

**Health Information and Quality Authority
Regulation Directorate**

**Monitoring Inspection report –
Child Protection and Welfare Services under
the National Standards for the Protection
and Welfare of Children under Section 8(1)
(c) of the Health Act 2007**



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Name of Service Area:	Cork	
Dates of inspection:	7/10/2014-22/10/2014	
No. of Fieldwork days:	12	
Lead inspector:	Carol Maricle	
Support inspector(s):	Sharron Austin	Patricia Sheehan
Type of inspection:	<input checked="" type="checkbox"/> Announced <input checked="" type="checkbox"/> Full	<input type="checkbox"/> Unannounced <input type="checkbox"/> Themed
Inspection ID:	703	

About monitoring

The purpose of monitoring is to safeguard vulnerable children of any age who are receiving child protection and welfare services. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality Standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer lives.

The Health Information and Quality Authority (the Authority) has, among its functions under section 8(1) c of the Health Act 2007, responsibility to monitor the quality of service provided by the Child and Family Agency to protect children and to promote their welfare.

The Authority monitors the performance of the Child and Family Agency (CFA) against the National Standards and advises the Minister for Children and Youth Affairs and the Child and Family Agency.

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

- **Assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **Seek assurances** from service providers that they are **safeguarding children** through the mitigation of serious risks
- **Provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **Inform** the public and **promote confidence** through the publication of the Authority's findings.

Monitoring inspections assess continuing compliance with the Standards, can be announced or unannounced.

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

Theme 1: Child Centred Services	<input checked="" type="checkbox"/>
Theme 2: Safe and Effective Services	<input checked="" type="checkbox"/>
Theme 3: Leadership, Governance and Management	<input checked="" type="checkbox"/>
Theme 4: Use of Resources	<input checked="" type="checkbox"/>
Theme 5: Workforce	<input checked="" type="checkbox"/>
Theme 6: Use of Information	<input checked="" type="checkbox"/>

1. Methodology

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

The aim of on-site inspection fieldwork is to gather further evidence of performance against the National Standards.

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

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

The key activities of this inspection involved:

- the interrogation of data
- the review of local policies and procedures, minutes of various meetings, 26 personnel files, audits and service plans
- reviewing 135 children's case files
- meetings with 8 children
- meetings and telephone interviews with 12 parents
- meeting with the service director, area manager, childcare manager, regional manager of the regional workforce development unit, a Children First implementation officer, a children and young people's services committee co-ordinator, an information officer, a public health nurse specialising in child protection, a social worker directly involved in the roll out of the Meitheal programme, manager of family support projects (x2)
- telephone interview with the regional quality assurance and risk management manager
- meeting with childcare leaders, family support workers, social workers and team leaders (individually and during focus groups)
- meeting with six principal social workers, the chairpersons of child protection case conferences (x2), a family welfare conference chairperson
- review of questionnaires from 21 stakeholders
- meetings or telephone interviews with external professionals including members of An Garda Síochána, public health nurses and educators
- observing staff in their day-to-day work

- observing practice in two child protection conferences, one family welfare conference, five multi-agency/professional meetings, one child and young people's services committee
- observation of four staff team meetings
- observation of duty and intake allocations meetings.

Acknowledgements

The Authority wishes to thank the children, parents, staff, and managers for the openness with which they engaged with the inspection process.

2. Profile

2.1 The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency – the Child and Family Agency – overseen by the Office of Children and Youth Affairs. The Child and Family Agency Act 2013 (No. 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

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

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

Child and family services have been merged into 17 areas and are managed under area managers. The areas are grouped into four regions each with a regional manager, known as a Service Director. The Service Directors report to the Chief Operations Officer who is a member of the national management team.

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

2.2 The Cork Area

Cork is one of 17 local areas in the Child and Family Agency (CFA). It is situated in the south of the country and borders counties Kerry, Limerick, Tipperary and Waterford. It is the largest county in the state covering 7,454 square kilometres. The overall population for the area based on the 2011 population Census was 519,032 which included 128,448 children.

