The Regulation and Quality Improvement Authority

A Review of Child Protection Arrangements in Northern Ireland

Overview Report

July 2011

informing and improving health and social care
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Table of Contents

EXECUTIVE SUMMARY

In May 2008 the Regulation and Quality Improvement Authority commenced a review of child protection services in Northern Ireland. Due to the nature and complexity of child protection issues, a phased approach was adopted. Stage 1 focused on corporate leadership and accountability reflecting the main themes in chapter 2 of the Social Services Inspectorate (SSI) Overview Report, Planning, commissioning, monitoring and management and provision of child protection services, December 2006. In October 2008, the trusts completed a self-assessment and evaluation against nine selected recommendations from chapter 2 of the SSI Overview Report.

During January 2009 a review team, comprising senior RQIA staff and experts from across the UK, interviewed a number of executive and non-executive directors in each of the five trusts, to assess the progress they had made against recommendations relating to leadership and accountability.

The discharge of statutory functions and governance oversight arrangements were generally well evidenced by trusts. The trust executives and non-executive directors, involved in the interview process, had a clear understanding of the corporate parenting role. There were, however, difficulties identified in workforce planning, recruitment and retention in some trusts and some ambiguity around the roles and responsibilities of lead and designated doctors. It was noted that trusts reported clearly on processes for the escalation of challenges in meeting statutory functions to the Health and Social Care Board and the Department of Health, Social Services and Public Safety (DHSSPS).

Stage 2 focused on chapter 4 of the SSI Overview Report and addressed recommendations concerning access to services by children and families, the implementation of case conference procedures, and how trusts responded when approached by members of the public about child protection concerns. The Voice of Young People in Care (VOYPIC) was commissioned to undertake a consultation exercise with a number of parents, across the five trusts, who had experienced child protection or family support services.

There was positive feedback in relation to user experience of contact with reception staff. Parents also reported general satisfaction with social work duty systems and social work response times. They advised that they were offered practical support to attend case conferences, receiving a copy of the report two days prior to the conference.

Despite this, families expressed confusion with regard to the concept of family support. They did not necessarily equate social work intervention with support for their families. Families across all five trusts reported varying waiting times for access to family support services and a wide variation in the quality of the physical environment of reception areas.

Stage 3 focused on recommendations 29 and 30 of the SSI Overview Report, which covered record keeping; file structure; evaluation; and case auditing by management. RQIA developed two audit tools; the first audit tool was based around measuring trust performance against recommendations 29 and 30. The second tool was based on the audit tool contained in the DHSSPS Regional Policy, Supervision Policy, Standards and Criteria and was used to conduct a detailed analysis of the quality of record keeping in selected files.

The review team, comprised of professional staff from other regulatory bodies in both the Republic of Ireland and Wales, carried out a records audit in each trust. The audit of files indicated that the Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment framework was becoming well established across the five trusts, although there were inconsistencies in the quality of completion of assessments both within and across trusts. The audit found inconsistent file structures across trusts and a lack of compliance with departmental Reform Implementation Team (RIT) led policies.

Deficits in compliance with regional child protection policies and procedures were identified in all five trusts. In four trusts, concerns were such that RQIA had to invoke the escalation policy and bring these to the attention of senior management within the trust. Highlight reports were issued to the respective trust chief executives and to the DHSSPS.

Stage 4 focussed on quality assurance, managing performance of service and access to services. This stage was delivered in two components. The first looked at the delivery of safeguarding from a trust perspective and the implementation of recommendation 36, to ensure that child protection services were responsive to the needs of children and their families. Services must operate to high standards, whilst conforming to regulations, guidance, policies and procedures and the monitoring of this by the Health and Social Care Board. RQIA constituted an expert review team to assess supervision processes in each of the trusts across social work, nursing and paediatric staff with safeguarding responsibilities. The specific focus was on recommendations 37 and 38 of the SSI overview report in relation to the provision and audit of supervision arrangements for staff with child protection responsibilities.

The second component consisted of an environmental assessment of a selection of children's services facilities across the five trusts.

There had been significant cooperation between DHSSPS, the trusts, the Health and Social Care Board and prior to this, the legacy health boards. This cooperation led to the establishment of the Reform Implementation Team (RIT). This initiative has been instrumental in developing a range of policies and procedures, designed to address the quality, coordination and consistency of approach across the region.

The various RIT products have had a significant positive impact on the delivery of child protection services across Northern Ireland. The review, however, did find some deficits in respect of the provision and recording of supervision, compliance with departmental guidelines for assessed year in employment (AYE) within two trusts, and a general lack of consistency around developing a robust caseload weighting system in all trusts.

In relation to medical and nursing staff, the review confirmed there was a drive towards establishing a supervision policy for nurses and midwives involved in safeguarding and a framework for supervised and supportive practice for consultant and career grade paediatricians.

The RQIA review team visited three children's services facilities in each trust. These local offices accommodate functions such as face to face interviews with children, young people and families, one to one work with young people, case conferences and looked after children reviews.

Progress was measured against recommendations 20 and 25 of the SSI Overview Report in relation to the promotion of access to services and the quality of facilities within local children's services offices. The RQIA team evidenced some well-designed and maintained facilities, however, in some facilities there were some significant issues relating to decor and maintenance.

