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The Focus and Methodology of Inspection in Ireland:

A documentary analysis of Health Information and Quality Authority (HIQA) child protection and welfare services inspection reports

2025

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EXECUTIVE SUMMARY

Background

Inspection offers important benefits including improving the quality of services, demonstrating safety and ensuring accountability of services (Van Dooren et al., 2015). However, the literature demonstrates that inspection can, at the same time, cause unintended consequences. What inspection focuses on strongly influences the effects, both intended and unintended, of inspection and is therefore an important focus for research. Much of the available literature, particularly on the negative effects of inspection, comes from England (Caffrey et al, forthcoming). Ireland is a unique context with its own inspection system, culture and history. Our previous review of the literature found no research on inspection in Ireland, indicating an important research gap worth filling. This research was commissioned by the Department of Children, Disability and Equality. For the first time, we analysed the inspection reporting process in Ireland via a documentary analysis of Health Information Quality Authority (HIQA) inspection reports of Tusla child protection and welfare services.

Methodology

The research used a documentary analysis of HIQA reports to examine the following research question: *What is the focus and methodology of HIQA child protection and welfare inspection reports?* We sampled all publicly available reports on the HIQA website on 1st July 2024 using the filter 'child protection and welfare' and included all reports that inspected against the National Standards for the Protection and Welfare of Children. The total sample comprised twenty-six reports over an inspection period of two years and eight months from March 2021-November 2023.

Findings

The Methodology of Inspection

- Most site inspections in our sample (85%) were in keeping with HIQA's expected duration of 3-4 days. Four out of 26 inspections (15%) were longer than the expected duration. Three of these were five days long and one inspection was an outlier at nine days long. Personal communication with HIQA suggests the length is flexible and

responds to issues arising. The variation was not explained by inspection outcomes: services judged 'non-compliant' were not more likely to experience a longer inspection. Nor was it explained by inspection type.

- There was consistency across inspections in the types of documents sampled for inspection. However, there was large variation in the number of case files sampled (between 8-79 files). Risk based and thematic inspections tended to sample higher numbers of cases (38-79), CPNS inspection tended to sample fewer cases (10/17 CPNS inspection had fewer than 20 cases). The number of CPNS cases sampled was not related to the number of CPNS cases in the service. A rationale was not provided for the large variation.
- Observations of practice can be more practically challenging than case file analysis as inspectors require the consent of parents to observe practice involving families and they can only observe practices that take place during the inspection timeframe. Compared to reviews of documents, direct observations of practice featured less frequently in the inspection methodology, and with less consistency. Twenty-seven per cent of inspections (n=7) did not feature an observation of practice and 54% (n=14) featured one observation of one type of practice.
- Reports consistently reported interviews with social work staff at various levels. However, the number of staff interviewed was not always detailed in reports.
- Including children in the feedback process can be challenging due to the need to obtain consent from both parents and the often-difficult circumstances of families. The number of children spoken with per inspection ranged from 0-8. The average number of children spoken with per inspection was two. In 19% of inspections, no feedback was received from children. When feedback was included, this was most commonly via an individual discussion with an inspector. Age of children was the most cited reason for their non-involvement, but reports did not state what age was considered appropriate to invite children to provide feedback.
- Reports often contained careful use of language that accurately reflected the uncertainty of outcomes in child protection services. Reports also generally made claims that were well supported with reference to data. However, there were some examples of unrealistic language around risk and risk reduction and some instances where the language used over-generalised from the findings.

- In keeping with the risk-based approach, the selection of National Standards and Themes for inspection is determined by HIQA's analysis of data and is made in consultation with Tusla Child and Family Agency. In the period of two years and eight months, represented by this sample of reports, 10 out of 27 National Standards (37%) and two of the six themes were not inspected against. There was a strong focus on themes and standards relating to leadership, governance and management and timely action to protect children and provide services. There was comparatively less focus on themes and standards focused on workforce quality and support, and on child-centred services.

The Focus of Reporting

- A dedicated section at the start of each report presented the feedback from children and families. However, this feedback was not always transparently integrated into subsequent analysis to inform the judgement reached. The absence of analysis across data types to integrate the findings led in some reports to conclusions, which were not transparently inclusive of children's direct feedback. At times, a contradiction between findings was resolved in a way that excluded children's self-reported experiences.
- The international literature highlights the importance of an integrated focus on the impact of process on service-users' experiences of practice. The inspection reports demonstrated a frequent focus on inspecting for whether a process took place or was in place. Of the process types inspected, timeliness and recording/records management were referenced most frequently in reports.
- Inspection reports tended to avoid a focus on process compliance as an end in itself. Instead, reporting tended to integrate consideration of process compliance with consideration of broader practice. Indeed, alongside inspecting for process compliance, reports focused on assessing quality of practice. This included, for example, going beyond checking whether case files were up to date, to assess the quality of recording. Similarly, inspection checked not just the occurrence of meetings, but also the quality of meetings.
- In reporting on service outcomes, reports tended to avoid using performance data proxy measures (e.g. using re-referral rates as a measure of services achieving child

safety). Instead reports focused on assessing relatively proximal outcomes, including, for example, the level of unmet need, which could be assessed more directly by examining numbers of unallocated cases. Reports also made use of child and family experience data to assess self-reported safety and understand what contributed to positive experiences. In this sense, reports helped provide practice direction by illustrating not just that but how outcomes came about.

- In terms of the learning focus of inspection, reports included detailed professional guidance for services on what constitutes 'good' practice. In addition, reports contained an example of the inspectorate encouraging a system level approach to learning across services via a focus on the Child and Family Agency's role in cascading learning from HIQA reports.
- In keeping with the National Standards, inspection was focused on inspecting Tusla services and inspection was structured by service issues. Data collected from children and families sought feedback on aspects of their experience, but it did not look to piece together an integrated 'service user journey' across the system of CPW. In the timeframe of reports we analysed, the focus of system-level inspection was primarily on inter-agency and inter-professional working, rather than on monitoring systems for services provided externally on behalf of the statutory agency.
- All reports featured a section titled 'profile of the service area' but the information in this section varied significantly between reports and inconsistently reported on socio-economic context and levels of deprivation of service areas. The context the service operated in – staffing, availability of placements for children, and the needs profile of families- was commonly recognised in reports but did not seem to ultimately affect the compliance judgement. In this sense, 'non-compliant' or 'substantially compliant' designated a service that was below standard, regardless of whether the reasons for non-compliance were outside of the control of the service. Therefore, HIQA compliance judgements can be understood as a judgement on the quality of provision available, not the quality of work and effort delivered by services. Contextual information was sometimes, but not always, provided with the judgement to make clear if a challenging resource context impeded the ability of the service to comply.

- The most frequent categories of actions in service 'compliance plans' were those focused on (1) governance (2) audit, review and monitoring (3) training and learning and (4) staffing and resourcing.

Conclusions and Recommendations

The findings of this report evidence the specific context of the Irish inspection system and the importance of research to explore it specifically. This study provides a detailed understanding of what inspection of child protection and welfare services focuses on and the methodology used. Below we make several recommendations in relation to immediate practice. Following this we set out recommendations for future research.

- Ensure consistent reporting in respect of the context of services, including benchmarked demographic, area deprivation and workforce data. The findings section references a good quality example of this from an inspection report that could be emulated. This information is provided to HIQA by Tusla services. Therefore, a template could be provided to services for completion.
- Ensure consistency of reporting on the number of staff who provide feedback in an inspection.
- Ensure consistency in how judgments are delivered in respect of integrating contextual information alongside the judgement to explain impediments to compliance (e.g. staff shortages).
- While HIQA is constrained by the current regulatory framework, at the national level, consideration should be given to the wording of 'compliance' in delivering judgements of services. Further research would help to inform this (discussed below).
- Notwithstanding the recognised challenges of engaging this cohort of children and parents, consideration should be given to whether there are opportunities to improve engagement. We recommend piloting the use of an anonymous online and smartphone compatible survey (for older children and adults). In addition, consideration should be given to whether perceptions of children's age/capacity may influence recruitment.

- Reports (or an overview report) should clarify the strategy used to invite and select children and families to provide feedback (i.e. the sampling strategy). This matters because the feedback received will be influenced by this process.
- Ensure that feedback from children and families (including verbal and non-verbal feedback) is consistently integrated into the wider findings of reports and accounted for in inspection judgements, particularly where children's self-reported experiences contradict other evidence collected.
- Emulating good practice recently introduced in HIQA inspection of residential centres, HIQA should demonstrate to children that their feedback matters by producing a young person's report of each inspection of child protection and welfare services. It should be noted that HIQA has been working to strengthen its engagement with children, with multiple recent initiatives introduced in this regard. Our recommendations could be considered within this already active area of work.
- Match the good practice that is evident in most inspection reports by ensuring that all reports avoid unrealistic language around risk and safety. Reports should avoid implying that services can 'ensure' children's safety. Rather the language of services 'supporting' safety would be more accurate.
- Ensure a formal process is in place to decide the minimum number of case files that will be sampled and how case files will be chosen (i.e. a formal sampling framework). In addition, in reporting, ensure consistent attention to the limitations of the sampling method used. With due consideration to the sampling framework used, agreement should be reached in terms of the rough expected sample size.

Recommendations for further research

- A study of Tusla staff experiences and perceptions of the inspection process in respect of the following:
    - The proportionality of the inspection process, including the length of on-site inspections and burden of work on staff.
    - Any impact of inspection on the focus of work.
    - The appropriateness of methods used to investigate practice and the validity of these in reporting on their work.

    - The process of recruiting children, families and staff to provide feedback on inspection and the validity of the data.
    - The way in which the context services work in (e.g. staff shortages, placement shortages, area deprivation) is outlined in reports and taken account of in inspection judgements and the wording of judgements in terms of services' 'compliance'.
- Research with HIQA inspectors in respect of their experiences and perceptions of the proportionality of the system, the appropriateness of methods, the process of recruiting children, families and staff and the way in which context features in reports.
- Research with children and families to understand their experiences of providing feedback on the inspection process.

1. INTRODUCTION

This research investigates the focus and methodology of child protection and welfare (CPW) services inspection undertaken by Health Information and Quality Authority (HIQA). It does so by examining all reports published in the two years and eight-month period between March 2021 to November 2023. In doing so, this research has been predated by an earlier phase of the project (hereafter referred to as phase 1), by the same team, involving a rapid review of international evidence to understand the focus of inspection. That rapid review produced a conceptual framework for inspection following screening of 5,142 sources. To the fore were seven categories that constituted the conceptual framework: (i) procedure compliance, (ii) outcomes, (iii) quality of practice, (iv) systems, (v) learning, (vi) service-user voice and (vii) context-sensitive (Caffrey et al., forthcoming b). It was concluded that procedure-compliance can come to govern the inspection process, with a typical focus also maintained on deviations from standards within an organisation. Insufficiency of attention to child and family voices, area deprivation and dissimilarity in the workforce were noted (Caffrey et al., forthcoming, forthcoming). The current research phase builds on this contribution to knowledge in turning attention to the nature of HIQA reports, as a documentary reflection of the inspection process.

Inspection offers important benefits including improving the quality of services, demonstrating safety and ensuring accountability of services (Van Dooren et al., 2015). However, the literature shows that inspection can, at the same time, cause unintended effects. Staff may focus excessively on bureaucratic process to the neglect of wider dimension of quality of practice, and they may experience inspection as a heavy administrative burden that diminishes time for front line work with families. Inspection can also induce staff anxiety, which in turn may lead to defensive practice and an increase in unnecessary intervention in families. What inspection focuses on strongly influences the effects, both intended and unintended of inspection and is therefore an important focus for research. Much of the available literature, particularly on the negative effects of inspection, comes from England (Caffrey et al., forthcoming). Ireland is a unique context with its own inspection system, culture and history. Our previous review found no research on inspection in Ireland, indicating an important research gap worth filling.

The HIQA was established in the Republic of Ireland as an independent statutory authority whose stated aim is to drive safe and high-quality care for users of health and social care services. It operates in line with statutory requirements of the Health Act 2007. To undertake

its work, HIQA produces standards and inspects against those standards to inform decision-making about the nature of health and social care service delivery (HIQA, 2024b). The establishment of HIQA follows a wider growth in the inspection of public services understood as a regulatory trend (Boyne et al., 2002). This trend is also evident in social work services (Benish et al., 2018; Munro, 2004), with social work constituting a cornerstone profession in Irish child protection and welfare services (Department of Children and Youth Affairs, 2017; McGregor, 2014). HIQA is a systems regulator using a monitoring system based on compliance (HIQA, 2024b). HIQA has the legal power to conduct a statutory investigation, when necessary, but (other than in Special Care units) HIQA does not have any powers of enforcement to help bring about required improvements. Instead, it relies on reporting inspection findings, monitoring compliance plans and escalating any significant concerns to the appropriate government department or Minister (HIQA, 2024b).

In the child protection and welfare arena, HIQA inspect compliance against the National Standards for the Protection and Welfare of Children (HIQA, 2012). These standards govern child protection and welfare services delivered by Tusla, the Child and Family Agency (hereafter 'Tusla'). HIQA may conduct an inspection of a child protection and welfare services against all the National Standards. HIQA also conducts 'risk-based inspections', which monitor providers of services against specific standards (HIQA, 2025). Generally, HIQA takes a 'risk based' approach to regulation. The approach prioritises regulatory activities based on HIQA's assessment of risk of the service. A risk assessment can be triggered in multiple ways including receipt of information (solicited or unsolicited), fieldwork events, enforcement actions, insights from overview reports or trend analysis of all sources of information (HIQA, 2024b).