Regionally, the area was under the direction of the service director for the Child and Family Agency Southern Region.

Prior to the establishment of the Child and Family Agency, Cork child protection and welfare service was made up of four distinct departments operating in West Cork, North Cork and two in Cork City named South Lee and North Lee. Following the creation of the Child and Family Agency, these four departments became one service area. There were five principal social workers responsible for four child protection and welfare

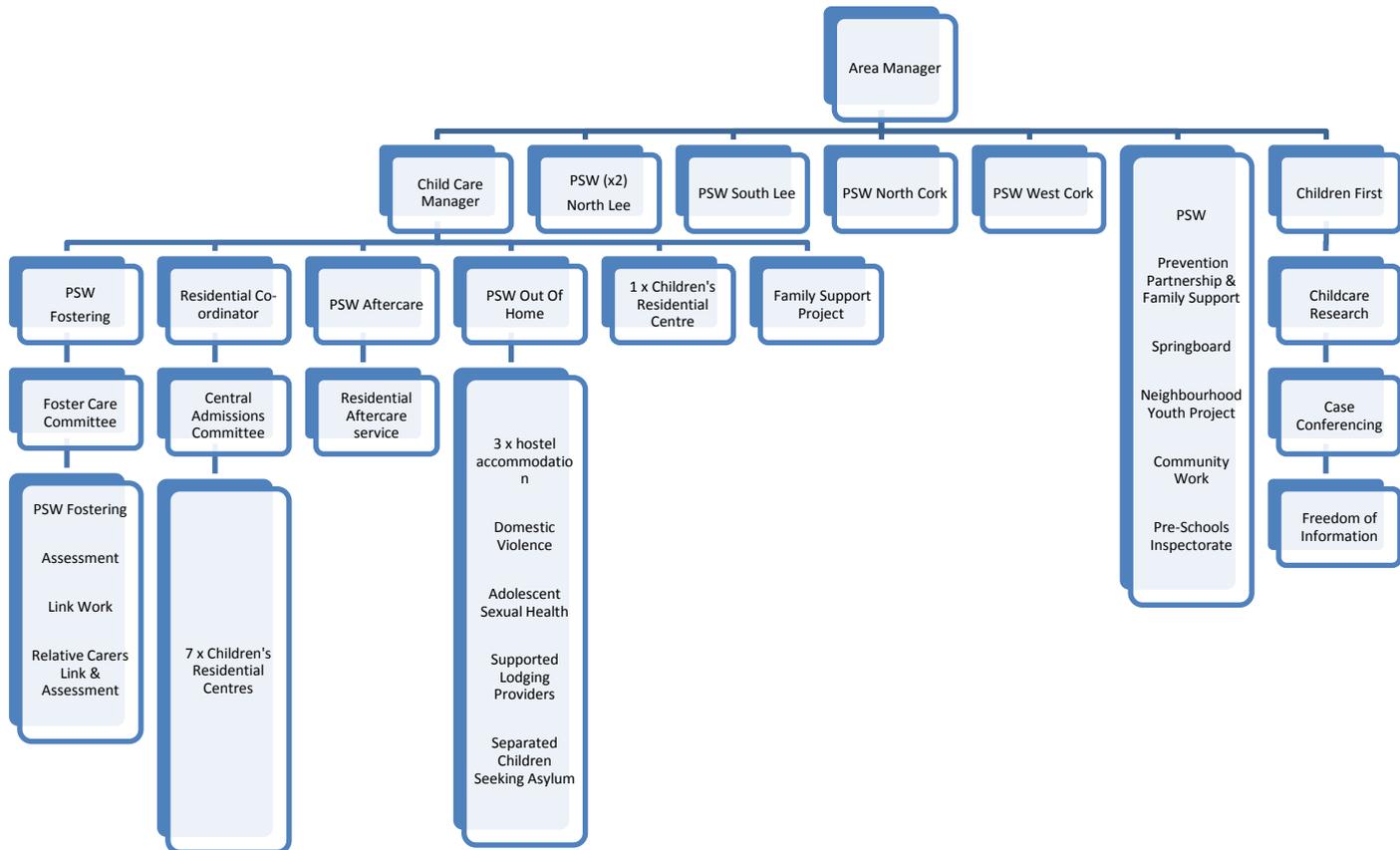
offices across the area. In addition, there was one principal social worker responsible for a service for young people who were out of home or at risk of becoming homeless. In each child protection and welfare service office, there were teams of social workers that reported to team leaders who in turn reported to principal social workers. Some teams also included childcare leaders and family support workers. A public health nurse specialising in child protection was based in one office. There were administrative/clerical staff based in each office.