Stage 5 focussed on interagency cooperation at the point of referral and measured trust compliance against recommendation 23 of the SSI Overview Report in relation to the arrangements for other agencies to receive information and feedback on referrals made by them. An audit was carried out by a team of RQIA staff with expertise in child protection, health visiting and quality improvement, using an audit tool developed around processes outlined in Area Child Protection Policy and Procedures. Selected case files were reviewed to assess the timeliness and quality of communication between social services and other agencies, at the time of referral, in line with Area Child Protection Committees' Regional Policy and Procedures.

This review team confirmed that systems were well established at the point of referral and social services staff responded to referrals in line with procedures. In the selected files audited, where child protection was identified at the referral stage, child protection procedures were initiated appropriately. The Understanding the Needs of Children in Northern Ireland (UNOCINI) assessment framework was evidenced in all files chosen for audit. The review team noted the lack of use of the UNOCINI framework by other agencies making referrals to social services. There was also a tendency for referring agencies not to follow up referrals in writing. This stage of the review also noted inconsistent approaches to the management of out of hour's referrals.

In all instances, recommendations were made at local trust level and at a regional level to effect improvement in the quality and safety of child protection services in Northern Ireland.

Section 1: Introduction

The Regulation and Quality Improvement Authority (RQIA)

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

RQIA's main functions are:

- to inspect the quality of health and social care services provided by health and social care bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies; and
- to regulate (register and inspect) a wide range of health and social care services delivered by HSC bodies and by the independent sector. The regulation of services is based on minimum care standards to ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality.

RQIA's Corporate Strategy 2009-12 provides the context for the representation of RQIA's strategic priorities. Four core activities, which are integral components of what the organisation does and critical to the success of RQIA and the delivery of the strategy, are:

- **Improving care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care.
- **Informing the population:** we publicly report on the safety, quality and availability of health and social care.
- **Safeguarding rights:** we act to protect the rights of all people using health and social care services.
- **Influencing policy:** we influence policy and standards in health and social care. Achievement of these core activities, underpinned by identified value drivers and resources, will help to drive the delivery of the corporate strategy.

Context for the Review

The United Nations Convention on the Rights of the Child (UNCRC) is an international treaty that grants all children and young people a comprehensive set of human rights. These include the right to grow up in an environment of happiness, love and understanding and the right to develop their personalities, abilities and talents to the fullest potential.

The Northern Ireland Government's 10 year strategy for children and young people Our Children and Young People - Our Pledge 2006, reflects these rights and identifies "living in safety and with stability" a key outcome for children and young people. The rights identified in the UNCRC and reflected in Our Children and Young People - Our Pledge are enshrined in the Children (Northern Ireland) Order 1995.

The statutory provisions under part VI of the Children (Northern Ireland) Order, in relation to duties and responsibilities around the protection of children, are delegated under schemes of delegation to the five health and social care trusts.

In May 2008, RQIA began a two year review of child protection services in Northern Ireland. The review focused on selected recommendations from the report 'Our Children and Young People Our Shared Responsibility' (referred to as the SSI Overview Report). Where relevant, it also took into account recommendations from the Independent Inquiry Panel into the deaths of Madeleine and Lauren O'Neill (referred to as the O'Neill Report), and the Independent Report into the Agency Involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their children (referred to as the Toner Report).

Due to the size and scale of child protection services in Northern Ireland and the number of recommendations in the SSI Overview Report, the review was subdivided into the following five discrete stages:

- Stage 1 - Corporate leadership and accountability
- Stage 2 - The views of service users
- Stage 3 - Quality of record keeping
- Stage 4 - Quality assurance, managing performance of service and access to services
- Stage 5 - Interagency communication at point of referral

This report aims to draw together a summary of the published findings of all five stages. It also provides a summary of actions taken by trusts in respect of recommendations made. This overview report is underpinned by individual trust reports for each stage of the review. These reports have been published and are accessible on the RQIA website at www.rqia.org.uk.

RQIA would like to thank and acknowledge the cooperation of staff in each of the five trusts and would particularly like to highlight the invaluable role played by each of the trust affiliates who facilitated the five stages of the review.

Terms of Reference for the Review

This review aimed to:

I. Evaluate the implementation of identified recommendations of the SSI Overview Report within HSC Trusts.

II. Inform on the actions being taken by HSC trusts to implement relevant Reform Implementation Team (RIT) policy directives and to apply the relevant RIT guidance documents (relevant to those recommendations of the SSI Overview Report under review).

III. Evaluate the implementation of key recommendations (relevant to those recommendations of the SSI Overview Report under review) of the Report of the Independent Inquiry Panel into the deaths of Madeleine and Lauren O'Neill which relate to child protection.

IV. Inform on the actions being taken by HSS Boards with regard to the transition arrangements in place to ensure continuity of child protection services.

V. Highlight for review in the future and, as appropriate, any other relevant issues which may arise during the course of this review.

The recommendations made within this overview report represent the high level recommendations made to each trust reviewed. More detailed information is available within individual trust reports.

Progress since the Review

As part of the compilation of this overview report, RQIA requested that trusts complete and submit to RQIA a template outlining the progress achieved against each of the recommendations made during the five stages of the review. Following a review of trust responses, RQIA were satisfied that all recommendations were fully addressed or in the process of being addressed.

Since the review the Health and Social Care Board has progressed a number of initiatives which address child protection arrangements across all trusts. These will remain in place until the establishment of the Safeguarding Board for Northern Ireland. The establishment of the Safeguarding Board for Northern Ireland will fundamentally change the governance of child protection services across Northern Ireland.