Each inspection involves a team of up to four HIQA inspectors visiting a CPW service over three to four inspection days (HIQA, 2024b) to engage with staff, children and families, examine documents and, where appropriate, observe meetings (HIQA, 2024b, 2025). HIQA has three overall inspection judgements that can be made following an inspection of a service, namely: compliant, substantially compliant and non-compliant. Inspectors also provide a colour-coded (red, orange, green) judgement on the level of risk to children associated with the compliance judgement (HIQA, 2025). In the Republic of Ireland, monitoring and inspection outcomes such as these can help to drive improvements in the child protection system, promote child safety, bring attention to legal and policy compliance and implementation as well as resource allocation (Burns et al., 2024).

Concurrent to its usual monitoring services, HIQA responds to identified risk and in recent years has included several specific inspection programmes. In 2019 HIQA introduced a programme of thematic (quality improvement) inspections. Services that participated in this initiative had a good level of compliance against the national standards. The initiative focused on further improvement on identified risks in relation to screening and preliminary enquiry and safety planning. It also reviewed the quality of initial assessments and governance and the management of CPW services was a key focus (HIQA, 2024b).

HIQA's 'focused' inspection programme targets areas were governance needs to be further strengthened. From 2021-2023 a two-year programme focused on inspections of the CPW service provided to children listed on the Child Protection Notification System (CPNS) and who have a child protection safety plan. Inspections took place across all 17 Tusla service areas. Since 2022, in response to increasing numbers of unaccompanied minors entering Ireland, HIQA has inspected Tusla's national service for Separated Children Seeking International Protection (SCSIP) (HIQA, 2024b).

Two more recent developments have characterised HIQA's inspection programme, although reports from these inspection programmes are not within the timespan of our study. Firstly, in 2023 HIQA commenced a programme of inspection to monitor Tusla's implementation of the Child Abuse Substantiation Procedure (CASP). Four inspections were completed in 2023 but as these were not published until January 2024 they fall outside of our sample of reports. Secondly, in response to identified national risks, in August 2023 HIQA commenced an 'escalated risk provider programme' (HIQA, 2024b, p. 36). Services with 25% or more children in child protection and/or foster care services unallocated to a named social worker were included in this programme. In this new approach Tusla's executive team and CEO have been requested to devise a national improvement plan and to attend monthly stakeholder meetings chaired by HIQA. The 'provider' approach is currently ongoing and falls outside of the timeframe of the inspection reports in our sample.

A core purpose of HIQA inspection against established standards, as with most inspection processes of publicly funded services, is to promote service transparency and accountability as a reassurance to the public (Hood & Dixon, 2015; Power, 1997). This aligns to Tusla operations, fitting under one of Tusla's three pillars, namely 'public confidence' (Tusla, 2024). Tusla elaborate that 'public confidence' entails ensuring 'services we deliver meet the standards our

service users are entitled to, and are compliant, high-quality, transparent and visible across communities, in order to promote public trust and confidence in Tusla' (Tusla, 2024, p. 4). Whilst child protection and welfare services are just one branch of the Agency's suite of service provision, this quality and compliance imperative remains instrumental to service delivery (Burns & McGregor, 2019; Tusla, 2024)

Tusla, as the national dedicated agency for improving outcomes and well-being for children in the Republic of Ireland, holds a distinct history of relevance to current inspection practices. It began operating fully from January 2014 (McGregor, 2014; Tusla, 2024) and was formed against a historical backdrop of media exposés and scandals surrounding individual child maltreatment cases and institutional child abuse inquiries (Burns & McGregor, 2019). The formation of the Agency became a watershed moment to drive needed system change in light of perceived failings to intervene and prevent abuses of the past (McGregor, 2014). So much was this the case, that then Minister for Children and Families Frances Fitzgerald, stated in 2012 that the forthcoming Agency would offer a "new reality out of the rubble of a system that has been crumbling for decades" (Fitzgerald, 2012). Nationally and internationally, inspection has played an important role in system change within child protection and welfare services, that ultimately are dynamic and complex (Canavan et al., 2022; McGregor, 2014). It is acknowledged that the level of staffing available to Tusla CPW services has been a challenge since HIQA commenced inspections. A high number of vacant posts and high turnover of staff alongside an increased demand for the service has consistently impacted Tusla's ability to allocate a social worker to each child in a timely manner and maintain consistency of social workers allocated. (HIQA, 2024b, p. 51).

HIQA conduct inspections of Tusla's child protection and welfare services, with respect to the afore-stated Standards, which also directly reference the implementation of Children First: National Guidance for the Protection and Welfare of Children (DCYA, 2017). HIQA is guided also by an assessment-judgment framework (HIQA, 2019, 2023). HIQA inspection follows common international practices of analysis of documentary evidence and compilation and examination of evidence (Benish et al., 2018). HIQA also replicates common international inspection practices of conducting 'site visits' entailing face-to-face encounters and direct observations with child protection practitioners/professionals and getting direct feedback from service users (Boyne et al., 2002; HIQA, 2019, 2023). HIQA inspection processes occur in tandem with a wider legislative and policy framework in the Republic of Ireland, which also governs provision of child

protection and welfare services, including the Child Care Act 1991 (Burns and McGregor, 2019; HIQA, 2023).

Internationally, an increasing shift in power is evident, toward regulating agencies and away from the autonomy and terrain of professionals and inspected organisations (Clarke, 2020). This reflects a rebalancing of the scales of governance systems that can lean away from professional discretion and toward regulatory exercise of control over services (Kröger, 2011; Munro, 2011a). Part of the operation of shifting power, is also the nature of inspection of an increasingly public affair, rather than a private matter of directly informing service improvement. The publication of inspection reports places them in the public eye with conditions of possibility then opened, for a 'name and shame' tactic in media and political life (Munro, 2004). In this context, and according to Boyne et al. (2002), inspection can be understood as the process by which an organisation regulates the performance and behaviour of another organisation. This process of inspection is a component of monitoring and regulation (Burns et al., 2024).

HIQA inspections occur against an international drive for increased public sector transparency, cost-efficiency and accountability that underpins public sector regulation internationally (Dunleavy & Hood, 1994; Flynn et al., 2024). So powerful is the current focus on performance management and regulation that terms like 'the new evaluation state' (Henkel, 1991) and the 'regulatory state' (Day & Klein, 1990) are interspersed across the literature (Caffrey et al., forthcoming). Power's (1997) reference to 'audit society' and Moynihan and Pandey's (2005) uptake of the term 'government by performance management' are also exemplary of the centrality of regulation and performance in modern public sectors.

In this context, the very act of regulation is subject to trends. Regulation, as per Selznick's lauded definition, refers to control exercised by a public agency over those activities which offer value to the community (Selznick, 1985). Public sector regulation is dynamic, evolving and entangled with trends and expectations that fluctuate across societies, and dictate what good performance ought to be. Oftentimes, the contemporary agenda of regulation surrounds effectiveness and quality (Bouckaert & Van Dooren, 2015). This modern regulation often follows a familiar pattern of setting standards, monitoring them and enforcing their implementation (Levi-Faur, 2011).

Widespread regulation of this kind in OECD countries has led to a strong performance measurement and management agenda within public sector services (Van Dooren et al., 2015). Child protection and welfare services also appear subject to increased focus in regulation of risk. Of note, risk adversity translates to expectations that organisations should manage, and even eradicate, risk and danger (Beck, 1992; Giddens, 1990; Hood et al., 2001). This occurs against a backdrop of sensationalist media coverage of child abuse that can drive public fear, promote blame culture, and create unrealistic expectations about what services can achieve (Ayre, 2001). These unrealistic expectations can affect the work of HIQA as much as the service providers that they inspect. To date, a gap in research exists around the views of Tusla staff and inspectors on these barriers meaning they remain poorly understood.

In the present study, the focus is on analysing a sample of HIQA child protection and welfare inspection reports. These reports offer a summary of given inspection processes, and are compiled with multiple audiences in mind, including the lay public. Whilst each report is not an exhaustive account of all details of the inspection undertaken and the exact application of all inspection methods, it does offer rich detail of a sufficient extent to determine the focus of inspection and its overall methodology. This determination is informed by the wider context of HIQA inspection as considered through review of relevant literature and integrated into discussion of findings.

2. RESEARCH STUDY METHODOLOGY

While the first phase of the research – the rapid international literature review – focused on child and family services generally, this phase focused specifically on Child Protection and Welfare services. This decision was taken to enable a deep analysis by focusing on inspection against one set of National Standards. The research sought to examine the following research question: *What is the focus and methodology of HIQA child protection and welfare inspection reports?* The objectives of this study were to:

- Empirically explore the focus of HIQA inspection reports that inspect against the National Standards for the Protection and Welfare of Children (HIQA, 2012).
- Examine the methodology of the inspection process.
- Analyse the inspection judgements and the action plans developed in response to inspection judgements.

2.1 Sampling procedure

As the focus of the study was on the inspection of child protection and welfare services, search results on the HIQA website were filtered by 'report type' using the search filter on the 'Reports and Publications' database on the HIQA website. The search was conducted on 1 July 2024 for all years for which reports were available. The automatic search returned a total 32 reports via the 'child protection and welfare' filter. Six of these reports were excluded as they were a cohort of inspections relating to children in residential care and therefore inspected against standards other than the National Standards for the Protection and Welfare of Children (HIQA, 2012). The search returned two inspections of services provided by Tusla's Separated Children Seeking International Protection (SCSIP) team. These were retained as they inspected against the National Standards for the Protection and Welfare of Children. The remaining 26 reports were included for analysis. These reports span a period of two years and eight months between March 2021 to November 2023 and therefore constitute a snapshot in time of all relevant reports in that period.

2.2. Data analysis

Each report was downloaded from the HIQA website before being imported into NVivo 14[1] software to manage and facilitate the coding and analysis of the data. The study drew on

[1] https://lumivero.com/products/nvivo/

thematic and content analysis techniques. In keeping with Braun and Clarke's (2006, 2021) framework the data was analysed using a stepwise process involving (i) familiarisation with the data, (ii) initial data coding (iii) review and consolidation of themes (iv) final analysis and (vi) report write up. The coding framework developed from our rapid review of the international evidence (previously undertaken in phase 1 of this research) was utilised to analyse reports. This provided a seven category, evidence-informed framework to structure the analysis and ensure that we explored issues identified as pertinent in the international literature. The seven categories in the framework were as follows: i) procedure-compliance focus ii) outcomes focus iii) quality of practice focus iv) systems-focus v) learning focus vi) service-user voice focus and vii) context-sensitivity. In addition, the analysis examined the methodology used across inspection reports. We derived the methodology of the inspection process by analysing the process as evident throughout the entirety of reports in our sample. This ensured that our analysis of the methodology was not confined to the method as articulated in the 'How we Inspect' section of each report. Our analysis considered the transparency of the process and therefore looked to highlights gaps where any aspect of the process was not clear from reports. The coding framework was used deductively to explore data using the existing codes. At the same time, flexibility and adaptability was built into the design via inductive analysis. Through this method, themes that were not identified in our initial framework but became evident through analysis of the data were inductively developed and coded for.

Following the familiarisation stage, we undertook continuous inter-coder reliability exercises to ensure robustness of the process. Initially, each member of the three-person research team (LC, SF, NQ) separately read and coded the three inspection reports and met to compare coding and discuss and agree definitions of codes. Once a consensus on codes, coding approach and application of the coding framework had been agreed across the team, the 23 remaining reports were coded using the updated coding framework. New codes and themes were agreed on by the team as they were developed, and team members met at regular intervals to check and discuss coding. Data relating to aspects of the inspection methodology, including data sampling and the Standard inspected against, was separately recorded in an Excel spreadsheet database. This data was used in conjunction with the coded data in NVivo to form the basis for the documentary analysis. In the sections that follow,

individual reports are referenced using the name of the service area, inspection type, and the inspection date.

The research team was supported by an advisory group comprised of Prof. Stephanie Holt and Sinead Tobin from the School of Social Work & Social Policy. The advisory group provided feedback on the draft report, which was incorporated into the final version.

2.3 Access and Ethical considerations

All data analysed in this report is in the public domain, available on the HIQA website. As the research does not involve human (or animal) participants and is confined to publicly available documents, the School of Social Work and Social Policy Research Ethics Committee classified the research as 'Level 0', which does not meet the threshold to require full ethical review.

Throughout the report we use pseudonymised identification numbers for each of the 17 Tusla areas. We chose to do this because, although the inspection reports are publicly available, we wish to discourage any focus in interpretation of our findings on the work of any particular service area or inspection team.

2.4 Stakeholder involvement

A stakeholder group was established for this research and comprised representatives from the Department of Children, Tusla Child and Family Agency and HIQA. The group was independently chaired by Dr. Kenneth Burns, senior lecturer in social work at University College Cork. This group met at the start of the research and was informed of the research methodology. The draft report was shared with the stakeholder representatives, a stakeholder group meeting was convened to discuss the findings, and the research team took account of feedback in drafting the final report. The final report was shared with the stakeholder group prior to publication. Representatives from HIQA and Tusla also met informally with the researchers during the study to help us understand the more informal aspects of the inspection process that are not visible from inspection reports.

In any research process it is crucial to maintain the independence of the research team and rigour and credibility of the research. While upholding this requirement at all stages, the stakeholder group aimed to ensure that key stakeholders were informed throughout the research process, that a mechanism for dialogue and discussion was in place, and that the

research was informed by the knowledge and expertise of the stakeholder group. Engagement with key stakeholders via the group aimed to make the research and recommendations relevant and useful to the key stakeholders. We are grateful to everyone who took part in this process. Any omissions or mistakes remain the authors' own.

3. FINDINGS

The report's findings are arranged into two key sections. Following an overview of the data, the findings in relation to the methodology of inspection are presented. Subsequently we present findings regarding the focus of inspection.