Additional staff reporting to the area manager included, but was not limited to, a childcare manager, a residential co-ordinator, a fostering resource unit, staff working in children's residential centres, a Children First implementation officer, a children's and young people's services committee co-ordinator, a childcare research officer, an aftercare team, case conference chairpersons (x2), family welfare chairperson (x2), a freedom of information officer, community workers (x4), family support project workers and neighbourhood youth project workers.

In the 12 months prior to the inspection, there were 4926 referrals received by the service. Figures supplied to the Authority indicated that there were 4,071 open cases in the area, 1167 of which were unallocated and 2904 which were allocated to a social worker. Of these unallocated cases, there were 234 assessed as high priority (priority one), 790 medium priority (priority two) and 143 low priority status (priority three).

The area had 93 children on the Child Protection Notification System (CPNS) at the time of the inspection, all of whom had an allocated social worker.

Figure 1: Organisational structure of the Child Protection and Welfare Service, Cork Area*



* Source: Child and Family Agency

3. Summary of Findings

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

In this inspection, the Authority found that of the 27 standards assessed, the service met six standards, required improvement in 19 standards while significant risks were identified in two standards. The findings are set out in Section 5 of this report and the action plan is published separately.

Staff at this service valued the safety of children and prioritised their work in this regard. Once children were allocated a social worker and received a social work service/intervention there was evidence that children were safer as a result but the timeliness of services provided to children was a risk. However, the effectiveness of the service was compromised due to the length of time it took for a social worker to be allocated to assess the needs of children and families and children could remain at risk while they waited for an assessment. Many children who were deemed to have a high level of need did not all have an allocated social worker or timely access to child protection and welfare interventions. Where allegations of retrospective abuse were made against adults, the service had not established the risks to all children who may have contact with these persons.

The rights of children were promoted by the service but improvements were needed to ensure that social workers helped children to understand better their right to be protected from abuse and neglect. There was a positive attitude towards complaints in the service and a strong emphasis on interagency cooperation. However, resources such as information leaflets on the service were not distributed to all service users and were not child-centred, available in different languages and adapted for those with sight and learning difficulties. Not all children and families felt they were communicated with effectively by those working in the service.

This service had clear lines of accountability and areas of responsibility. Managers made the best of the resources they had and displayed good leadership. The service was provided by a skilled and supported staff team that were organised and managed in such a way that they had the required skills, experience and competencies to respond to the needs of children.

The service was not sufficiently resourced to deliver a child-centred, safe and effective service that met the needs of children and families. There were long waiting lists at point of receipt of referral and following the completion of an initial assessment and staffing numbers were not sufficient to cope with the level of demand for the service. Some offices were in poor condition and not a suitable place for children and families to meet their social worker. Not all offices in the area had electronic information systems which meant that data was processed manually, making the system unsafe as it lessened the effectiveness of information collection and collation. A comprehensive needs analysis for the service had not been carried out and it was not possible for managers to deploy what resources they had in the most effective manner.

During this inspection, two immediate risks were identified in relation to the safety and effectiveness of the service:

- children who were deemed to have a high level of need and who were at risk did not all have an allocated social worker or timely access to child protection and welfare interventions.
- not all retrospective disclosures were managed in line with Children First and national policy.