The Health and Social Care Board continues to address a range of work streams as indicated through the structure of the RIT process. The work streams include the following:

- information systems
- roles and grades
- evaluation
- Safeguarding Board for Northern Ireland
- training
- children's services planning
- guide to case management in public law
- looked after children
- caseload management model

Section 2: Overview of Stages 1 - 5

1.0 Stage 1: Corporate Leadership and Accountability of Organisations

1.1 Introduction

Stage 1 focused on corporate leadership and accountability which are the main themes in Chapter 2 of the SSI Report, Planning, commissioning, monitoring and management and provision of child protection services. Reference was also made to the Quality Standards for Health and Social Care, theme one, Corporate Leadership and Accountability of Organisations.

1.2 Key Findings

1.2.1 In all trusts there were clear lines of management accountability and professional responsibility from front line staff through to the chief executive and the trust board.

1.2.2 There were clear and transparent lines of responsibility for child protection services through a named lead director. Systems and processes were in place to support the director to meet these responsibilities.

1.2.3 Trusts roles and responsibilities as a corporate parent were clear, appropriately supported and well established.

1.2.4 Governance arrangements and procedures were in place across all trusts, including risk management, however the robustness of these processes varied.

1.2.5 All trusts had developed good relationships with the commissioner which included robust monitoring and reporting mechanisms and all trusts were able to demonstrate the discharge of their statutory functions.

1.2.6 The roles of the named doctor and named nurse were apparent in all trusts; however integration into trust structures was at differing stages of progression.

1.2.7 Trusts outlined significant pressures and resource limitations in the deliverance and maintenance of services within the climate of the comprehensive spending review.

1.2.8 There were capacity issues in relation to support services within children and young people's services which require a resolution. There was an absence of an overarching workforce strategy noted within the Western Trust.

1.2.9 Within the Southern, South Eastern and Western trusts there were significant issues relating to the recruitment and retention of social work staff within children's services and the related issue of the number of assessed year in employment (AYE) staff in front line posts.

1.3 Recommendations

The following represents a composite overview of high level recommendations made in respect of all trusts. The recommendations relating to specific trusts can be found within the individual trust reports.

1.3.1 Trusts should ensure they have a robust governance programme in place including directorate level risk registers and incident reporting.

1.3.2 Where deficits were identified the specific trusts should prioritise the need for the urgent recruitment and retention of social workers within children's services.

1.3.3 The Western Trust needed to develop an overarching workforce strategy as a matter of priority.

1.3.4 Where integration of roles of the named doctor and named nurse is limited, trusts should consider how the dedicated child protection resource can be developed to provide child protection services throughout all aspects of health care.

1.3.5 Trusts should have auditable information that demonstrates the effectiveness of professional responsibility and accountability; this should include systems for capturing all training provided to staff.

1.4 Progress as identified in Action Plans

1.4.1 All trusts reported having robust governance programmes in place including directorate level risk registers and incident reporting.

1.4.2 Where deficits were identified the specific trusts reported continued efforts to proactively recruit and retain social workers within children's services.

1.4.3 The Western Trust confirmed that it has commissioned work to produce an overarching workforce strategy for the organisation. This remains a work in progress.

1.4.4 It was reported that systems are either established or temporary interim systems are in place across all trusts to record details of all training provided to staff

1.4.5 The Health and Social Care Board reported having developed and implemented the Regional Child Protection Committee (RCPC) which replaces the legacy Area Child Protection Committees arrangements. The Regional Child Protection Committee adopts a regional focus drawing on membership at a senior level from a range of statutory and voluntary agencies. The RCPC convenes every two months. The work of the committee is supported by a number of working sub-groups:

i. Case Management Review Sub-Group
ii. Policy and Procedures Sub-Group
iii. Education, Training and Audit Sub-Group
iv. Communication and Public Relations Sub-Group

The Regional Child Protection Committee Chair and Safeguarding Officer also meet regularly with Trust Child Protection Panel Chairs (TCPP). The Regional Child Protection Committee developed and implemented a quarterly statistical report which is presented to the Regional Child Protection Committee. The report highlights key themes at both regional and Trust levels identifying trend data on child protection activity. Trust Child Protection Panel chairs also provide regular updates on local activity to the Regional Child Protection Committee. The Regional Child Protection Committee completed a review into gateway thresholds which was presented to the RCPC on the 28 January 2011.

1.4.6 The Director of Social Work and Children, Health and Social Care Board chairs a Children's Services Improvement meeting involving Directors of Social Work from each of the health and social care trusts. The meeting addresses issues around demand and capacity; thresholds; court work; dual process arrangements for children on the Child Protection Register who are also looked after and staffing arrangements. It is also a vehicle to take forward key issues within children's services on a cross trust basis.

2.0 Stage 2: Regional Views of Service Users

2.1 Introduction

Stage 2 concentrated on Chapter 4 Access to Services and addressed recommendations 20, 21, 24, 25 and 26 of the SSI Overview Report. Recommendation 28 from Chapter 5 was also covered as this had a particular emphasis on user involvement and engagement with social services.

Given VOYPIC's particular experience in engaging service users, they were commissioned to undertake a consultation exercise with a number of parents across trusts that had experience of child protection, or family support services. The objective of the consultation was to ascertain the views of parents against the recommendations from the SSI Overview Report set out above.