3.1 Overview of the Data

The search for HIQA inspection reports returned a total of 26 reports focused on Child Protection and Welfare services inspecting against the National Standards for the Protection and Welfare of Children (HIQA, 2012). The sampled reports span a period of two years and eight months, from March 2021 to November 2023. Of the 26 reports, 17 focused on the inspection of child protection and welfare services provided to children on the Child Protection Notification System[2] (CPNS). Four reports comprised 'risk-based' inspections and two additional reports were 'risk-based follow-up' inspections. Two were inspections of services provided by Tusla's Separated Children Seeking International Protection (SCSIP) team. The final report in the sample was a thematic inspection from 2021, focused on quality improvement.

The CPNS focused inspections were a HIQA inspection programme that commenced in 2021 and carried out CPNS focused inspections of all 17 TUSLA service areas (HIQA, 2022). These inspections therefore aimed to assess compliance in relation to delivery of the national standards to children on the CPNS.

Risk-based inspection refers to HIQA's approach to regulation. The approach prioritises regulatory activities based on HIQA's assessment of risk of the service. A risk assessment can be triggered by receipt of information (solicited or unsolicited), fieldwork events, enforcement actions or trend analysis of all sources of information (HIQA, 2024c). The focus of the risk-based inspections in this sample were (i) unallocated cases (Area 2, 2021); (ii) a service's delivery and governance arrangements to ensure children were safe from the point of referral to the point of completing an initial assessment (Area 11, 2021); (iii) the governance and timeliness of child protection and welfare referrals from initial receipt of the

[2] The CPNS is a national electronic record of all children who are assessed by Tusla as being at ongoing risk of significant harm. Children placed on the CPNS have a child protection plan which is agreed at a child protection conference.

referral to completion of the initial assessment (Area 5, 2022); and (iv) progress on areas deemed non-compliant in the last inspection (Area 14, 2021). In risk-based follow ups, inspections were conducted to assess the services' progress in coming into compliance in areas which were previously judged 'non-compliant'.

The first SCSIP report states that it was the first inspection of Tusla's Separated Children Seeking Asylum team. The thematic inspection report detailed that this thematic programme arose from a statutory investigation into Tusla's management of child sexual abuse allegations and HIQA's thematic programme. It focused on defined points in the CPW services provided by Tusla from initial point of contact or reporting to the completion of an assessment.

3.2 The Methodology of Inspection

Examining the methodology of inspection, the below sections present the findings in relation to the data collection methods used in the inspection reports and the language used to represent organisational risk and generalisability of the findings. In addition, this section details the findings in relation to the National Standards and Themes inspected against.

3.2.1 Data collection and analysis

Across the sample of 26 inspection reports, inspections' data collection methods included feedback from service users and staff members, review of documentation and observations of practice. Reports list 'analysis of data' as a key activity in the inspection process. As set out elsewhere, this includes, (a) information from previous HIQA inspections of the service (b) notifications of serious incidents or death of a child (c) relevant unsolicited information received by HIQ in relation to the services (HIQA, 2025, p. 113).

Duration of inspections

HIQA states that inspections take place over 3 to 4 days (HIQA, 2024b, p. 40). Table 1 presents the number of on-site inspection days by frequency across the sample of inspections. Across our sample, 22/26 inspections lasted (85%) three or four days. Four inspections (15%) were outside of the expected duration. Three of these were five days long and one outlier inspection was nine days long. In the latter, five out of the nine days were full (7/8 hour) days. On the remaining four days, inspectors were on site for 1.5 hours on three days and 3 hours

on one day. This inspection was nonetheless the longest in our sample, totalling the equivalent of six days.

In our analysis, the number of site visit days was not related to the compliance judgement. The service with the greatest number of site visit days received zero 'non-compliant' judgements. Some services judged 'non-compliant' on several standards had the shortest number of site visit days. Neither was the duration of inspection related to the inspection type.

Table 1: Number of days inspectors were on site

Number of inspection days[3]	Number of inspections of this duration
3	10
4	12
5	3
9	1

Document Review

All 26 inspections included the collection of documentary data, and our research analysis suggests consistency in the documents sampled. The sampled reports included a review of documents such as policies and procedures; audit reports; meeting minutes; service plans; supervision files; and case files. Case files were also used to inspect the degree to which the voice of children was represented.

Table 2 provides an overview of the variation in the number of case files sampled. The number of case files reviewed varied significantly between inspection reports ranging from 8-79 case files. The rationale for the number of case files sampled is not stated in the reports. In the 17 focused inspections the number of cases sampled ranged from 8-34 but, as illustrated in Table 2, this does not seem to be related to the number of children on the CPNS. In the two SCSIP inspections 27 and 38 cases were sampled. The five Risk-based inspections ranged from 38-79 cases, and the thematic inspection sampled 51 cases.

Table 2: Case Files Sampled

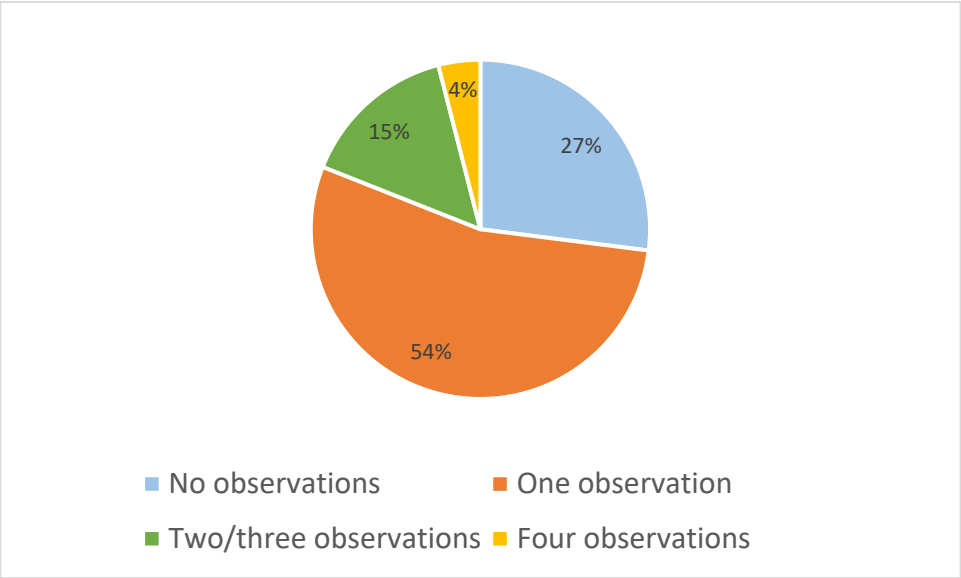
[3] Includes remote site visits. Includes days when the inspector was not on site for the full day

Service Area	Type of Inspection	No. of case files reviewed	No. of children listed on CPNS (At time of CPNS Focused-Inspections)
Area 2	Risk Based	79	
Area 11	Risk Based	69	
Area 14	Risk Based	57	
Area 5	Risk Based	38	
Area 14	Risk based Follow Up	49	
Area 5	Risk Based follow up	46	
SCSIP	Inspection Follow-up	38	
SCSIP	Inspection Announced	27	
Area 11	Focused CPNS	34	93
Area 2	Focused CPNS	25	67
Area 12	Focused CPNS	24	66
Area 14	Focused CPNS	24	75
Area 5	Focused CPNS	24	29
Area 16	Focused CPNS	24	88
Area 17	Focused CPNS	20	60
Area 9	Focused CPNS	19	54
Area 1	Focused CPNS	18	76
Area 4	Focused CPNS	18	51
Area 10	Focused CPNS	16	41
Area 13	Focused CPNS	15	55
Area 15	Focused CPNS	15	40
Area 8	Focused CPNS	15	77
Area 7	Focused CPNS	10	24
Area 3	Focused CPNS	8	25
Area 6	Focused CPNS	10	34
Area 8	Thematic	51	

Observations of practice

Compared to reviews of documents, direct observations of practice featured less frequently in the inspection methodology, and with less consistency. Reports conducted during the Covid pandemic reported remote observations. As Table 3 below illustrates, in seven inspections (27% of the sample), the reports did not reference any direct observations of practice. Most (54%, n= 14) featured one observation of one type of practice. Only four inspections (15%) (two risk-based, the SCSIP and the thematic inspection) observed two or three different aspects of practice. The SCSIP inspection is an outlier in the sample with four observations of the duty team undertaken alongside two observations of intake/assessment.

Figure 1: Number of reported observations of practice across the 26 inspections



The CPNS-focused inspections that included observations of practice exclusively observed one Child Protection and Welfare Conference. In five CPNS focused inspections (29%), no direct observations of any practice were reported. The risk-based inspections observed a range of practice. Two inspections observed a Family Welfare Conference and a Referral Meeting, one inspection observed a Review, Evaluate and Direct (RED) Meeting. Three risk-based inspections (two were follow up inspections) did not feature any observations of practice. The Thematic inspection featured an observation of the Duty team and of a staff meeting. In the follow-up report, one intake and assessment team were observed. The SCSIP inspection recorded four observations of the duty team and the follow up inspection included one observation of the duty and intake team.

Table 3: Observations of practice

Report	Duty Staff / Duty Team	CPC / Review CPC	Family Welfare Conference	Referrals Meeting	Staff Meetings	Intake/ Assessment	Review Evaluate and Direct (RED) Meeting	Observation of children with staff
Area 1, CPNS, 2022								
Area 10, CPNS, 2022								
Area 11, CPNS, 2023		1						
Area 4, CPNS, 2022		1						
Area 2, CPNS, 2021		1						
Area 17, CPNS, 2021		1						
Area 12, CPNS, 2022		1						
Area 13, CPNS, 2021		1						
Area 14, CPNS, 2022		1						
Area 15, CPNS, 2022								
Area 7, CPNS, 2022		1						
Area 5, CPNS, 2023								
Area 6, CPNS, 2021		1						
Area 16, CPNS, 2021		1						
Area 8, CPNS, 2021		1						
Area 3, CPNS, 2022								
Area, 9, CPNS, 2021		1						
Area 14, Risk Based follow up,2023							1	
Area 5, Risk Based follow up, 2022								
Area 11, Risk based, 2021			1	1				
Area 2, Risk Based, 2021			1	1				
Area 14, Risk Based, 2021	1							
Area 5, Risk based, 2022								
SCSIP Inspection, 2023	4					2		1
SCSIP Follow-up, 2023						1		
Area 8, Thematic, 2021	1				1			
TOTAL	**6**	**12**	**2**	**2**	**1**	**3**	**1**	**1**

Staff Feedback

All inspection reports contained information on the method used to gather staff feedback. However, aspects of reporting on this were inconsistent across reports. Table 4 outlines the methods used to capture the views of CPW service staff. Area managers were interviewed in all reports, and the number of participants was consistently reported. The views of Principal Social Workers (PSWs), team leaders and social workers were gathered through focus groups and interviews. However, the number of participants was not consistently reported. The number of PSWs interviewed was reported in 12/17 reports (71%) and the number of focus group participants was reported in 7/9 (78%) reports. Only seven (27%) reports detailed the number of social workers who participated. Similarly, 25 reports included focus groups with team leaders but only six reports (23%) outlined the numbers that participated.

Table 4: Data Collection – Staff Views

	Number of Reports	Number of Reports that detail number of participants
Interviews with Area Manager	26	26
Interviews with PSW	17	12
Focus Groups with Team Leaders	25	6
Focus Group with PSWs	9	7
Focus Group with Social Workers	26	7

Child and Family Feedback

All 26 inspection reports include a section representing the views of children and parents under the heading '*Views of people who use the service*'. As illustrated in Table 5, the number of children spoken with per inspection ranged from 0-8. The median number of children spoken with was two. In 19% of inspections, no feedback was received from children. Only 15% (n=4) of inspections heard the views of more than three children. Where children's feedback was included, this was most commonly via an individual discussion with an inspector. In one report a survey was used. However, the survey received only one response.

In some, but not all reports, it was explained that children were invited but had declined to speak with inspectors. Reports referenced challenges to gaining children's feedback. Across reports, the age of children was the most cited reason for their non-involvement in the inspection. Consistently, age rather than capacity was the reported reason for non-

involvement in the inspection process. The reports did not state what age was considered appropriate to invite children to provide feedback.

The SCSIP inspection report referenced the trauma children using the service may have experienced. It did so with reference to the rationale as to why a small sample of children were consulted about participating in the inspection process:

> *"Due to the trauma children may have experienced in their journey to a safe destination, being alone and in an unfamiliar country, only a small number of children were consulted with to ask whether they wished to speak with inspectors about their experiences."* (SCSIP, First Inspection, 2023)

Across the sample of reports more parents and family members were spoken with than children (see Table 5). Where family members' feedback was included, the number of individuals spoken with in an inspection ranged from 3- 12. Three inspection reports did not include any family members' views, but this is explained by the inspection type: two follow up risk inspections and an SCSIP inspection.

The extent to which each report's findings on service users' views are representative of people who use the service generally is dependent, not just on the number of people who participate, but on who participates in the discussion with inspectors and how they are sampled. While some reports outline how the service area selected children, not all reports make clear how those who participated were selected and recruited.