Due to the seriousness of these risks, the Authority sought an immediate response from the area manager and requested that arrangements be put in place to address these risks through an immediate action plan. The response set out in the action plan indicated that a number of controls had been put in place to address these risks.

This report makes a number of findings which the provider is required to address in an action plan. The provider's action plan is published separately to this report.

4. Summary of judgments under each Standard

During the inspection, inspectors made judgments against the National Standards. They used four descriptors:

Exceeds Standard – services are proactive and ambitious for children and there are examples of excellent practice supported by robust systems.

Meets Standard - services are safe and of good quality.

Requires improvement – there are deficits in the quality of services and systems. Some risks to children may be identified.

Significant risk identified – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

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

<p>Standard 2:4</p> <p>Children and families have timely access to child protection and welfare services that support the family and protect the child.</p>	<p>Significant risk identified</p>
<p>Standard 2:5</p> <p>All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence.</p>	<p>Requires improvement</p>
<p>Standard 2:6</p> <p>Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.</p>	<p>Meets Standard</p>
<p>Standard 2:7</p> <p>Child protection plans and interventions are reviewed in line with requirements in Children First (2011).</p>	<p>Meets Standard</p>
<p>Standard 2:8</p> <p>Child protection and welfare interventions achieve the best outcomes for the child.</p>	<p>Meets Standard</p>
<p>Standard 2:9</p> <p>Interagency and inter-professional co-operation supports and promotes the protection and welfare of children.</p>	<p>Requires improvement</p>
<p>Standard 2:10</p> <p>Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.</p>	<p>Requires improvement</p>
<p>Standard 2:11</p> <p>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.</p>	<p>Requires improvement</p>
<p>Standard 2:12</p> <p>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.</p>	<p>Significant risk identified</p>

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

working in the service to improve outcomes for children.	
Theme 6: Use of Information	
Standard 6:1 All relevant information is used to plan and deliver effective child protection and welfare services.	Requires improvement
Standard 6:2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	Requires improvement
Standard 6:3 Secure record-keeping and file management systems are in place to manage child protection and welfare concerns.	Requires improvement

5. Findings and judgments

Theme 1: Child Centred Services

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

Inspection findings

The service took a child-centred approach through the promotion of children's rights and their participation in decision-making processes about their lives. The service valued the views of children and their families and included these views in their day-to-day work. The service took into account the diverse needs of children and placed a strong emphasis on the rights of these children. Improvements were required in the way in which staff communicated with children on a day-to-day basis, especially young people. Complaints were well managed but parents and children were not sure of how to make a complaint and staff did not know what policy was in place. The service engaged with the wider community in raising awareness about their service but needed to ensure that the public understood how the service was delivered.

Children's Rights

This inspection found that the universal rights of children as set out in the United Nations Convention on the Rights of the Child were respected and promoted by those working in the service. However, improvements were needed to ensure that there was consistency in how staff informed children about their right to be protected from abuse and neglect. Children were not aware of their rights as a user of the service therefore there was a risk that they might not exercise these rights.

Staff promoted the rights of children in their day-to-day work and strove to keep children safe from harm. During focus groups, social workers showed a good understanding of the universal rights of children and their responsibilities to keep children safe from harm. However, there was no particular policy or procedure to ensure that staff were consistent in their approach. Inspectors met children who had some understanding of the role of the social worker in keeping them safe from harm but this was not always explained by the social worker to them. Not all children and families were aware of their rights as a user of the service, and the children did not know that they had a right to access information (where appropriate) in their files.

Decisions made about children showed that their rights were upheld by the service. Social workers made decisions to improve the safety of children on a day-to-day basis through their case work and more formally through the case conference and court systems. They challenged care-givers and took action when they had concerns about children's rights not being upheld at home. Inspectors viewed evidence of childcare leaders working with children in a way that helped children understand their universal rights, the way in which the social work service operated and their rights within the service as a service user.