2.2 Key Findings

Family Support

2.2.1 There was a waiting list for family support services in all five trusts.

2.2.2 There was very positive feedback in relation to reception and duty social work staff, who were described in the consultation as being courteous and responsive.

2.2.3 There was positive feedback in relation to social work response times to service users' individual queries.

2.2.4 The physical standard of reception, waiting and meeting rooms varied both across and within trusts. There was a positive response regarding the design of the new health and wellbeing centres.

Child Protection

2.2.5 The majority of parents received case conference reports at a minimum of two days before a case conference, with only isolated examples falling out-side this timeline.

2.2.6 The majority of parents stated that they had received practical support to attend case conferences.

2.2.7 Case conferences and meetings were not always arranged in consultation with parents.

2.2.8 The majority of parents who had children on the child protection register expressed an understanding of the protection plan and what needed to happen to ensure deregistration.

2.3 Recommendations

The following represents a composite overview of high level recommendations made in respect of all trusts. The recommendations relating to specific trusts can be found within the individual trust reports.

2.3.1 Trusts should produce clear and concise information on all services that families in need can avail of. This should detail the process involved in accessing these services and the contact and referral details.

2.3.2 Trusts should involve families who have experience of family support and child protection services in the development of information materials.

2.3.3 Trusts should ensure compliance with the Regional Child Protection Policy and Procedures in relation to the involvement, preparation and participation of children, young people and parents in the child protection process.

2.4 Progress as identified in Action Plans

2.4.1 Trusts reported having produced information leaflets on all services that families in need can avail of including Gateway and Family Support services which are available at point of referral. Trust websites also provide access to some of this material.

2.4.2 In addition to individual trust actions, the Health and Social Care Board is in the process of developing a family support database which will be made available to all five trusts and to all other stakeholders. The database will contain information on all services available to families in need.

2.4.3 Trusts reported continued use of different mechanisms to involve families and young people, with experience of family support and child protection services, in the development of information materials.

2.4.4 It was reported that trusts continue to ensure compliance with the Regional Child Protection Policy and Procedures in relation to the involvement, preparation and participation of children, young people and parents in the child protection process. This includes the enhanced participation of young people in case conferences.

2.4.5 The Regional Child Protection Committee reported having commissioned the development of information leaflets on the Child Protection Process for Under 12s and Over 12s which has been taken forward by VOYPIC (Voice of Young People in Care) in consultation with young people.

3.0 Stage 3: Quality of Record Keeping

3.1 Introduction

Stage 3 of the review focused on an audit of social work case files relating to initial referral, child in need and child protection. The audits took place across the five trusts between January and March 2009. Record keeping was selected for audit as it was a recurring theme and is referenced in the SSI Overview Report, Toner and O'Neill Reports. In February 2008, the DHSSPS published Supervision Policy, Standards and Criteria, and Administrative Systems, Recording Policy and Standards. Regionally these policies and standards were being implemented by co-ordinators appointed in each trust.

At the time of this review these policies had only recently been published, therefore full compliance was not expected. Where possible any findings and recommendations made were structured to support the full implementation of these standards.

3.2 Key Findings

3.2.1 There was a lack of consistent file structure both within and across trusts. This included limited progress in the implementation of Recommendation 30 from the SSI Overview Report and compliance with regional administrative systems and recording policy, however work was under way in relation to implementing this policy across the trusts.

3.2.2 In the majority of files audited, there was an absence of case management evaluation and audit, as outlined in recommendation 29 of the SSI Overview Report and the regional Supervision Policy. However, in contrast, it was noted that in two social work teams, in the Belfast and Western trusts, practice in this area was found to be of a very high standard.

3.2.3 In the Southern and Western trusts, there was a significant issue relating to the protracted timescales for processing cases through the gateway service, with a number of cases falling outside departmental guidelines (Gateway Services Processes, Guidelines April 2008).

3.2.4 In all trusts, the volumes of work processed through the gateway service created difficulties in relation to prompt allocation to Family Intervention/Support Teams. It was noted across all trusts that the receiving teams continued to hold generic type caseloads, including court related work and Looked After Children cases.

3.2.5 In all trusts, deficits were noted regarding compliance with Area Child Protection Committee, Regional Policies and Procedures, including:

- misidentification of child protection cases at referral stage
- deficits in initial assessments
- difficulties in ensuring case conference quorums are met, as outlined in ACPC Policy and Procedures
- poor definition of Core Groups within Protection Plans and lack of contingency planning and action when they do not take place.
- in all four Trusts there were examples where child protection case conference minutes were not produced in line with ACPC timescales.

3.2.6 The audit showed that the use of the UNOCINI assessment tool at the initial referral stage was well established in practice, 92% of the files examined contained a UNOCINI assessment.

3.2.7 Deficits were noted in four trusts with regards to the standard of completion of the UNOCINI. The development of the UNOCINI format, beyond the initial assessment, into Child Protection, Family Support and Looked After Children was less evident.

3.2.8 All trusts had a number of child protection UNOCINI's completed within their child protection cases. Two of the trusts had examples of family support pathway assessments completed within their Family Support teams.

3.3 Recommendations

The following represents a composite overview of high level recommendations made in respect of all trusts. The recommendations relating to specific trusts can be found within the individual trust reports.

3.3.1 Trusts should continue the implementation of the new file structure directly informed by Departmental policy and guidance and ensure all files include a summary and chronology of significant events within case planning. Records should evidence planned and purposeful work with children, young people and their families.