Table 5: Data Collection – Child and Family Feedback

Service Area, year	Year	Type of Inspection	No. of parents/ family members spoken with	No. of children spoken with
Area 1	2022	Focused CPNS	12	8
Area 2	2021	Focused CPNS	10	4
Area 3	2022	Focused CPNS	6	4
Area 4	2022	Focused CPNS	3	3
Area 5	2023	Focused CPNS	4	3
Area 6	2021	Focused CPNS	5	3
Area 7	2022	Focused CPNS	8	2
Area 8	2021	Focused CPNS	5	2
Area 9	2021	Focused CPNS	5	2
Area 10	2022	Focused CPNS	4	1
Area 11	2023	Focused CPNS	8	1
Area 12	2022	Focused CPNS	5	1
Area 13	2021	Focused CPNS	5	1
Area 14	2022	Focused CPNS	6	1
Area 15	2022	Focused CPNS	5	1 Survey Returned
Area 16	2021	Focused CPNS	3	1
Area 17	2021	Focused CPNS	2	0
Area 11	2021	Risk Based	10	7
Area 5	2022	Risk Based	9	0
Area 2	2021	Risk Based	10	2
Area 14	2021	Risk Based	4	0
Area 5	2022	Risk Based follow up	4	0
Area 14	2023	Risk based Follow Up	0	0
SCSIP	2023	Inspection Follow-up	0	2
SCSIP	2023	Inspection Announced	0	3
Area 8	2021	Thematic	11	3
Total			144	55

3.2.2 Language and generalisability

Reports often contained careful use of language that accurately reflected the uncertainty of outcomes in child protection services where regardless of the quality of practice, children cannot always be kept safe. However, there were some examples of unrealistic language around risk and risk reduction. In the following example, the language of 'ensure' overstates what child protection and welfare services can be reasonably expected to achieve. Services may 'support' safety outcomes, but, given the uncertainty of outcomes in child protection work, it would be unrealistic to expect that, no matter how good their work, services can 'ensure' children's safety:

> *"The service performed its functions in accordance with relevant legislation, policies and standards, and by doing so it ensured that children were kept safe."*
>
> (Area 6, CPNS, 2021)

Additionally, while reports generally made claims that were well supported with reference to data, there were examples where the conclusion extended beyond what could be validated from the data. In the example below, the language over-generalises from the findings:

> *"The children were aware of or actively involved in the safety plans, with the exception of one child who was too young. All risks were identified and the children's support networks were involved in ensuring the children's safety."*
>
> (Area 11, Risk Based, 2021)

In the example above the wording of 'ensuring the children's safety' goes beyond what can reasonably be expected of services or networks. It would be more accurate to use the wording of 'supporting' safety, to indicate that services cannot ensure safety, even when they practice well. Secondly, in reference to this finding, thirteen safety plans were reviewed by inspectors, but all available case files in the service were (justifiably) not reviewed. Therefore, it would be more appropriate to refer to the thirteen case files examined, rather than 'the children' in general. In addition, while case file analysis provides an important indication of the involvement of children in safety planning, it does not necessarily ensure that children are aware of safety plans. Children themselves were not consulted to verify that they were aware of, or involved in, their safety plan. Therefore, while the files indicate that children were consulted, this was not validated by children themselves and so the data cannot support the conclusion that 'the children' were aware of or involved in the safety plans. Similarly, it would not be possible to validate that 'all risk were identified'. In this case, a more caveated conclusion would be supported by the data.

3.2.3 The National Standards and Themes inspected

HIQA inspect under six Themes, which are set out in the National Standards for Child Protection and Welfare Services (HIQA, 2012). In the sample of inspection reports for this study, 17 of the 27 Standards (62% of Standards) across four of the six themes were inspected against during the period of two years and eight months between March 2021 – November 2023. It should be noted that information relevant to a Theme or Standard that was not

inspected was sometimes included in reports, however this does not constitute formal inspection of the Theme or Standard. Formal inspection is a mechanism to ensure the spread of attention across the Themes and Standards and is therefore the focus of our analysis. The following themes were inspected:

- Child Centred Services (*Theme 1*)
- Safe and Effective Services (*Theme 2*)
- Leadership, Governance and Management (*Theme 3*)
- Workforce (*Theme 5*).

No report in our sample inspected against Use of Resources (*Theme 4*) nor Use of Information (*Theme 6*). This section examines the formal inspection of National Standards and Themes.

A full list of the standards inspected across the sample is featured below in Table 1, alongside the Standards (n=10, 38%) and Themes (2/6) not inspected against. The 17 CPNS focused inspection reports all reported exclusively against *Theme 2* and *Theme 3*. The intention to focus on these themes is stated clearly in each CPNS focused report but the justification for this focus is not outlined. There are 16 standards within these two themes, but the reports all inspected exclusively against the same six standards, three in each theme. These six standards are highlighted in grey in Table 1 below. Despite the stated focus on *Themes 2* and *3*, one standard in *Theme 3* was not inspected against and nine standards in *Theme 2* were not inspected against. The rationale for the absence of inspection on these standards is not stated in the reports. The three other inspection report types - risk-based, SCSIP and thematic - inspected against varying standards. The rationale for choosing these standards and themes is also not outlined in the reports.

TABLE 6: Standards inspected against across full sample of reports (in descending order of standards most inspected against)

Standard	Theme	Number of reports where Standard is inspected against	% of reports (Total reports in sample N=26)
3.2 Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	3. Leadership, Governance and Management	23	88.46%
3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	3. Leadership, Governance and Management	22	84.62%
3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.	3. Leadership, Governance and Management	20	76.92%
2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.	2. Safe and Effective Services	18	69.23%
2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	2. Safe and Effective Services	17	65.38%
2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.	2. Safe and Effective Services	17	65.38%
2.3 Timely and effective action is taken to protect children.	2. Safe and Effective Services	8	30.77%
2.5 All reports of child protection concerns are assessed in line with Children First and best available evidence.	2. Safe and Effective Services	7	26.92%
2.4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	2. Safe and Effective Services	6	23.08%
2.2 All concerns in relation to children are screened and directed to the appropriate service.	2. Safe and Effective Services	5	19.23%
5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	5. Workforce	4	15.38%

1.3 Children are communicated with effectively and are provided with information in an accessible format.	1. Child-Centred Services	3	11.54%
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.	2. Safe and Effective Services	2	7.69%
5.2 Staff have the required skills and experience to manage and deliver effective services to children.	5. Workforce	2	7.69%
1.1 Children's rights and diversity are respected and promoted	1. Child-Centred Services	1	3.85%
2.1 Children are protected and their welfare is promoted through the consistent implementation of Children First.	2. Safe and Effective Services	1	3.85%
5.1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.	5. Workforce	1	3.85%
1.2 Children are listened to and their concerns and complaints are responded to openly and effectively.	1. Child-Centred Services	0	0%
2.8. Child protection and welfare interventions achieve the best outcomes for the child.	2. Safe and Effective Services	0	0%
2.10 Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.	2. Safe and Effective Services	0	0%
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.	2. Safe and Effective Services	0	0%
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 and standards	3. Leadership, Governance and Management	0	0%
4.1 Resources are effectively planned, deployed and managed to protect children and promote their welfare	4. Use of Resources	0	0%
5.4 Child protection and welfare training is provided to staff working in the service to improve outcomes for children.	5. Workforce	0	0%
6.1 All relevant information is used to plan and deliver effective child protection and welfare services.	6. Use of Information	0	0%
6.2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	6. Use of Information	0	0%
6.3 Secure record-keeping and file-management systems are in place to manage child protection and welfare concerns.	6. Use of Information	0	0%

Table 1 suggests that across the full sample of 26 reports, the most frequent focus was on leadership, governance and management (*Theme 3*). This is influenced by the 17 CPNS focused inspections (65% of the sample), which all inspected against *Theme 3*, but this theme also featured in other inspection reports. Overall, 88% of reports inspected against *Standard 3.2*, 85% against *Standard 3.1* and 77% against *Standard 3.3*. Nonetheless, none of the reports in our sample inspected against *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 and standard*s*). Compared to *Theme 3*, the three *Theme 2* standards that were the focus of the CPNS focused inspections, featured comparatively less frequently across other inspections. *Standard 2.6* and *2.7* only featured in the CPNS focused reports and *Standard 2.9* featured in only one non-CPNS focused report.

Excluding the six standards that were the focus of the 17 CPNS focused inspections, Table 1 demonstrates that the next most frequently inspected standard was *Standard 2.3* (Timely and effective action is taken to protect children), which featured in 31% of reports (n=8). This was followed in frequency by *Standard 2.5* (All reports of child protection concerns are assessed in line with Children First and best available evidence), featured in 27% of reports (n=7) and *Standard 2.4* (Children and families have timely access to CPW services that support the family and protect the child), featured in 23% of reports (n= 6). Therefore, in the reports sampled, as well as a strong focus on governance, there was a strong focus on inspecting for timely action to protect children and provide services.

Although *Theme 2* featured frequently, none of our sample reported against *Standard 2.8* (CPW interventions achieve the best outcomes for children), *2.10* (CPW case planning is managed and monitored to improve practice and outcomes for children) or *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 practices at all levels). As noted above, none of the reports in our sample inspected against *Theme 4* or *Theme 6.* The rationale for the absence of inspection against these themes and standards was not stated.

The workforce theme (*Theme 5*) was inspected against comparatively less. Only one report in the sample (4%) inspected against *Standard 5.1* (safe recruitment practice and required competencies). Just two reports (8%) inspected against *Standard 5.2* (staff have the required skills and experience). Four reports (15%) inspected against *Standard 5.3* (all staff are supported and receive supervision). No reports in our sample inspected against *Standard 5.4* (child protection and welfare training is provided to staff working in the service to improve outcomes for children). Therefore, in our sample, there was comparatively less focus on inspecting for workforce quality and support.

In our sample, *Theme 1* – Child-centred services – was inspected against in relatively few reports. There are three standards in *Theme 1* but only two featured in our sample. *Standard 1.2* (children are listened to and their concerns and complaints are responded to openly and effectively) did not feature in our sample. Three reports (11.5% of the sample) inspected against *Standard 1.3* (children are communicated with effectively and are provided with information in an accessible format). Only one report (4% of sample) inspected against *Standard 1.1*. (children's rights and diversity are respected and promoted).

Overall, therefore the analysis demonstrates that in the more than 2.5-year period between March 2021 and November 2023, not all the themes or standards set out in the National Standards for Child Protection and Welfare were inspected against. The rationale for which themes and standards were the focus of inspection (or not) was not set out in reports. There was a strong focus on themes and standards relating to leadership, governance and management and timely action to protect children and provide services. There was comparatively less focus on themes and standards focused on workforce quality and support and on child-centred services.

3.3 The Focus of Reporting

The following sections employ the seven-category evidence informed framework (available in Appendix 1) we previously derived from the international literature on inspection as a broad structure to report our analysis. The section begins by detailing the findings in relation to how inspection reported on child and family voice. This is followed by the findings in relation to process compliance and quality of practice, and the integration of these categories. Subsequently we present findings on how inspection reported on outcomes. Following this, we report the findings regarding how inspection supported learning and systematic analysis, and how inspection reports integrated child and family experiences data. This section further details how the context services operated in was accounted for in inspection reports and in inspection judgements. The final section outlines the findings in relation to the action points agreed with services in response to inspection judgements.

3.3.1 Child and family voice focus

A focus on child and family voice within reports incorporated what service users report as important, their experience of services, the self-reported impact of the service, and whether service users report that their rights were upheld. As well as obtaining the views of children through interview, inspection focused on the analysis of case files to assess how children were included within services. The inspection reports demonstrate a stated commitment to centring the voice of children and their experience of child protection and welfare services.

A dedicated section at the start of each report presented the feedback from children and families. However, this feedback was not always transparently integrated into subsequent analysis to inform the judgement reached. The judgements at times seemed to be based only on the case file analysis, although direct feedback was available. For example, in the report below, children outlined concerns in relation to their inclusion in safety planning and not having someone they felt they could inform that their safety plan was not working:

> *"One child told inspectors that even though they were included in safety planning, they could have been included more. Another child told inspectors that they had a safety plan but it was not working and there was no one they could tell as the worker they got on best with was on leave. An inspector agreed to pass this on to the social work manager."*

However, the subsequent review of case files did not integrate the information provided by children, and their experiences are not accounted for:

> *"The 13 safety plans reviewed by inspectors were all adequate. Parental capacity to safeguard was appropriately assessed. The children were aware of or actively involved in the safety plans, with the exception of one child who was too young. All risks were identified and the children's support networks were involved in ensuring the children's safety. The safety plans were reviewed where required."*

The report concluded that

> *'Safety plans were of good quality but not all children who required one had a safety plan"* (Area 11, Risk Based, 2021)

Therefore, types of data (here, direct feedback data and secondary analysis of case files) were considered separately. The absence of analysis across the data to integrate the findings led, at times, to conclusions that were not transparently inclusive of children's direct feedback. In this example, the contradiction between findings was resolved in a way that excluded children's self-reported experiences.

3.3.2 Process-compliance focus

The analysis of inspection reports considered the relative focus on compliance with processes. This category is distinguished from a quality of practice focus (explored below), which goes beyond investigating whether a process took place to analyse the quality of practice. However, our analysis does not treat these as wholly separate categories since, as phase one of this research project identified, process compliance can be integral to quality of practice (Caffrey et al, forthcoming). Instead, the analysis below considers whether inspection integrates the inspection of process and practice.

As would be expected due to formulation of the National Standards, the inspection reports demonstrated a frequent focus on inspecting for whether a process took place or was in place. Table 6 below reports the relative frequency of reference to the five most common process types. Timeliness and recording/records management were referenced most frequently in reports, together accounting for 67% of procedural references. The remaining 32% of references comprised of references to whether a service had in place systems of audit

(14%), the occurrence or frequency of supervision (11%) and meeting occurrence and attendance (9%).

Table 7: Frequency of reference to process types

Procedure type	**Definition**	**No. references**	**% of total references (n= 762)**
Timeliness	Reporting on timeliness of procedures and processes.	277	36%
Recording and records management	Reporting whether case files are up to date and on the management of records e.g. creation of records, maintenance and updating of records.	225	31%
Audit	Reporting on whether the service has in place systems of audit	106	14%
Supervision occurrence	Reporting on whether supervisions take place or frequency of supervision	82	11%
Meeting occurrence and attendance	Reporting on occurrence of meetings, attendance and meeting minutes.	72	9%

As illustrated in detail below, the analysis suggests that inspection reports tended to avoid a focus on process compliance as an end in itself. Instead, reporting tended to integrate consideration of process compliance with consideration of broader practice.