There was inadequate information developed and used by the service in helping children and families to access information about their rights. In some reception areas of the service, there were rights-based posters displayed for children and families to read. A service information leaflet was available in the area to inform children and families about the social work service, the role of the social worker and the child's right to be kept safe from harm. Inspectors met children who had not seen this leaflet. They did not recall being spoken to by their social workers about their rights in general nor their rights as a service user when they first met their social worker or subsequently thereafter. Furthermore, the information leaflet was not always distributed by staff to children with whom they worked with as the staff themselves were also not aware of this leaflet. This meant that children as service users may not be able to understand when their rights were not upheld.

There was a strong awareness of a child's right to privacy, respect, dignity and confidentiality by those working in the service. Inspectors viewed written reports that were sensitive to the rights of children in this regard. An inspector observed two child protection case conferences and a family welfare conference where children were referred to in a dignified manner and respectfully by those involved. Inspectors observed staff at meetings being considerate of a child's right to privacy and confidentiality. This was especially the case when professionals from agencies in the wider community attended meetings, such as school staff.

The service appropriately advocated for children. Children had access to required advocacy services and the service of a court-appointed guardian-ad-item. Staff proactively sought out specialised services in order that a child's need in a specific area could be met. Inspectors reviewed files that showed how the service strongly advocated for services that were required for children. They referred children to in-house or external services that could offer a more intense therapeutic or specialised relationship with the child. Childcare leaders advocated for children and their involvement with the child was respected by social workers when decisions were being made.

Diversity

The service valued diversity and was inclusive of children and families who had specific needs as a result of their culture, gender, religion, race, ethnicity, sexual orientation, disability or geographic location. Those working in the service strove to access particular services for children and families. Some improvements were needed in the resources available to social workers.

Staff working within the service had a good knowledge and understanding of the needs of children from diverse backgrounds. When staff identified a gap in their knowledge they were pro-active in consulting with relevant services, referring the children for specialised assessments and including professionals from those services throughout their case work with children and families. Inspectors viewed evidence of social workers accessing translation services when there were language barriers and court documents were translated for some families in the child's file. Interpreters were used by the service when children and parents found it difficult to communicate through the English language. There was evidence of social workers working well with agencies such as traveller and migrant support groups and respecting the relationships that some families had already formed with these groups prior to their involvement with the service. A number of staff in one office had liaised with an academic in 2014 on research about the Roma community. A staff member told an inspector that it was his/her intention to distribute the learning from this piece of work to their colleagues in order to enhance practice in this area; an inspector observed this taking place at a staff team meeting. The regional workforce development unit offered training to social workers in cultural diversity as part of their 2014 training schedule. This was to take place in November 2014. Inspectors viewed a sample of personnel files and there was evidence that some staff had already attended training in areas such as cultural awareness of the travelling community.

The service used resources available to them to meet the needs of children but improvements were required. There were no Braille or loop systems available for staff to use. This meant that children or families with challenges in this area might find it difficult to communicate with those in the service.

Communication

There was evidence that staff communicated well with children and families in a respectful and effective way about important issues in their lives but not all children and parents felt this was the case when asked about their prior or current experiences with the service. Inspectors read case files that documented what was communicated to children and families during their involvement with the service and the majority of files viewed had evidence of good communication with children and families. In one office

there was very good practice in this area, inspectors viewed written correspondence sent to parents following the completion of initial assessments; the decisions of the social worker were set out and the parent was told what would happen next. This helped the parent understand what the social worker did as part of their assessment and the judgments that they reached. In some cases, the recording of what was communicated to children and families were not as comprehensive and did not always include the viewpoint of the child and family.

Inspectors observed a number of child protection case conferences and family welfare conferences where staff communicated effectively with families. An information leaflet was available for families attending child protection case conferences and all parents were met with or spoken with by chairpersons prior to the conference. This helped them to understand the purpose of the meeting. During these conferences, staff were respectful of children. Where children were part of a sibling group, inspectors observed the chairpersons considering each child an individual and encouraging professionals to do the same. This meant that no one child's needs were of less importance than their siblings.