3.3.2 Trusts must ensure case supervision is consistent across the organisation. This should include the evaluation and audit of a proportion of case files by senior managers, as outlined in the RIT Supervision Policy, Standards and Criteria.

3.3.3 Where there are unallocated cases, trusts should ensure that following initial referral, allocation and social work intervention should occur within statutory timescales. If this cannot be managed, it should be noted and be subject to on-going risk assessment and risk management.

3.3.4 Trusts should ensure on-going adherence to the Area Child Protection Committee Regional Child Protection Policy and Procedures in relation to investigation and assessment timescales and multidisciplinary attendance at child protection case conferences.

3.4 Progress as identified in Action Plans

3.4.1 Trusts stated that they are continuing to implement the new file structure directly informed by departmental RIT policy and guidance, which includes the use of a summary and chronology of significant events within case planning records.

3.4.2 The Health and Social Care Board, in partnership with the DHSSPS and trusts, developed an audit tool to address the RIT products. This was piloted within two trusts and a regional training day has now been scheduled for all trusts in preparation for implementation.

3.4.3 To ensure consistent case supervision across organisations, all trusts reported having systems in place for the evaluation and audit of a proportion of case files by senior managers, as outlined in the RIT Supervision Policy, Standards and Criteria.

3.4.4 Where unallocated cases were identified, trusts have given assurances that unallocated cases are subject to on-going risk assessment and risk management including reporting to the trust board.

3.4.5 Trusts confirmed that they report compliance with Area Child Protection Committee Regional Child Protection Policy and Procedures, reporting timescales for investigation and assessment to the Health and Social Care Board.

4.0 Stage 4: Quality Assurance and Managing Performance of Service

4.1 Introduction

Stage 4 of the review consisted of two parts. In the first part, the review team assessed the delivery of the safeguarding function from the trust's perspective and the implementation of recommendation 36 by the Health and Social Care Board (This recommendation in the SSI Overview Report was originally directed at the legacy boards).

4.2 Key Findings – Part 1

4.2.1 Following the publication of the SSI Overview Report, significant co-operation was noted between the DHSSPS, trusts, the legacy health boards, and from 1 April 2009, the Health and Social Care Board. This has been brought about through the establishment of the Reform Implementation Team, whose work has made a significant impact on the delivery of child protection services across the region.

4.2.2 Since the establishment of RIT a range of products and polices to address consistency, integration and co-ordination of services across each of the health and social care trusts have been developed and implemented.

4.2.3 Each trust confirmed their participation in the interim Regional Child Protection Committee (RCPC). The Health and Social Care Board ensured that schemes of delegation were fully implemented and verified through the trusts Statutory Function and Corporate Parenting reports. The Health and Social Care Board ensures that all functions are appropriately discharged. This also facilitates the monitoring of child protection processes.

Findings in Relation to Social Work

4.2.4 Supervision was in place across all disciplines and at all levels however the extent to which this is embedded varied across trusts. For social work grades, other than those in their assessed year in employment (AYE), the review team found supervision to be a well established process, happening in line with departmental policy. Supervision time was protected and cancellations were rescheduled within appropriate timescales.

4.2.5 In relation to social work staff in the assessed year in employment (AYE), it was evident that supervision was taking place fortnightly, in compliance with guidelines and policy. However, in some trusts, there were concerns in relation to the frequency of supervision and quality of support for AYE staff. In the Southern and South Eastern trusts the review team could not be confident that AYE staff had a managed workload, including sufficient time for learning and development.

4.2.6 In contrast, in the Belfast Trust, AYE staff spoke very positively about the support they received from managers through the formal supervision process and also the opportunities available for on-going advice and guidance. AYE staff were appreciative of the support and mentoring provided by senior practitioners and by more experienced practitioners within the team.

4.2.7 In the Western Trust innovative practice initiatives such as the team health check and the safety in partnership initiative promoted staff engagement and facilitated accountability across all levels within the organisation. The supervision process was enhanced by a system which promoted staff input into cases.

4.2.8 Senior staff were accessible to practitioners and a clear line of accountability was evident. The review team commented favourably on the use of the principal practitioner grade in mentoring less experienced staff and supporting practitioners in particularly complex cases.

4.2.9 In the Southern and South Eastern trusts, the review team had a clear perception that there was no caseload differentiation or managed workload for AYE staff. All staff felt there was an expectation that, regardless of caseload, they must manage their work requirements through reliance on additional home working or by working overtime on a regular basis. Therefore staff faced continuing difficulties in achieving an appropriate work life balance.

4.2.10 With regard to the Knowledge and Skills Framework (KSF), the review team did not find evidence of a link with the supervision process, as recommended in departmental policy. The team was informed that this was a regional issue which is being addressed.

4.2.11 Trusts described sound audit activity in relation to the frequency of and adherence to standards and procedures for supervision. There was periodic audit of the supervision records, however, the audit recorded only the frequency of supervision and had no element of qualitative analysis of the standard of supervision.

4.2.12 In some trusts, staff remained unaware of audit outcomes. Where there were gaps in the dissemination of audit results to practitioners, audit findings were not being effectively used to inform practice and service development via the supervision process.

4.2.13 In the Western Trust, the review team noted, the use of the 'team health check' as an audit tool to verify aspects of a team's functioning. A critical component of this health check was the provision and frequency of supervision, which was clearly recorded. An improving quality together programme, coordinated all practice improvement activity within childcare services, including the extraction and dissemination of learning from case management reviews.