Timeliness referred to the timeliness of processes occurring. For example:

> *"Inspectors found the service area had good performance overall in ensuring timely initial child protection conferences (ICPC). Requests for a CPC were timely once an initial assessment identified children were at ongoing risk of significant harm. Review child protection conferences were timely and comprehensive."* (Area 4, CPNS, 2022)

However, for the most part, timeliness was not positioned simply as an objective in its own right. Reports often emphasised its importance for families, highlighting that process compliance is also concerned with quality of practice and not wholly separate from it:

> *"Children received a responsive service in a timely way which prioritised their safety and this meant that children and their families received support when they required it most. There was good communication between social workers and the child protection chairperson which allowed for good planning to meet children's needs."*
>
> (Area 7, CPNS, 2022)

Similarly, the focus on recording often went beyond inspecting whether records were up to date. Inspection reports considered how the robustness of recording and documentation aided quality of practice. For example:

> *"CPC records were comprehensive and clearly outlined the identified risks and what was required to reduce them. In all 15 files reviewed by inspectors, the views of all attendees were recorded, which led to comprehensive multi-disciplinary assessments of children's needs. Detailed discussions were recorded which led to robust decision making, based on the evidence and information presented."* (Area 8, CPNS, 2021)

Furthermore, while reporting focused on the level and quality of recording there were examples where a lack of recording in itself was not seen as a risk to children and their families:

> *"Whilst social workers had developed good practice in consulting with the CPC chairperson as required, this was undertaken in an informal manner and was not formally recorded by the CPC chairperson. This meant that the service may not be accurately capturing the level of work undertaken by the CPC chairperson in this informal way. This would lead to further quality improvement of their process rather than being indicative of any risk within the service or regarding children and their families."* (Area 7, CPNS, 2022)

Inspection reports considered whether meetings integral to the child protection process took place and who was in attendance. However, in the same vein to other aspects of procedural compliance, inspection often went beyond checking occurrence to report on the quality of practice in those meetings. For example:

> *"The chairperson facilitated inclusive participation of all those in attendance, namely the parents of the child, Tusla staff and external services. While the child had decided not to attend the conference, they had completed the 'Me and My Conference' booklet used by social workers in the area. This booklet provided information on the child's views and wishes for their future, and ensured that their voice was included in the decision making process. Reports received were shared, and a clear decision was*

agreed as to why the child was to be listed as inactive on the CPNS register." (Area 6, CPNS, 2021)

3.3.3 Quality of practice focus

Linked to the focus on procedure compliance is the focus of inspection on quality of practice. As described in the section above, across reports there was a strong focus on inspecting whether a service followed procedures and protocols. However, inspectors also focused on evidencing quality of practice from records and not just accounting for whether a case file was up to date or that records had been updated in a timely manner.

For example, in the extract below, a qualitative judgement is made regarding the quality of front-line practice. Specific examples are provided to support the judgement and to set out the required standard:

> *"Information provided by social workers in CPC reports to the chair and external professionals and families, in preparation of the CPC, was mixed. Inspectors found that in some instances, the analysis of past harm was weak. For example, in one case the harm was described solely within context of the behaviours of parents and there were limited details of the impact of harm on the child and or the child's lived experience. In another case reviewed by inspectors, the analysis of past harm excluded a recent incident of physical abuse pertinent to the case; and in another case there was no acknowledgement of actual harm to the child detailed in a previous referral to the service. Weak analysis of risk and harm hindered decision making processes for children using the child protection and welfare service, and this meant that the service could not always ensure that children were responded to at the right threshold."*
>
> (Area 2, CPNS, 2021)

When referencing practice relating to relationship building with service users some reports outlined what good quality practice looked like. For example:

> *"Social workers said they routinely went through their assessment/case conference report and recommendations with parents in advance of the review case conferences. This was important in order to facilitate buy in from families and to strengthen*

collaboration practice between social workers and children and families. Inspectors found that these consultations were not always recorded on file and this required improvement." (Area 17, CPNS, 2021)

As noted above in relation to the methodology of inspection, it was less common for frontline practice to be directly observed. More commonly the quality of practice was assessed by examining case files. In the extract below, expert judgement is used to assess the safety of practice in relation to removal of children from the CPNS:

"Inspectors reviewed 11 cases of children who had been removed from the CPNS in the six months prior to inspection for the purpose of examining the practice in reaching decisions to remove a child. Of 11 such cases reviewed, five related to children who had been received into care and six related to children who remained in their families but for whom risks had sufficiently reduced and progress had been sustained in keeping children safe. Inspectors found that in all cases examined the decision to remove or de-list a child from the CPNS was appropriate. Decisions were discussed and agreed with all professionals and family members involved in the child's care and planned effectively to ensure sustained safety for the child or children concerned."

(Area 2, CPNS, 2021)

The quality of practice inspected in reports included both front line practice with families and managerial and leadership practice. As illustrated above, in relation to managerial practice, inspection included aspects of procedural compliance, including whether audit systems were in place and whether supervision and other meetings took place. However, inspection also went beyond this to consider the quality of managerial and leadership practice.

Inspection included reporting on the quality of supervision and support to staff. This tended to be assessed via supervision meeting notes and feedback from staff, rather than direct observations of supervision meetings. For example:

"Supervision records reviewed by inspectors evidenced a clear focus on the quality of child protection practice. Decisions and actions regarding next steps in the management of complex cases were clearly recorded. Frontline staff spoke positively about managers having an open door policy and benefiting from a supportive

organisational learning culture. A suite of practice tools had been developed by managers to support practitioners in gathering a consistent standard of information and analysis of risk." (Area 8, Thematic, 2021)

Similarly, while services judged to have used audits to inform practice were reported on positively, reporting also scrutinised the quality of auditing. In the extract below, the report states that audits should focus on the quality of social work rather than provide an account of whether a visit occurred, or documentation was completed:

"Improvements were required at managerial level to capture the quality of the work undertaken with children and their families. While both the tracker and the audits ensured that required actions occurred, they did not check for the quality of the actions undertaken. For example, the tracker noted when the visit occurred but what happened during the visit was not looked at." (Area 7, CPNS, 2022).

Several inspections reported on the quality of organisational culture within a service, including a culture of openness and transparency, communication and organisational learning, and how these strands of organisational culture impacted staff, and in turn service outputs. As illustrated in the extract below, feedback from staff was commonly used to assess these issues:

"There was a strong culture where staff recognised the interdependency of each other's work and where appropriate information sharing was promoted. There were strong established working relationships and senior managers spoke about viewing their service as a whole area rather than just the area for which they had responsibility. Inspectors found that this led to the development of a collective thinking about what the service could offer children and their families." (Area 16, CPNS, 2021)

A focus on accountability also featured across the sample of reports referencing whether lines of accountability were clear within the service. It was not always clear whether accountability, as reported on, referred to procedural accountability (in organisational documents) or accountability in practice, as it is implemented in an organisation. For example:

"The overall accountability for the delivery of the service was clearly defined and there were clear lines of accountability at individual, team and service levels. There was a

stable and experienced management team with clearly defined roles with respect to management of children listed on the CPNS." (Area 13, CPNS, 2021)

3.3.4 Outcomes Focus

As discussed in section 3.2.3 above, Standard 2.8 – *CPW interventions achieve the best outcomes for children* – was not inspected against in the 2 years and 8-month period represented by our sample of reports. Therefore, reports did not inspect for this aspect of outcomes reporting. Nonetheless, reports do contain reporting on outcomes in relation to the other standards inspected.

While inspection reports included performance data, this did not include population level distal outcomes assessed via performance data. Such data is used in some countries' inspection systems and requires quantitative service-level data and use of a proxy measure. For example, child safety for the population of children using the service is sometimes measured by the proxy measure of the service's performance in terms of re-referral rates.

Instead, in HIQA reports, more proximal (closer to practice) quantitative performance data was used to assess families' and children's safety and experiences. For example, in the extract below, the number of cases awaiting a child protection service is used to indicate the outcome of level of unmet need:

"Despite consistent reduction in the numbers of children and families impacted, at the time of inspection children identified as medium or low risk still waited unacceptable amounts of time for an assessment of their safety in many cases and long delays resulted in prolonged and increased risks for some of these children. At the time of inspection 711 cases were awaiting a child protection service at varying stages of the process." (Area 2, 2021, Risk Based)

Reports also at times assessed the outcome of a service change to improve practice. In the example below, training was introduced to improve the quality of preliminary enquiries. The efficacy of training in terms of the outcome of improved practice is assessed by examining recording in case files to ascertain whether decisions considered cumulative harm:

"The service had implemented training for staff as part of its plan to improve the quality of preliminary enquiries. This was effective as there was an improvement in the

recording of history of involvement with the service in records. Inspectors saw numerous examples of staff recording decisions made based on consideration of cumulative harm". (Area 14, 2022, Risk Based)

In considering service outcomes, reports made use of the qualitative feedback from children and families. In some reports this was used to assess the outcome of self-reported or family reported child safety. For example, the extract below reports on a small number of service users' self-reported experiences of safety. Here the outcome of 'feeling safe' is process traced to understand what brought about the positive outcome:

"Each was aware of their safety plan and felt that it had brought about change for the better and they felt safer as a result. The children described good experiences of their social workers and, for two children, being allocated a support worker in the community made a big difference in their lives". (Area 2, CPNS, 2021)

The qualitative feedback was also utilised to detail experiential, rights-based outcomes for families. For example, below the report details how the practice of informing parents contributes to the outcome that parents report feeling included and aware:

"Parents told inspectors that they received written minutes from child protection conferences and copies of safety plans devised by social workers to promote the safety and welfare of children. This supported their sense of inclusion and participation in the service being provided and they were aware of the actions to be taken to reduce risks to children." (Area 17, CPNS, 2021)

Overall, reports avoided using performance data proxy measures. Instead reports tended to focus on assessing relatively proximal outcomes, including, for example, the level of unmet need and improvements in practice, which could be assessed more directly by examining numbers of unallocated cases or the recording of practice in files. Reports also made use of service user experience data to assess self-reported safety and understand what contributed to positive experiences. In this sense, reports helped provide practice direction by illustrating not just that but how outcomes came about.

3.3.5 Learning Focus

As illustrated in the quality of practice section above, reports included detailed professional guidance for services on what constitutes 'good' practice. In addition, reports contained examples of the inspectorate encouraging a system level approach to learning across services. In the extract below, the inspectorate set out the expectation that services should learn from previous inspection of other services, not just their own service:

> *"From a review of team meeting minute's inspectors found there was learning from reviews and serious incidents and this was shared with staff to inform the development of best practice and service improvements through team meetings and supervision. However, as this was the last of the 17 Tusla service areas to be inspected as part of the CPNS thematic inspection programme, the level of non -compliances found indicated that learnings from previous CPNS inspections had not been effectively put in place."* (Area 5, CPNS, 2023)

The focus on the Child and Family Agency's role in cascading learning from HIQA reports, is reflective of a focus on improving practice by examining the wider network that individual services are situated in.

3.3.6 Systems Focus

In phase one, our international review of the literature on inspection, we identified what we termed, a 'systems focus'. This refers to the integration of care and the service user experience across organisations and multi-disciplinary professionals. It also refers to inspection of how well services and professionals work together and coordinate activities.

In keeping with the National Standards, inspection was centrally focused on inspecting Tusla services and inspection was structured by service issues. Data collected from children and families sought feedback on aspects of their experience, but it did not look to piece together an integrated 'service user journey' across the system of CPW. The issue of integration of services comprises two National Standards. *Standard 3.4* inspects against the expectation that *'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 and standards'*. As discussed above, this standard was not inspected in our sample and so the process did not focus on the monitoring of services provided on behalf of statutory service providers. National Standard 2.9, which assesses whether '*interagency and inter-*

professional cooperation supports and promotes the protection and welfare of children', was inspected in 18/26 inspections (69% of inspections) in the time period we examined. Therefore, in the timeframe of reports we analysed, the focus of system-level inspection was primarily on inter-agency and inter-professional working, rather than on monitoring systems for services provided externally on behalf of the statutory agency.

As illustrated above in Section 3.3.5 'learning focus', inspection reports included a macro level focus on the coordination of learning and monitoring across Tusla services. In addition, inspection of inter-agency cooperation included a focus on the availability of formal coordination systems, appropriate information sharing, and the quality of information gathered from external professionals. The focus in reports therefore was not just on the availability of systems for coordination across the child protection and welfare system, but on evidenced good use of those systems. As illustrated in the extract below, reporting provided a professional judgement on the quality of interprofessional and interagency practice:

> *"The management of the service had systems in place to ensure that there was good information sharing and co-ordination of child protection cases amongst social workers, stakeholders and local services. Inspectors found mostly good levels of information sharing between social workers and a broad range of agencies and professionals involved with children. Good quality information was gathered from other professionals and this helped social workers to better understand the needs of children and parents."* (Area 17, CPNS, 2021)

Inspection also went beyond understanding working arrangements, to include analysis of underpinning supports for effective interprofessional working. This included the provision of training to ensure professionals in other agencies had sufficient understanding of their role in CPW processes. For example, in the report below the service was judged 'substantially compliant' because it was identified by the social work team that professionals in allied organisations were deemed to have insufficient understanding of Signs of Safety (the national framework for CPW practice) and their role in Child Protection Conferences. The inspection deemed that the service should continue with its plan to provide training to external agencies:

> *"The service promoted positive and cooperative relationships with other agencies to ensure effective case management and to improve outcomes for children and their*

families. There was a gap identified by social workers and managers about the knowledge held by other agencies with regard to case conferences. Further child protection and welfare training was required on an interagency basis to ensure child protection case conferences were as effective as possible". (Area 7, CPNS, 2022)

As outlined in this example, inspection considered the working of the wider child protection system but inspection itself was centrally focused on inspecting Tusla services, rather than the wider CPW system. Therefore, due to its scope, the inspection methodology was reliant on inter-agency working issues being identifiable within or by the Tusla service inspected. In the above example, staff in the service identified poor understanding of the national practice framework by external agency professionals as an issue. If staff had not themselves identified this issue, it may not have been evident.