Inspectors spoke with parents about their experience of being communicated with. There was mixed feedback from parents who had current or prior experience of the service. Some felt listened to, respected and had experience of plans being shared with them by their allocated social worker. Other parents did not recall a positive experience with staff at the service and felt that they were judged by social workers, not listened to and did not have plans regarding their children shared with them.

The children who met inspectors had experienced a number of social workers during their involvement with the service and most were able to identify at least one social worker with whom they formed a good relationship. They felt that these social workers had listened to them and encouraged them to participate in decisions about their lives. They took the time to get to know them and spent time with them outside of the family home/carer home or formal meetings. However, their collective experience was that they did not feel listened to or communicated with effectively by all social workers about decisions that affected their lives. Some children said that because of their age, they wanted more information to be shared with them. Other children told inspectors they wanted less information and just wanted to get on with their interests and lives. Some wanted to spend more time with their social workers outside of formal meetings while others wanted to see their social worker less. They told inspectors that each social worker needed to work out with them a way and style of communication that suited them.

The voice of the child was considered throughout the social work process from the initial assessment phase through to case conferencing and planning of interventions.

Training was provided by the regional workforce development unit in June 2014 on 'the voice of the child in social work assessments' and this course was made available to those working in the service. Inspectors viewed evidence that some staff had completed this course and others had completed a course on the 'voice of the child in family law'. Childcare leaders were employed at all four offices of the service and an inspector reviewed a sample of their case files and these recorded the voice of the child appropriately throughout their case notes. These records showed that they communicated very well with children, the children opened up to them over time and they were helped to understand their lives and decisions that were being made about them.

A children and young people's services committee was set up in the service since May 2014 and one of the sub groups in this committee focused on the voice of the child. A principal social worker was responsible for the development of this sub-group and together with a national advocacy service for children they formed a consultation group with young people. At the time of the inspection, the objective and goals of the group were being finalised and the principal social worker told inspectors that it would act as a consultative forum for the service and that the children themselves would be empowered to set and realise their own goals and objectives for the group.

Complaints

Complaints and concerns were well managed once they were made to the service but there was little information available to children and families about making a complaint and some uncertainty amongst staff about what the complaints procedure actually was.

There was a good system in the service to receive and manage complaints. All offices in the area maintained up-to-date complaints files or a complaints register and a principal social worker in each office was responsible for managing complaints. Those working in the service were aware of a child and family's right to complain or raise a concern. The area manager told inspectors that he was often contacted by family members wishing to make a complaint and welcomed these complaints made directly to his office.

Inspectors reviewed a sample of formal complaints; some complaints were dealt with in a timely fashion and conclusions or appeals recorded, others were not and dates of key events were not obvious and conclusions not recorded. Furthermore, it was difficult to see if the complainants were informed of their rights to an appeals procedure so that they could have access to a review of their complaint should they request this.

Information leaflets on how to raise a concern or make a complaint were not widely available to children and families. Some staff were not sure if the move of the service to the Child and Family Agency meant that the complaint mechanism outlined in 'Your

Service Your Say' was still valid given that this was a Health Service Executive process. There was no standardised complaints form or a procedure across the service that children and families had access to other than the HSE process. Children told inspectors that they did not know how to go about raising a concern or making a complaint and did not have any awareness of 'Your Service Your Say'. They told inspectors that they would not have the confidence to contact their local social work office and ask for the complaints procedure or form to be sent to them. Parents in general told inspectors that although they were not familiar with the complaints process they did have the confidence to bring concerns or complaints to their social worker or a manager.

Where concerns were expressed by children and families and these did not become formal complaints, records of these concerns were generally kept in the individual case file, but not in a distinct section of the case file. This meant that it was difficult to collate information about concerns, and identify trends and patterns of concerns in the journey of a child through the system.

Raising awareness in the Community

Staff raised awareness of the service appropriately throughout the community. Deficits in this area were being addressed by staff in the service.

