff did not know what to do if a client requested a copy of their file, some said they would advise an application under Freedom of Information legislation and others said they would give the information.

Record keeping

Generally, the records kept on children and families were of a good standard but were not always up-to-date. Social work files were computerised and password protected. Inspectors found that the records were factual and accurate and were generally available on the information system. However, case notes were handwritten at the time of meeting and were not always inputted in a timely manner. Inspectors found some casenotes that were up to three months out of date. Therefore the records did not accurately reflect the work carried out. Parents were aware that records were kept on their interactions with social workers and told inspectors that the social worker listened to them and wrote down what they said.

Chronologies were not always available on files and this made it more difficult to track all the important events in a case file and to identify long term trends especially of neglect.

Case recording was not standardised throughout the area. The principal social worker for children and families had identified that a policy on case recording was needed to help guide practice. She had issued a guidance document to the team leaders in December 2015 on how to record case notes, but it did not include instructions to social workers to follow the guidance or any suggestion that files would be audited to ensure its implementation. In addition to computer files social workers notes in hard back books from which they updated their computer records but practice in relation to how these were stored or destroyed was inconsistent.

There was an efficient case archiving system in place which staff were aware of and used appropriately. Archived hard copy files were stored externally by a private company. Social workers said they did not have any difficulties with accessing closed files.

There was some auditing of record keeping in the 12 months prior to the inspection but it was not clear to inspectors what actions had been taken to improve recording as a result of these audits.