3.3.7 Context Focus

All reports featured a section near the start of the report titled 'profile of the service area'. This information is requested by HIQA and provided by each service[4]. The information contained in this section varied significantly between reports and inconsistently reported on socio-economic context and levels of deprivation of service areas. Some reports provided a detailed overview of trends in population and deprivation levels, benchmarking to national trends to contextualise the information. For example:

"There were 37,587 children (27.3%) of the total population which was slightly above the national average of 26% […]. [Area] is ranked as a deprived area relative to the national average (Pobal H.P deprivation index) with an unemployment rate of 12.4% in Monaghan and 15% in Cavan compared to the national average of 12.2%. 13.2% of the population in the area classify themselves as non- Irish nationals, while 0.54% of the population classify themselves as Irish Travellers […].

The Census had highlighted that less than one third of the Area's population lived in towns with a population of more than 1,500 people. This had resulted in a very high

[4] Information provided by stakeholder consultation group

rural dispersion of the remaining two thirds of the population. This had significant implications for the delivery of all types of services across the area."

(Area 10, CPNS, 2022)

Other reports only referred to population data, did not include a national benchmark to help the reader understand and contextualise the information, and did not provide area deprivation data. For example:

"The area comprises of [area] and has a population of 280,260 (Census 2016). According to data published by Tusla in 2018, the service area has a population of children from the ages of 0-17 years of 73,130." (Area 9, CPNS, 2021)

Where relevant, reports also described external events, such as the Tusla cyber-attack and the Covid-19 pandemic and detailed the impact of these events on services.

In addition, this section featured workforce information. Reports outlined the composition of the senior management team, the length of time an area manager had been in place and staffing numbers and vacancies at the time of inspection. CPNS-focused inspections also reported on the numbers of children on the CPNS and whether they had been allocated a social worker. Some reports stated if vacancies were covered by agency staff, as the example below illustrates.

"At the time of the inspection, there were 10 frontline social work/social care vacancies in the child protection and welfare teams. Out of eight permanent social work vacancies, seven were covered by agency staff. All children on the CPNS were allocated a social worker at the time of the inspection. At the time of the inspection, there were 54 children listed as active on the CPNS and 60 children who had been de-listed in the previous six months." (Area 9, CPNS, 2021)

Staffing shortages were identified in many reports. Within these reports, (in keeping with the National Standards) inspection reporting was mainly focused on how services responded to workforce shortages in order to achieve compliance with standards. For example:

"The development and retention of staffing was a key priority for the child protection and welfare service, as staff vacancies impacted on the service's capacity to provide a timely service." (Area 14, Risk Based, 2021)

Although reports frequently detailed that staffing and resource challenges compromised the ability of services to meet standards, a challenging context did not seem to influence the compliance judgement reached. Rather the compliance judgement simply assessed whether the service was compliant with the Standard.

In the following extract, in reference to Standard 3.3[5], it is acknowledged that the service has in place management systems to assess effectiveness and safety. However, despite the services' efforts, under-staffing and a lack of care placements continued to undermine the ability of the service to provide a quality, safe service. Although the reports' analysis suggests that a resourcing context (highlighted in bold below) is the issue of concern, rather than the service's systems for managing these risks, the service was deemed "non-compliant".

> *"There were risk management systems in place to ensure that all risks in the service were reported on and managed. Some risks were addressed such as risks associated with COVID-19 and the recent cyber-attack, but other risks persisted.* ***Ongoing risks such as the lack of placements, high levels of staff vacancies and staff turnover, and high caseloads made it continuously difficult for practitioners to sustain the level and quality of intervention required in cases of children listed on the CPNS. The service did not have the necessary resources in place to meet the service's needs and this posed a risk to the quality and safety of the service provided****.*
>
> *Judgment: Not Compliant."* (Area 17, CPNS, 2021)

Similarly, below, the service is reported to have a good system and practice in place in relation to Standard 2.9[6]. However, because a suitable placement was unavailable for a child with complex needs the services was judged 'non-compliant':

> *"The service supported and promoted multidisciplinary involvement and cooperation to ensure that the needs of children were met in a timely way. There were communication systems in place to ensure that information was appropriately shared with the relevant professionals. Challenges in the provision of suitable alternative care placements in the area had resulted in the needs of a child with complex needs*

[5] 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

[6] Standard 2.9 Interagency and interprofessional cooperation supports and promotes the protection and welfare of children.

not being met. Judgment: Not Compliant" (Area 15, CPNS, 2022)

In the first example above, the 'not compliant' judgement is contextualised to make clear that the context the service was operating in constituted a significant explanation as to why the service could not comply. However, data analysis highlighted that judgements were not always contextualised to highlight reasons that impeded the ability of the service to comply. For example, the extract below delivers a judgement for Standard 2.6. The report found several reasons that CPC were not always on time. This included CPCs assertation that sometimes more time was needed to ensure meaningful engagement with families and a good outcome, and that the service was understaffed. The 'service area' of the report also detailed understaffing. Specifically, that there were 10 frontline social work/social care vacancies in CPW teams and 7 of 8 permanent social work vacancies were covered by agency staff. However, this contextual information did not feature in the delivery of the judgement. Here, the reason for non-compliance is reduced simply to a lack of 'consistent practice as to what constituted timely process':

> *"Initial CPCs were not always convened in a timely manner. There was no consistent practice as to what constituted a timely process between a request for an initial CPC and a CPC taking place. While inspectors found that children were not placed at immediate risk while awaiting a CPC, given there were significant child protection concerns for these children, these delays were not acceptable. It is for this reason that the judgement is not compliant."* (Area 9, CPNS, 2021)

Therefore, the context the service operated in – staffing, availability of placements for children, and the needs profile of families - was commonly recognised in reports but did not seem to ultimately affect the compliance judgement. In this sense, 'non-compliant' or 'substantially compliant' designated a service that was below standard on an aspect of service provision that was the responsibility of that service, regardless of whether the reasons for non-compliance were outside of the control of that service. Contextual information was sometimes, but not always, provided with the judgement to make clear if a challenging resource context or national level issue impeded the ability of the service to comply.

3.3.8 Inspection Judgements and Compliance Plans

Following the inspection's judgement on each standard inspected, reports include the services' response in the form of a 'compliance plan', which is agreed with HIQA. These plans were analysed to understand the types of action points contained within them. Table 8 sets out the types of action points included in compliance plans and the frequency of action points with reports. Action points can be understood as consistent with, and influenced by, the themes and standards inspected, as outlined in Section 3.2.3 above.

Table 8: Compliance plan action points by type and frequency

Action point category	Category definition	Frequency coded
Governance	Clarify or develop protocols of action or role responsibility.	114
Audit monitor or review	Actions to audit, monitor or review practice with action taken where needed, or where possible.	89
Training and learning	Training and learning events.	85
Staffing and resourcing	Allocating newly recruited staff to specific actions, efforts to recruit staff, and make business cases for staff. Also includes actions to review caseloads, efforts to address placement availability and the quality of a buildings.	83
Timely response	Actions that commit to a timeframe for response and actions that set timeliness as a discussion point in meetings.	46
National Reform	Responses that identify that the issue is being or will be addressed by a national response, which the service will implement.	31
Recording	Commitment to recording action, risks and decision on files.	29
Supervision	Actions to standardise supervision, including listing actions for discussion, and setting frequency of supervision meetings.	27
Engaging children and families	Actions to engage with children/families or uphold their rights.	17
Multi-professional response	Actions to engage multi-professional working including information sharing and training, attendance at meeting and establishing fora to agree a process with other agencies.	14
Allocated worker	A commitment to allocating a worker (e.g. social work, social care or family support or providing statutory service through a duty system) to all children.	6

The two most frequent categories of points were closely related. A commitment was commonly made to auditing, reviewing and monitoring to identify issues (n =89), alongside developing or clarifying governance arrangements and roles and responsibilities to action

issues identified (n=114). The category of supervision (n=27) is also relevant to governance and monitoring. Action points in this category specified items that would be included in supervision for discussion, and thus encouraged consistency of process and oversight of practice.

The next most common category was training and learning events (n=85) to develop and cascade learning in the organisation and ensure consistency and quality of practice. This frequently included training on the relatively new national practice framework, Signs of Safety. This was followed by action points relating to staffing and resourcing (n=83). The staffing and resourcing category reflected the frequency of vacant posts and high staff turnover in services. This included action points where the service had successfully recruited new staff and reported where they would be deployed in specific capacities to address issues. However, it also included examples where the service was continuing to contend with resourcing gaps and the action centred on efforts to recruit or retain staff, or to make a business case for more staff. A small number of action points (n=6) specifically committed to allocating workers to children.

Further actions included ensuring recording of specific information on files (n=29) and committing to specific timelines of action (n=46). Regarding timeliness, these actions were not always changes in practice. Instead, they sometimes referred to continuing to complete an action in a certain timeframe. Timeliness was on occasions, positioned as contingent on resourcing. For example:

> *"Targeted timeframes for the completion of preliminary enquiries on each of the Intake Teams will be as follows […]. The QRSI TL will assist in the verification of the compliance with timeframes above and report back to PSWs on this. Current staffing vacancies in the area are acknowledged. However, the area has developed this intermediate response which is a trajectory towards meeting Tusla timelines. This is phase one while acknowledging that the trajectory needs to move towards achieving the timelines and when posts are filled this will assist."* (Area 14, Risk Based follow up, 2023)

Not infrequently (n=31) action points highlighted national developments that were taking place, for example by the Tusla National Office, which would be implemented locally when available. Where this occurred, interim arrangements at local level were specified.

In lower frequency, action points related to multi-professional working (n-14) and direct points of action for engaging children and families (n=17). The former included, for example, updating information booklets for children and young people to make them more reader friendly and to provide them in multiple languages.

4. DISCUSSION

This report presents the findings of the first independent, empirical study of HIQA inspection in Ireland, with this study's focus on the area of child protection and welfare services. International literature evidences the importance of empirically studying inspection because, although inspection has important benefits, it can, at the same time, cause unwanted effects. Crucially, what inspection focuses on can influence these effects (Caffrey et al, 2024). Our review of the literature found no previous research on inspection in Ireland, indicating an important research gap worth filling. This research begins to fill this gap by exploring (a) what inspection in Ireland focuses on and (b) the methodology of inspection. Below we discuss the findings in the context of the literature and offer some recommendations.

4.1 Reporting on process and practice

The international literature raised the concern that because procedure-compliance is easier to inspect, it can come to dominate the inspection process to the neglect of inspection of wider quality of practice (Ferguson, 2017; Hood et al., 2019; Impower, 2015; Pålsson, 2020; Rutz et al., 2016). Consequently, staff may understand 'good practice' simply as compliance with process and may neglect aspects of practice that are crucial but not prioritised in the inspection process (Murphy, 2022). It has been argued that an integrated focus on the impact of process on service-users experiences of practice is required (Munro, 2014). This study therefore analysed how well HIQA reports integrate consideration of process as it relates to practice and service user experience.

Our findings highlight that, in common with the international literature, compliance with processes featured strongly in reporting. This included a focus on both front-line practice and managerial/leadership practice. Timeliness, recording and records management were frequently cited in reports in relation to front line practice, while audit, supervision and other meeting occurrence were inspected in relation to procedural compliance at a managerial level. However, a key finding from this study is that reports tended to avoid a focus on process compliance as an end in itself. Rather we found that reporting tended to integrate inspection of process compliance with consideration of broader quality of practice. Commonly, reports included qualitative judgments regarding the quality of practice, specifying examples to

support the judgement and to set out the standard required. This integrated focus may help to avoid unintentionally encouraging staff to focus excessively on procedure compliance to the neglect of wider quality dimensions. However, effects are likely to be mediated by other factors, including staff interpretation of inspection, indicating the importance of further research to explore how staff experience this aspect of inspection.

Internationally, the literature has been critical of the tendency of inspection to focus primarily on case file analysis rather than on direct observation of practice (Ferguson et al., 2019). Observations are a more challenging method for inspection as they are dependent on children and parents' consent and the practices that happen to occur during the inspection. Our analysis of HIQA reports found that analysis of practice strongly focused on case file evidence, and it was less common for analysis to be based on direct observation of practice. Indeed, while all reports featured case file analysis, 27% of reports in our sample (n=7) did not report any direct observation of practice, and 54% (n=14) featured only one observation of one type of practice. Further research could therefore helpfully explore whether staff perceive reports of their practice as accurately reflective of it and whether they perceive that the methods used are indeed best placed to report on practice. It would also be helpful to understand inspectors' views in this regard.