There was a newly established children and young people's services committee in this area, formed in May 2014 whose membership consisted of the child protection and welfare services and other key services such as the professionals from the statutory services, community and voluntary services. An inspector met the acting coordinator of this service and found that the purpose of the committee was clear and well planned. A leaflet was available for the public describing the purpose of the committee. The committee was tasked with the development of a three year plan for children and young people that was to reflect local needs and outcomes for the sector. The group planned to roll out information and briefings to local professionals and the wide community about their brief.

There was a need to develop literature for the general public to increase their awareness of the child protection and welfare service. There was no written information available for the public who had communication difficulties. Braille, loop or picture exchange systems were not in use. Leaflets were not translated into a variety of languages. An inspector met with a Children First implementation officer working in the service and she discussed developments that were taking place nationally in the service such as leaflets about the service being translated into a range of languages for children and families and videos being developed for those with visual impairments and hearing difficulties.

Theme 2: Safe and Effective Services

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

Inspection Findings

This inspection found that staff promoted the safety of children through the assessment of risk and implementation of policies and procedures to address these risks. Elements of this service were delivered in an effective manner, but overall the service was significantly hampered by its inability to cope with the high number of referrals received yearly by the service. Children at immediate risk of harm were assessed as high priority by the service and appropriately allocated a social worker. Children assessed as having acute and/or highly complex needs were also assessed as high priority but were placed on waiting lists for social worker intervention. The systems in place to manage concerns of a retrospective nature were in need of significant improvement.

Protecting children

The service used standard business processes and Children First (2011) to deliver child protection and welfare services in a consistent way.

There were standard procedures in place to receive and manage concerns of a child protection and welfare nature across the area in accordance with the standard business processes and Children First (2011). Inspectors observed team leaders during staff team meetings share information with staff on policies and procedures that reflected the standard business processes and Children First (2011).

Concerns forwarded to the service were appropriately prioritised. Inspectors observed the systems in place in each office to manage waiting lists and found that all of these lists operated on a priority basis and a threshold of need basis. Staff with responsibilities in this area all followed the national thresholdⁱⁱⁱ of need guidance in assessing risks to children.

The service took action to protect children at risk of harm and all concerns reported to the service were screened, which included preliminary enquiries. Where immediate risks of harm were identified these were acted upon by staff at all levels in all four offices without delay, and this was observed by inspectors.

The service had an out-of-hours (OHP) social work service and inspectors found that this was an effective service. This was a piloted service established in Cork in 2011. The purpose of the service was to provide an out-of-hours social work service to children and families. An internal review of the service was conducted by an implementation officer and principal social worker and this showed that calls made to the service were predominantly welfare-based and related to placement breakdowns, young people missing from care and young people out of home. Inspectors spoke with members of An Garda Síochána who placed a high value on this service, confirmed they used the service regularly, found it to be effective and that it helped to meet the needs of children and families.

Those working in the service demonstrated a strong awareness of the impact of long term harm and neglect but accurate data indicative of long term harm and neglect was not available to all social workers quickly. Staff were aware of the impact of multiple referrals and business processes prompted social workers to identify prior concerns reported to the service. During duty and allocations meetings, staff took note of referrals received that were of a repetitive nature and considered this as relevant information. Reports such as court reports or reports submitted for case conferencing provided a historical context to the family's involvement with the service.

During focus groups, social workers discussed the findings of published inquiries relevant to child protection and welfare, the recommendations of which they said were implemented by them in their day-to-day practice, such as, the effect of long term harm and neglect on children. An inspector observed two child protection case conferences where on both occasions social work staff from the service placed a significant emphasis on the impact of long term harm arising from patterns of neglect in each case.

There was a good knowledge displayed by team leaders and principal social workers of families who had been involved with the service for long periods of time and some offices had dedicated teams of social workers that worked with such cases. However, there was no electronic information system across the entire service to help social workers to identify families about whom repeated concerns had been received. Newly allocated social workers who were unable to access prior social workers were dependent on the principal social workers and team leaders knowing about such cases and they had to retrieve and read large numbers of archived hard copy files for information. This situation was fraught with the possibility that critical information might

become lost or unavailable. Due to the waiting list system in place, inspectors found new referrals of a multiple nature awaiting allocation of a social worker to conduct an assessment.