Findings in Relation to Nursing

4.2.14 Supervision for all grades of nursing staff involved directly with the safeguarding functions was established, at differing levels, within trusts. Supervision was well structured and had a strong component of case direction and guidance and involved a process of peer review.

4.2.15 Trusts had adopted a proactive approach in advance of the anticipated implementation of the draft regional Safeguarding Supervision Policy for Nursing. They were working towards the implementation of the draft policy, and the review team strongly endorsed its adoption.

4.2.16 Formal supervision processes were supplemented with specific advice and guidance in relation to cases, as required.

4.2.17 Trusts are at differing stages of developing arrangements to enhance supervision and support in other areas of nursing which could have a safeguarding interface.

4.2.18 There was a commitment to audit within trusts. If the draft Safeguarding Children Supervision Policy for Nurses is adopted, there will be an expectation that an audit programme will be developed, focusing directly on compliance against the standards outlined in this policy.

Findings in Relation to Paediatrics

4.2.19 Clear processes for formal supervision of all trainees were in place, as required, by the Royal College of Paediatrics and Child Health (RCPCH) and the General Medical Council (GMC). There were informal systems of supervision in place for paediatricians including shared supervision, group consultation and informal consultation with peers. Trusts raised difficulties of balancing these with service pressures.

4.2.20 There was evidence of a common desire to move towards the introduction of supervision and peer review as a mandatory requirement. However, it was recognised that there were barriers to this, including the competing priorities of clinical commitments and the need for protected time to dedicate to peer review and reflective practice.

4.2.21 The RCPCH was developing a proposal for supervised and supportive practice for paediatricians. It was anticipated that this work would act as a benchmark for future development in relation to the supervision and support of paediatricians across the region.

4.3 Recommendations – Part 1

The following represents a composite overview of high level recommendations made in respect of all trusts. The recommendations relating to specific trusts can be found within the individual trust reports.

4.3.1 Where deficits were identified, trusts must ensure compliance with the Departmental Supervision Policy, Standards and Criteria, February 2008, including a robust system for the supervision and support of AYE staff.

4.3.2 Where deficits were identified, trusts must develop or ensure that existing audit mechanisms, for all staff involved in safeguarding, have the capacity to assess the quality and effectiveness of supervision.

4.3.3 Trusts must ensure that findings from the audit process are provided to all relevant practitioners in a timely fashion.

4.3.4 Where good practice is identified, trusts should explore opportunities for sharing good practice with others (regionally, nationally and beyond).

During the course of the review, in addition to individual trust recommendations the review team also made a number of regional recommendations.

4.3.5 In 2008 the DHSSPS issued guidance on caseload management, which had been developed by the Reform Implementation Team. The DHSSPS should work with trusts to evaluate the effectiveness of this guidance and to ensure there is appropriate caseload weighting for all social work staff, including AYE staff.

4.3.6 The DHSSPS should clarify, the requirement of trusts to implement KSF arrangements as outlined in the Supervision Policy, Standards and Criteria, February 2008, thus ensuring that staff meet the post registration requirements for the Northern Ireland Social Care Council (NISCC).

4.3.7 The DHSSPS should agree to endorse the draft Regional Safeguarding Supervision Policy for Nurses and Midwives, with a view to regional implementation.

4.3.8 The DHSSPS should develop a formalised model for supervised and supportive practice for all consultant and career grade paediatricians engaged with safeguarding children.

4.3.9 The DHSSPS should consider development of a formalised model of supervision for all consultants and career grade staff who treat children.

4.4 Progress as identified in Action Plans

4.4.1 It was reported that requirements to comply with the Departmental Supervision Policy, Standards and Criteria, February 2008, continue to be reinforced within trusts through a range of fora. Where difficulties had been experienced, mentoring and group supervision arrangements have been put in place to address this.

4.4.2 Trusts reported continued development of their existing audit mechanisms for all staff involved in safeguarding to ensure they appropriately assess the quality and effectiveness of supervision. Where robust audit processes are fully established and working well, they are to be extended to other disciplines.

4.4.3 Trusts have given assurances that organisational structures and networks must ensure timely dissemination of findings from any audits undertaken.

4.4.4 Where good practice was identified, trusts reported that they continue to look at opportunities to promote and share information with others on systems which are working well.

4.4.5 It was reported that the Health and Social Care Board commissioned Principal Social Work Practitioners across all five trusts with a specific remit in child protection.

The second part of the review assessed trust performance against recommendations 20 and 25 of the SSI Overview Report, with particular emphasis on client access to services. This included access to information and the quality of the physical environment.

4.5 Key Findings – Part 2

Access to Services

4.5.1 In all centres, reception staff provided appropriate responses to queries relating to child protection. It was encouraging to note that there was, generally, always someone available from the social work teams to speak to service users on request.

4.5.2 Reviewers found a varied selection of posters and leaflets relating to trust services. Opportunities to allow service users to give feedback to the trust were generally well promoted and information was also displayed in relation to the trust's complaints procedures.

4.5.3 The Southern Trust had posters and leaflets which prominently displayed information on child protection services and the availability of gateway services. A free phone number was available for this service.

4.5.4 The review team was advised that information on trust children's services could be accessed in a variety of formats.

Physical Environment

4.5.5 In most of the facilities visited the review team was impressed with the general physical environment which was clean, appropriately decorated and in a good state of repair. Within the Belfast Trust the review team was particularly impressed with the facilities in the new health and wellbeing centres which were described as modern, tidy and relaxing.