It was not always clear if inspection report findings related to managerial procedure (as set out in documents) or managerial practice (the reality of implemented practice). Consideration could be given to making this consistently clear in reporting. Where relevant, it should be noted that inspecting via policy documents alone assesses formal managerial process (e.g. in relation to roles and responsibilities) but does not assess practice, and implementation should not be assumed. However, aspects of reporting clearly did focus directly on the quality of managerial and leadership practice and included consideration of organisational culture and staff relationships.[7]

[7] It goes beyond the scope of this study, but it is worth noting that the national framework for child protection social work practice, Signs of Safety, includes an organisational theory of change and conceptualises a 'parallel process' in which the practice principles of working with families cascade down to families via the managerial and leadership practices experienced by social workers. Signs of Safety emphasises the importance of organisational alignment such that leaders exemplify the framework principles (working relationships, prepared to admit you are wrong, focus on what works in practice) and disciplines (plain language, focus on behaviour). Leaders and managers should also foster a psychologically safe organisation with distributed leadership. Inspection reporting is a strong and important influence on this practice at both front line and managerial levels, therefore, consideration should be given to ensuring alignment between inspection and Signs of Safety's

4.2 Accounting for the contexts affecting services' work

International research has raised the concern that while a de-contextualised approach to inspection may deliver a uniform approach to all services, services are not equal in terms of the challenges they face in their service delivery context. It is argued that by failing to account for differences in the context services work in, inspection creates inequality (Hood et al., 2019; Impower, 2015). Large-scale quantitative studies in England have found that area deprivation is associated with inspection judgement outcomes: more deprived areas are more likely to receive more negative judgment outcomes (Wilkins & Antonopoulou, 2020a, 2020b). Lower agency rates were also correlated with better inspection ratings, indicating that workforce conditions also matter (La Valle et al., 2016). In terms of the focus of inspection therefore, research has argued that in the delivery of judgements, inspections may not adequately account for the varying contexts services are working in (Bennett et al., 2022; Hood et al., 2019; Impower, 2015; Wilkins & Antonopoulou, 2020a, 2020b). Research with inspectors in England highlighted that, like staff in services, they were concerned about contextual information but that they were constricted by the inspection framework, with no real way to take it into account (Ferguson et al., 2019)

We found that the HIQA reports in our sample all contained a section near the start of the report titled 'profile of the service area' but that this inconsistently reported on the service area context. Some reports provided benchmarked information on socio-economic context and levels of area deprivation, but others did not contain this information. Therefore, consideration should be given to improving the consistency of reporting in this regard to ensure fair reporting across all inspections. Our stakeholder consultation group confirmed that this information is provided by Tusla services, and that greater guidance may help improve the consistency of information provided to HIQA.

Our analysis makes two central contributions in respect of understanding how context is integrated into delivery of HIQA inspection judgements. Firstly, some reports provided information about issues affecting service delivery early in the report (e.g. staff vacancies) but did not integrate this information into the delivery of compliance judgments section.

organisational and practice theories of change. We did not find non-alignment in this regard but could not consider it in full depth within the confines of this study's scope.

Therefore, the reasons underpinning the service provided was inconsistently reported in respect of how judgements were delivered.

Secondly, although reports frequently detailed that staffing and resource challenges compromised the ability of services to meet Standards, a challenging context did not seem to influence the compliance judgement reached. Rather the compliance judgement simply assessed whether the service was compliant with the Standard. Therefore, HIQA compliance judgements can be understood as a judgement on the quality of provision available, not the quality of work and effort delivered by services.

These findings raise several issues worthy of consideration and further research. Firstly, research in England has highlighted that inspectorate judgements of services *and* how those judgements are delivered matters in terms of staff morale, motivation and retention (Ferguson et al., 2019; Hood & Goldacre, 2021; Munro, 2014; Murphy, 2022). In delivering inspection judgements, the sole focus on the quality-of-service provision can be understood in terms of HIQA's remit to determine the quality of services, regardless of the factors underpinning the ability of the service to deliver quality. However, reports are consumed by the public and the language of 'compliance' may inadvertently suggest that it is always in a service's control to comply. Therefore, given our findings in relation to how context is integrated into judgements, future research is required to understand how staff experience and perceive HIQA judgements and the language of 'compliance'. This is particularly so given the national concerns regarding retention of child protection and welfare social workers, and efforts to improve retention of social workers (O'Meara & Kelleher, 2022). Inspectors' perspectives are also important in this regard. Furthermore, our analysis of services' compliance plans shows that staffing and resourcing was the fourth most frequently cited action point. Future research could helpfully ascertain whether staff believe that the actions set out in reports will effectively address the issues identified.

In August 2023, HIQA commenced an 'escalated risk provider programme', which constitutes a new approach to addressing a persistent national workforce problem: that substantial numbers of children in care did not have allocated social worker. Services that had 25% or more children in care and/or foster care services without a named social worker were included in this programme. HIQA requested Tusla's CEO and executive team to devise a national improvement plan focused on reducing waiting lists and achieving sustained

improved compliance against relevant national standards. Inspections of these services began in early 2024 alongside frequently national meetings between Tusla and HIQA (HIQA, 2024a). This programme was not in place during the time the inspections in our sample took place. Future research could therefore helpfully explore how this parallel programme of inspection work is experienced by Tusla services and whether it leads to changes in inspection reporting for individual services.

4.3 Taking account of child and family voice

The findings in relation to the involvement of children and families in the inspection process reflect international research findings and concerns. In keeping with available research elsewhere (Ferguson et al., 2019; Pålsson, 2020), the findings of this study highlight that small numbers of children (between 0-8 children), and sometimes no children, were spoken with to ascertain their feedback. It is important to recognise that this is a very challenging cohort of children to engage. It can be challenging to get feedback from children and families because social workers may deem families too vulnerable to participate in a feedback process. In addition, the requirement to obtain consent from both parents to speak with children can pose a further impediment to engagement[8]. Notwithstanding these recognised challenges, consideration could be given to how children are currently engaged and whether there are opportunities to improve the process. Our findings highlight several avenues for consideration in this regard. Firstly, when explaining why few children were engaged, we found that reports most often cited children's 'young' age. Commenting on Article 12 of the United Nations Convention on the Rights of the Child, the UN committee has emphasised the importance of assessing children's capacity to participate and discouraged countries from introducing age limits in law and practice, which may impact the implementation of this right (UN Committee on the Rights of the Child, 2009). In this context, it is worth considering how children's capacity to participate in the inspection process is understood by inspectors and professionals who support this process. Indeed, research on the inspection process in Sweden found that individual inspectors exerted an influence on the extent to which children were involved (Pålsson, 2020). In Ireland, as elsewhere, social workers report the challenge of supporting vulnerable children to participate and the importance of support and training for staff

[8] Personal communication with HIQA

undertaking this difficult work (Tierney et al., 2018). Therefore, research is needed to explore how inspectors and Tusla staff experience and perceive the process of supporting children to feedback as part of the inspection process, and the barriers and enablers to engagement.

In addition, international research has raised the concern that methods of inviting children's and parents' feedback may lead to a sample of individuals who are not representative of the wider population of families using services. In addition, research elsewhere found that, in practice, little effort was made to include parents' experiences (Ferguson et al., 2019). HIQA reports did not detail how children or parents were invited to participate, however our stakeholder consultation group confirmed that the inspection team now selects families based on its sample of cases. The children and parents are then invited by social workers to meet with HIQA inspectors to provide feedback on their experience of services. Physical posters are also made available in the service to inform parents of a telephone line they can use to can contact HIQA directly. This process has the important benefit of an objective method of sampling families, rather than services themselves selecting families to provide feedback. In addition, there is some opportunity for families to contact the inspection team directly via the telephone line, advertised via posters displayed in the service.

Consideration could be given to further developing the ways in which families can provide feedback. Firstly, the current method of social workers inviting families to participate is not anonymous, since service providers will be aware of who was invited to participate, and families may be concerned that their feedback could influence the service they receive. While the telephone line may be anonymous it may not be perceived as anonymous by parents. Anonymous, online parent and young person surveys, which do not collect any personal data and can be accessed via a smartphone, may provide a higher response rate and more representative sample of children and families. Secondly, HIQA report elsewhere that inspectors encourage children to draw pictures, write songs or poems and play to show how they feel about a services (HIQA, 2024b). However, no report in our sample reported using non-verbal feedback methods. Where these methods are used, consideration should be given to how this feedback is transparently integrated into reports and taken account of in reaching conclusions. Finally, research could helpfully explore and learn from children, young people and parents' experiences of the inspection process.

The available international research highlights a concern that even when children were interviewed as part of an inspection, their voices rarely exerted any great influence on the inspection (Pålsson, 2020). We found this issue occurred in Irish reports too. Reports demonstrate a stated commitment to centring the voice of children and include a dedicated section at the start of the report for child and family feedback. However, the reports sampled for this study demonstrated that this feedback was not always transparently integrated into subsequent analysis to inform the judgment reached. Furthermore, at times judgments seemed to be based only on the case file analysis, although direct feedback from children on their self-reported experiences of services was available. Children's voices were therefore at times heard but did not transparently influence the analysis and conclusions. Perhaps due to the structure of inspection reports, which separated out child and family feedback from other data, reporting tended towards combining (including multiple) data sources rather than integrating them. The result was that contradictions in findings across data sources were not always transparently highlighted and resolved. In this process, children's feedback could unintentionally become silenced.

It would seem particularly important to address how child and family feedback is sought and transparently integrated into inspection findings and judgements because research on the CPW system highlights the importance to children of feeling listened to and feeling that adults have taken account of what they tell them (Holt et al., 2023). This wider research highlights that, particularly where children are considered 'vulnerable' or 'hard to reach', children's views can become marginalised due to the tension between the child's right to be heard and their right to protection. The need to protect children from the harm that might arise from participation can, in practice, lead to children experiencing opportunities to participate as tokenistic or limited (Costello & Holt, 2024; Warrington & Larkins, 2019).

Over the past ten years HIQA has worked to give greater prominence to the voice of children in inspection reporting. Since 2018 multiple initiatives have been introduced in this respect. This includes development of a programme of training for inspectors to enhance communication and engagement with children, training for inspectors in and application of the 'Lundy Model' of child participation, the development of child friendly consultation tools, and the addition of the section currently available in reports, which details what children told inspectors about their experiences. In 2023 HIQA also consulted a group of children in statutory residential centres to understand their experiences and feedback on the inspection

process. In the same year, HIQA began producing a young person friendly report of each inspection of statutory children's residential centres, which is provided to each service for children to access (HIQA, 2024a, 2024b). Most recently, HIQA commissioned a review of the international literature on this issue.[9] Notwithstanding, these important achievements and developments, our findings highlight the above areas of practice that should be considered for further improvement as part of HIQA's ongoing and active work in this area. In addition, with the aim of showing children that their feedback matters, the good practice of providing young person friendly inspection reports, already in place in residential care, should be expanded to child protection and welfare services.

4.4 Inspecting CPW outcomes

The international literature highlights the need for caution where inspection focuses on use of performance data to assess outcomes. Defining service outcomes involves the reduction of complex human experiences (e.g. child safety) into measurable indicators (e.g. numbers of child protection re-referrals) and these indicators are likely to be contested (Flynn et al., 2024; Forrester, 2017; La Valle et al., 2016). In our sample of inspection reports, reporting tended to avoid a focus on distal service outcomes measured using service performance data. Indeed, Standard 2.8- CPW interventions achieve the best outcomes for children – was not inspected against in the 2 years and 8-month period represented by our sample of reports, indicating perhaps less focus on outcomes of interventions in our sample of reports.

Instead, we found that more proximal performance data was used to assess families' and children's safety and experiences. This included proximal service outcomes e.g. using the number of cases awaiting a child protection service to indicate the outcome of level of unmet need. In considering service outcomes, reports also made use of qualitative feedback from children and families. This included self-reported experiences of safety following CPW intervention. Therefore, impact in HIQA reports was conceived of not just as an organisational outcome, but rather child and family experience was reported on as an outcome in its own right. This is important from a rights perspective since how services are experienced is integral to ensuring due process (Forrester, 2017).

[9] Personal communication with HIQA

International research on inspection has observed that, at times, inspection reporting in other countries used unrealistic language in relation to risk and researchers urged more cautious use of causal language (Hood et al., 2019; Munro, 2014). We found that HIQA reports often contained careful use of language that accurately reflected the unpredictability of outcomes in child protection services. However, our analysis identified reports that referred to services 'ensuring' children's safety. This may create an incorrect assumption that risk can be eliminated, and that quality practice can reliably 'ensure' safety. Rather, the language of 'supporting' safety would be more realistic in this regard. Therefore, reporting should ensure consistent use of careful language in relation to risk and causation. As representatives in our stakeholder consultation group pointed out, the Children First National Guidelines (2017) contain frequent use of wording that is inconsistent with recognising the uncertainty of outcomes in child protection work[10]. Therefore, consideration should be given to consideration of this issue, not just in inspection reporting, but more broadly in national child protection policy and guidance.

4.5 Beyond services: considering the CPW system

Internationally, inspection typically focuses on inspection of individual services. However, there is increasing interest in understanding the wider child protection system, experienced by children and families when they engage with CPW services (UNICEF, 2021). A focus only on individual services or issues, can create a fragmented response, which does not capture service-user's full experience and can lead to unmet needs and inefficiencies in service delivery. In keeping with this interest in systems approaches, the Netherlands has complimented its service-focused inspection with a 'journey tool', which enables a systems level understanding of integrated service provision by analysing children's journey through the system (Rutz et al., 2016).

Our analysis identified that, in keeping with the common trend, HIQA inspection focuses on individual services. Inspection did look to understand how each service interacted with allied services and professionals. Notwithstanding this, data collected from children and families

[10] For example, "Support is offered to help the family to overcome any difficulties and to ensure that the child is safe" (P.2). "One of the main objectives of the Children First Act 2015 is to ensure that your organisation keeps children safe from harm" (P.3)

sought feedback on aspects of their experience, but it did not look to piece together an integrated 'service user journey' to understand how services connected (or not) to create service-users' experience. Similarly, the focus on allied professionals and services was inspected from within the Tusla service and relied on data from these services to identify issues with allied services. The perspectives of other (external/non-Tusla) professionals (such as CAMHS) were not sought. Future research could helpfully explore how this focus is experienced by Tusla staff, and any impact of this on the focus of work in and between services. The views of inspectors would also be helpful here to understand how they perceive and experience this aspect of inspection.