4.5.6 In the Shankill Centre (Belfast Trust) the general decor was tired and dated. The review team was subsequently informed that the trust will relocate staff into a new purpose built health and wellbeing centre which was due to be completed in 2010.

4.5.7 Environmental deficits were identified in both Slemish Community Services office (Ballymena) and the Ellis Street Complex (Carrickfergus) within the Northern Trust, particularly the decor in the meeting rooms. In the Legahory Centre and E floor of the South Tyrone Hospital (Southern Trust) the décor was tired and worn. In particular E Floor in the South Tyrone Hospital suffered from significant maintenance deficits. The review team considered the rooms within this facility were not fit for purpose.

4.5.8 All meeting rooms had disabled access except in the Legahory Centre. Here the meeting room was situated on the first floor with no means of access to wheelchair users or to parents with buggies or push chairs.

4.5.9 In all facilities there were telephones available for free and direct access to the trusts gateway teams.

The Service User Experience

4.5.10 Staff were welcoming in their approach, polite, courteous, professional and sensitive to the needs of clients. Service users were treated with empathy, understanding and respect.

4.5.11 All confidential discussion and day to day work took place in secure areas to which only staff have access. All computer screens at reception areas were positioned so they could not be seen by the public. The privacy of service users was further protected by ensuring that meetings were not interrupted.

4.5.12 Reception staff advised that customer care was included at induction training. Staff presented as being well equipped to deal with clients in a considerate way, sensitive to their individual needs. It was encouraging to note that all reception staff were mindful not to discuss confidential details at the reception desk.

4.5.13 Social work staff indicated that training in communication and handling different situations was inherent in their professional training, however some had availed of additional in-service training offered by trusts.

4.6 Recommendations – Part 2

The following represents a composite overview of high level recommendations made in respect of all trusts. The recommendations relating to specific trusts can be found within the individual trust reports.

4.6.1 Where deficits were identified, trusts should assess children's services facilities with a view to immediate or longer term redecoration or refurbishment, where appropriate.

4.6.2 Where deficiencies in the accessibility to children's services facilities were identified, trusts should ensure these are addressed, as appropriate.

4.6.3 Where confidentiality issues were identified, trusts should assess public access to secure areas and address weaknesses or vulnerable access points.

4.7 Progress as identified in Action Plans

4.7.1 Where deficiencies, including confidentiality issues, in children's services facilities, were noted assurances have been given by trusts that these have been fully addressed or are being addressed, as appropriate, either by refurbishment or relocation of services.

5.0 Stage 5: Interagency communication at point of referral

5.1 Introduction

Stage 5 focused on the quality and effectiveness of interagency communication and processes at the point of a safeguarding referral. This related to recommendation 23 of the SSI Overview Report.

An audit of case files was undertaken in each of the five trusts. An audit tool was designed specifically to provide an analysis of communication between the referrer, relevant agencies and the health and social care trust. This was based on requirements set out in the Area Child Protection Committees' (ACPC) Regional Policy and Procedures.

5.2 Key Findings

5.2.1 Trusts were involved in a number of initiatives to promote, enhance and support interagency working. These included work with the PSNI Public Protection Unit, schools and other health professionals. This served to develop a mutual understanding of the roles and responsibilities of different agencies and helped to inform and improve knowledge and awareness of systems and processes in child protection.

5.2.2 Trusts had established a number of internal multi-professional groups which in conjunction with statutory forums such as the trust child protection panel and the interim Regional Child Protection Committee enhanced multi-disciplinary working.

5.2.3 Trusts ensured that referral agencies were informed of interventions made as per the requirements of the Regional ACPC Policy and Procedures and the Gateway Services Processes, Guidance (April 2008).

5.2.4 There was appropriate use of the Protocol for Joint Investigation for alleged and suspected cases of child abuse in Northern Ireland and the associated PJI suite of forms. There were however some omissions with regards to the use of the PJI7 form which should be used to document the decision to conclude a joint investigation.

5.2.5 Where a UNOCINI was not used as a referral tool, there were significant deficits in referring agencies providing written referrals to social services as per the requirements of the ACPC policy and procedures. The trust continued to encourage other agencies to engage in the UNOCINI process and acknowledged that this remains an area which requires further attention and development.

5.2.6 Although there was evidence of robust sharing of information between out-of-hours services and day time services, the out-of-hours service did not use the UNOCINI framework. The review team felt that communication between gateway and the out-of-hours service could be enhanced by the adoption of the UNOCINI framework by out-of-hours social work staff leading to better standardisation of practice.

5.3 Recommendations

The following represents a composite overview of high level recommendations made in respect of all trusts. The recommendations relating to specific trusts can be found within the individual trust reports.

5.3.1 Trusts should continue to ensure that all professionals with safeguarding responsibilities are familiar and competent in the use of the UNOCINI assessment framework. The trusts should liaise with other agencies to encourage the development and use of the UNOCINI assessment framework when making referrals to social services.

5.3.2 Trust should adopt the use of the UNOCINI assessment framework within the out-of-hours social work team/service.

5.3.3 Trusts should ensure compliance with the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged Cases of Child Abuse.

5.3.4 Where deficits were identified trusts must ensure compliance with ACPC Policy and Procedure in relation to written confirmation to the referrer.

5.4 Progress as identified in Action Plans

5.4.1 It was reported that processes under the Reform Implementation Team include multiagency participation in the development and the use of the UNOCINI framework. Trusts continue to promote the development and use of the UNOCINI assessment framework when making referrals to social services underpinned by the provision of training to all professionals with safeguarding responsibilities.

5.4.2 A regional review of the Joint Protocol is underway; in the interim, trusts continue to monitor compliance with the Protocol for Joint Investigation by Social Workers and Police Officers of Alleged Cases of Child Abuse. Two gateway teams from the Belfast and South Eastern trusts have been involved in a pilot project with the Police Service of Northern Ireland (PSNI) focusing on UNOCINI referral and information exchange.

5.4.3 The Health and Social Care Board, in conjunction with trusts, is undertaking a review of the out-of-hours system including the use of the UNOCINI assessment framework within the out-of-hours social work team/service. In the interim, trusts continue to use their own dedicated referral forms which inform the UNOCINI referral and initial assessment.

5.4.4 Where deficits in compliance with ACPC Policy and Procedure were identified, trusts have given assurances that procedures are reinforced to staff on a regular basis.

Section 3: Conclusion

RQIA recognises the complexity of safeguarding and child protection work and understands the challenges that working in this demanding and rapidly changing area brings for front line staff and managers. Trust staff were committed in their safeguarding duties, support of families and improving the quality and effectiveness of interventions.

This review took place over a two year timeframe and over this time RQIA noted a process of meaningful engagement by the trusts in the review process. RQIA review teams noted improvements in key areas as they moved through the stages of the review. Examples of this would include the restructure of the UNOCINI assessment format to facilitate a more appropriate flow of information on the completed template. By the conclusion of stage 5, there was a noted improvement in the structure of files, with key information readily accessible. In each trust area working groups were established to progress the recommendations from each of the stages of the review demonstrating that the RQIA review process itself became a vehicle for improvement.

In conclusion this review demonstrates fulfilment against the four core activities outlined in RQIA's corporate strategy, and reflects the key principles and outcomes of these core activities.

- **Improving Care:** As evidenced throughout this report, RQIA made a number of recommendations at each stage of this review in relation to improvements within a variety of elements of the child protection and safeguarding systems. This complimented the work already underway by the Health and Social Care Board and each of the five trusts. Each trust developed working groups and action plans to progress each recommendation.

- **Informing the Public:** RQIA published reports at the conclusion of each stage of the review. These reports are available through the RQIA website. In addition the review was covered in the Northern Ireland Assembly and senior RQIA officials gave evidence to the Committee for Health Social Services and Public Safety. In addition RQIA engaged in a robust public information strategy in relation to the review, through the release of press statements and senior RQIA officials taking part in a range of media interviews.

- **Safeguarding Rights:** The review of child protection services across the region examined these services to determine whether they are safe, responsive and protect the most vulnerable in our society. This review assists in providing this assurance.

- **Influencing Policy:** Throughout the period of this review RQIA has reinforced RIT products as they relate to child protection. The review has informed the need to revise elements of the RIT products, e.g. the revision of the structure of the UNOCINI template. In addition, the review has added weight to already established initiatives such as the draft Regional Safeguarding Supervision Policy for Nurses and Midwives and a model for supported practice for all consultant and career grade paediatricians who are engaged with safeguarding children, as recommended by the Royal College of Paediatricians.

Where it is clear that each of the five trusts have put in place action plans in relation to the recommendations from this review, a number of these remain works in progress and require to be brought to conclusion. The HSC Board and each of the trusts should ensure that these action plans, which have been described as works in progress should be addressed, and systems should be put into place to quality assure the continued progress.

With the establishment of the Safeguarding Board for Northern Ireland (SBNI), this overview report could provide a useful snap shot of the current status of child protection services across Northern Ireland and will provide a benchmark against which the new body could measure progress. In addition both the SBNI and the HSCB may wish to consider the comments of Professor Munro in her review of child protection in England[1].

RQIA recommends that the HSCB continues to monitor progress against all of the recommendations made at all stages of the child protection review, in order to assure continued improvement in processes and practices that relate to child protection in Northern Ireland.

[1] The Munro Review of Child Protection: Final Report, A Child-Centred System. Professor Eileen Munro, April 2011.

Appendix 1: Glossary of Terms

ACPC	Area Child Protection Committee
AYE	Assessed Year in Employment
CAHMS	Child and Adolescent Mental Health Services
DHSSPS	Department of Health, Social Services and Public Safety
FIT	Family Intervention Teams (Field social work teams)
Gateway Teams	Initial referral social work teams
GMC	General Medical Council
HPC	Health Professions Council
HSCB	Health and Social Care Board
HWIP	Health and Well-Being Investment Plan
LAC	Looked After Children
NISCC	Northern Ireland Social Care Council
NMC	Nursing and Midwifery Council
RCPC	Regional Child Protection Committee
RIT	Reform Implementation Team
RQIA	Regulation and Quality Improvement Authority
SBNI	Safeguarding Board for Northern Ireland
SOSCARE	Social Services Client Administration and Retrieval Environment
SSI	Social Services Inspectorate
SSI Overview Report	Our Children and Young People - Our Shared Responsibility. Inspection of Child protection Services in Northern Ireland Overview Report, December 2006
TCPP	Trust Child Protection Panel

UNOCINI	Understanding the Needs of Children in Northern Ireland (Assessment Framework)
VOYPIC	Voice of Young People in Care

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