4.6 Supporting learning

We previously identified what we termed a 'learning focus' in inspection. This can be distinguished from other possible objectives, such as "steer and control" (seeking to be in command of services), or the aim of "giving account", summatively assessing performance (Van Dooren et al., 2015). Applying Munro's (2011b) work on learning-focused CPW systems to inspection, we defined a learning focus as inspection that goes beyond identifying what practice is or is not in terms of compliance. It looks to delve beneath the surface, to understand and explain *why* a practice is or is not occurring, and to then use this to support staff and their organizations, to improve. Learning thus involves a collaborative approach between the inspectorate and the inspected (Caffrey et al., forthcoming). However, a collaborative approach in theory risks a less critical approach, which could jeopardise the interests of service users (Benish et al., 2018, p. 233)

Our analysis identified several ways in which HIQA reports went beyond simply checking compliance to support learning. This included providing detailed professional guidance for services on what constitutes 'good' practice and an expectation in the HIQA approach that services should learn from previous inspection of other service areas within Tusla, not just their own service. Future research could helpfully explore how staff experience the balance in HIQA's focus between inspecting for compliance and providing inspection feedback that can be used by services to support professional learning, and whether/how inspection influences their professional development.

4.7 Transparent reporting of the inspection methodology

International research has found that individual inspectors varied in how they undertook aspects of inspection (Ferguson et al., 2019; Pålsson, 2020) and called for greater specification and transparency in relation to the inspection process. Specifically in relation to case file sampling, research in England (Ferguson et al., 2019) found that differences in approach influenced the evidence that was eventually collected and concluded that the case sampling method was 'too random and contingent' (Ferguson et al., 2019, p. 56). The HIQA reports in our sample included detail on the methodology of each inspection. However, some aspects of the inspection methodology that would be required to understand the validity of findings were not clear or not reported in some reports.

Case sampling forms a cornerstone of the inspection process. We found large variation in the number of case files sampled (between 8 and 79 files). However, there was no rationale provided for the number of cases selected and the reports did not state how they were selected. This information is important because it underpins the extent to which findings are generalisable to a service's work in general or biased by the method used to select the files, and a formal method of selecting files supports consistency in application of inspection methodology. Our stakeholder group confirmed that case file sampling is based on inspectors' analysis of the data. Given HIQA's 'risk based' approach, some variation in the number of files sampled would be expected and even desirable, as inspectors follow 'leads' in the evidence. However, the large variation suggests that consideration should be given to ensuring that a formal sampling procedure is being used (including baseline expected sample size) consistently across inspections. The need for this is also underpinned by our finding that in CPNS inspections, the number of files sampled was at times very small but not proportional to the number of files on the CPNS. Caution in reporting should be exercised where the inspection relies on a small number of files.

We found that other aspects of the methodology were inconsistently or incompletely reported. The number of staff who participated was sometimes, but not always reported. The number of children and family members was consistently reported. Information on how children were selected was not reported but we were informed of the process via our stakeholder consultation group. Greater transparency in relation to data collection and

sampling is important because it underpins consistency of the inspection process and the generalisability of the data.

Finally, the findings highlight that over the 2 year and 8-month period in which the inspections were carried out, ten National Standards (38% of the total) and two of the six Themes were not inspected. There was a strong focus on themes and standards relating to leadership, governance and management and timely action to protect children and provide services. There was comparatively less focus on themes and standards focused on workforce quality and support, and on child-centred services.

The 'risk-based' approach does not require inspection across all Standards or Themes. Rather those of interest are selected by HIQA in consultation with Tusla Child and Family Agency[11], based on the evidence available to HIQA. Frequently inspecting all Standards and Themes would create an undue burden on services and inspectorates. It is therefore logical to continue with a risk-based approach. However, our analysis suggests that, when selecting which Standards and Themes are inspected, alongside taking account of issues of concern, consideration should also be given to the overall spread over time of Standards and Themes inspected to ensure that inspection does not unintentionally lose focus on particular Standards or Themes. This is important because the focus of inspection may impact practice since what is inspected is known to influence what workers and organisations focus on (Murphy, 2022). Further research could explore professionals' experiences of whether and how the overall spread of standards and themes inspected influences practice.

4.8 Proportionate inspection

HIQA aims for 'proportionate' inspection, which reduces unnecessary burdens of inspection, while maintaining a strong focus on risk (HIQA, 2023). This is important because while international research has highlighted that inspection offers important benefits, staff can experience inspection as highly stressful and as a process which can take time away from front line work with families (Ferguson et al., 2019; Murphy, 2022). Our previous review of the literature did not identify any research in Ireland exploring how staff experience and perceive the proportionality of inspection (Caffrey et al, forthcoming). Our findings highlight

[11] Personal communication with HIQA

several important points in this regard and point to specific avenues in relation to research with staff.

Firstly, the number of days inspectors are on site has been found to impact the pressure and intensity staff experience in the inspection process (Ferguson et al., 2019). Research evidencing the negative impact of inspection on staff is located primarily in England. Our findings suggest that, compared to England, Ireland's on-site inspection process differs in several important respects.

Firstly, we found that in our sample, 4/26 inspections (15%) were outside of HIQA's expected duration of 3-4 days (HIQA, 2024b, p. 40). Three of these were five days long and one 9-day inspection was an outlier. For comparison, in England, prior to 2018 the inspectorate delivered a standard four-week inspection of all Local Authorities. Since 2018[12] the English process, like HIQA's, uses continuous monitoring of services to inform when and for how long inspection takes place. However, the English inspectorate now use a menu of two-day (focused), one week (short) and two week (standard) inspections, providing a rationale for each pathway (Ofsted, 2024). By contrast, therefore, our findings suggest that, in practice, HIQA inspections were a more standardised duration, but some inspections (15%) did fall outside the expected duration.

Secondly, analysis of the current English inspection framework (ILACS) found that, in keeping with the inspectorate's aims for a 'proportionate' approach, inspectors spend more time with services judged poorly (Ofsted, 2019). In our sample of HIQA reports, the number of days spent on site was not related to the outcome of inspections: services judged 'non-compliant' were not more likely to have longer inspections. Nor was it related to the inspection type.

HIQA's process allows for flexibility and for the inspection to be extended due to matters arising. For example, it may be extended to enable family members to speak with inspectors on a day they are available or to enable a manager on leave to meet with the HIQA team when they return[13]. While this flexibility has certain benefits consideration should be given to the rationale for variation in the number of days inspection takes place, its proportionality, and how the length of inspection is experienced by staff. Relatedly, our finding (reported

[12] The inspection of Local Authority Children's Services (ILACS) framework was introduced in 2018 replacing the Single Inspection Framework (SIF)
[13] Personal communication with HIQA

above) that there was a large variation in the number of case files sampled may indicate large variation in the inspection workload experienced by services. Future research could helpfully investigate how staff experience the duration and workload of inspection. The variation may be well justified and inspectors' rationale for variation could also be explored.

4.9 Limitations of the study

This study has several limitations, which are important to note. Firstly, the research provides an analysis of a snapshot in time. A strength of this study is that we analysed all publicly available Child Protection and Welfare inspection reports on 1st July 2024. However, the reports are limited to a period of two years and eight-month period from March 2021 to November 2023. It cannot be assumed that the findings generalise outside this time. Inspection may have changed over time, but this was not a focus of the current study. Secondly, to focus the study and ensure depth of findings we focused on HIQA reports inspecting the National Standards for the Protection and Welfare of Children. HIQA inspects other types of Tusla services using other National Standards. Since the same process of inspection is used across service types, there may be some commonality in focus, but we did not research other services, and our findings should not be assumed to generalise beyond the area studied. Finally, this study provides an empirically grounded understanding of the focus of reporting and the methodology. However, in keeping with the aims of the study and the nature of documentary analysis (Flick, 2023), it cannot not provide an understanding of how inspection is experienced. Inspection is also a broader process than reporting and much of the work of inspection is not visible from the reports. Therefore, this study lays the groundwork in understanding what inspection focuses on and further research is needed to understand how inspection is experienced and with what impact.

5. CONCLUSION AND RECOMMENDATIONS

The findings of this report evidence the specific context of the Irish inspection system and the importance of research to explore it specifically. This study provides a detailed understanding of what inspection of Child Protection and Welfare services focuses on and the methodology of inspection, as evident from the inspection reports. Below we make several

recommendations in relation to immediate practice. Following this we set out recommendations for future research.

- Ensure consistent reporting in respect of the context of services, including benchmarked demographic, area deprivation and workforce data. The findings section references a good quality example of this from an inspection report that could be emulated. This information is provided to HIQA by Tusla services. Therefore, a template could be provided to services for completion.
- Ensure consistency of reporting on the number of staff who provide feedback in an inspection.
- Ensure consistency in how judgments are delivered in respect of integrating contextual information alongside the judgement to explain impediments to compliance (e.g. staff shortages).
- While HIQA is constrained by the current regulatory framework, at the national level, consideration should be given to the wording of 'compliance' in delivering judgements of services. Further research would help to inform this (discussed below).
- Notwithstanding the recognised challenges of engaging this cohort of children and parents, consideration should be given to whether there are opportunities to improve engagement. We recommend piloting the use of an anonymous online and smartphone compatible survey (for older children and adults). In addition, consideration should be given to whether perceptions of children's age/capacity may influence recruitment.
- Reports (or an overview report) should clarify the strategy used to invite and select children and families to provide feedback (i.e. the sampling strategy). This matters because the feedback received will be influenced by this process.
- Ensure that feedback from children and families (including verbal and non-verbal feedback) is consistently integrated into the wider findings of reports and accounted for in inspection judgements, particularly where children's self-reported experiences contradict other evidence collected.
- Emulating good practice recently introduced in HIQA inspection of residential centres, HIQA should demonstrate to children that their feedback matters by producing a young person's report of each inspection of child protection and welfare services. It should be noted that HIQA has been working to strengthen its engagement with

children, with multiple recent initiatives introduced in this regard. Our recommendations could be considered within this already active area of work.

- Match the good practice that is evident in most inspection reports by ensuring that all reports avoid unrealistic language around risk and safety. Reports should avoid implying that services can 'ensure' children's safety. Rather the language of services 'supporting' safety would be more accurate.
- Ensure a formal process is in place to decide the minimum number of case files that will be sampled and how case files will be chosen (i.e. a formal sampling framework). In addition, in reporting, ensure consistent attention to the limitations of the sampling method used. With due consideration to the sampling framework used, agreement should be reached in terms of the rough expected sample size.

Recommendations for further research

- A study of Tusla staff experiences and perceptions of the inspection process in respect of the following:
    - The proportionality of the inspection process, including the length of on-site inspections and burden of work on staff.
    - Any impact of inspection on the focus of work
    - The appropriateness of methods used to investigate practice and the validity of these in reporting on their work
    - The process of recruiting children, families and staff to provide feedback on inspection and the validity of the data
    - The way in which the context services work in (e.g. staff shortages, placement shortages, area deprivation) is outlined in reports and taken account of in inspection judgements and the wording of judgements in terms of services' 'compliance'.
- Research with HIQA inspectors in respect of their experiences and perceptions of the proportionality of the system, the appropriateness of methods, the process of recruiting children, families and staff and the way in which context features in reports.
- Research with children and families to understand their experiences of providing feedback on the inspection process.

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Appendix 1

Table 1: Coding Framework: Analysis of HIQA Child Protection and Welfare Inspection Reports

Code	Description
Focus of Reporting	
Procedure-compliance focus	Findings focused on compliance with service outputs (procedures/processes) i.e. whether service procedures, which aim to achieve service outcomes, are implemented. For example, reporting on compliance with standards or rules, document recording procedures and timeliness. *N.B.* procedure-compliance is distinct from a focus on reporting regarding the quality of practice observed in that process and outcomes that are achieved (these codes are defined below).
Outcomes focus	Findings focused on the effects (outcomes) of service provision. For example, findings regarding the effect of service-provision on children's safety and well-being. Outcomes also include, for example, re-referral rates and repeat child protection plans.
Quality of practice focus	Findings reporting on the quality of practice. For example, the quality of risk assessments. Quality assessment involves an analytic judgement based on evidence. This may include, for example, whether risk assessments were comprehensive and sufficiently analytical, or they may identify specific aspects where quality was lacking in this regard. Reporting on quality may also refer to the quality of relationships between staff and service-users.
Systems-focus	Findings focused on the integration of care and the service-user experience across organisations and multi-disciplinary professionals. Reporting regarding on how well services and professionals work

	together and coordinate their activities, including the availability of allied service outside of social work.
Learning focused	Findings that report an explanation from professionals or service-users regarding the barriers or supports to procedural-compliance, good practice or outcomes.
Service-user voice focus	Reporting from service-users, including children, parents, carers and family members. This includes where service-user data is used to inform findings or actions.
Context focus	Reporting regarding the context of service provision. This includes, for example, socio-economic, cultural, and political context. This code encompasses how context is used to inform findings or actions.
Judgements and action plans	
Linking action to identified cause	Whether action points in actions plans are linked to a cause of the problem, which is identified in the report.
Focus of action	Focus of the action in response to report. For example, whether the action point is focused on delivering increased monitoring or focused on provision of additional resources to staff or focused on multi-professional response.
The inspection process	
Methodology	The methodology of the inspection report including, for example: a) number of days in the inspection process b) number of interviews completed in each group (separately: children, parents, social workers, team leads etc) c) number of surveys completed in relation to groups d) areas of practice observed e) sampling procedure

Transparency of analysis	How claims are supported with data
Language	The language used in the inspection report with reference to the implications of the words