Referrals and assessments

Screening and preliminary enquiries of reported concerns were conducted by the service appropriately in line with the relevant standard business processes although referrals were not always screened within 24 hours, as evidenced by the dates recorded on the relevant paperwork. Overall, the systems that each office had in place ensured that screening was prioritised by duty social workers and there were internal systems in place to ensure that a duty social worker was available for the public to consult with each working day. There was sufficient information recorded on intake records to support the professional judgments that social workers made. Children with the greatest need of a social work response were effectively identified by this system.

All intake records received sufficient managerial oversight and team leaders signed off on intake records following completion by the relevant duty social worker. Information was gathered from agencies within and outside of the Child and Family agency. Intake records viewed by inspectors showed correct and consistent classification of referrals as welfare or child protection cases. However, it was not clear that appropriate feedback was provided to persons who made a referral to the service, within the confines of confidentiality and in line with Children First (2011).

Reports of child protection concerns were assessed in line with Children First (2011) and the standard business processes but the quality of some initial and further assessments varied. Initial assessments were carried out by social workers to reach preliminary conclusions about the risk of harm. Inspectors viewed assessments that clearly recorded the developmental needs of the child, the age and their vulnerability and other factors such as family and environmental factors, risk behaviours and the capacity of the family to respond appropriately to the child's needs. Inspectors found some assessments that did not show evidence of all considerations being taken into account. Some sections of the assessments were not completed and the reason for non completion was not explained by the relevant social worker. The length of time it took for initial assessments and further assessments to be completed was often outside of the recommended timeframes.

Staff were fully aware of the standard frameworks in place that guided them in assigning priority to referrals and practice was consistent in this regard across the service. The Child and Family Agency had introduced guidance on the application of a threshold of need for social workers and these were being applied across the service. An implementation officer told an inspector that training had been provided to those

working in the service in September 2014 and inspectors found that staff were familiar with this guidance and used it accordingly. Prioritisation of cases and threshold of need status was not always clearly recorded on case files but was stated on the relevant waiting list. As a result there was a risk that the status of some cases might not be known by a social worker without him/her viewing the accompanying waiting list.

Planning for children at risk

There was a dedicated well run service in place to ensure children had a child protection case conference or review child protection case conference when required. Child protection case conferences and review case conferences were held for children at risk of significant or ongoing harm and these adhered to the guidance set out in the standard business processes and Children First (2011). An inspector observed two conferences, both of which had the required number of attendees. The parents of children were invited to attend these meetings and had the option of bringing a support person. Given the ages of the children involved, they were not asked to attend the meeting, which was appropriate but their views were considered by all professionals at the meeting and the chairpersons were seen to regularly remind professionals of the need to keep the focus of discussions on the child. While some professionals at the conferences were reluctant to form an opinion as to whether they considered the child to be at risk of on-going or significant harm, the chairpersons were appropriate in reminding professionals about the need for them to answer this question. This was a key decision to be made at the conference as it determined whether a child would be placed or remain on the child protection notification system with a child protection plan specifying the actions to be taken to protect the child.

A sample of child protection plans and minutes of child protection case conferences were reviewed by inspectors and these were found to be well documented and of a high standard. There was evidence that plans were issued to parents and professionals in a timely manner after the meeting. Inspectors found that actions agreed at conferences addressed the risks identified. Plans identified who was responsible for specific actions and time-lines were clear. An inspector observed a review case conference which demonstrated that the plans that had been put in place since the initial case conference had led to the reduction of some risks. The existing plan was reviewed, changes of circumstances were taken on board and the ongoing level of risk was identified and acted upon. Social workers valued the case conference system and told inspectors that the plans put in place at these conferences helped to formalise social work interventions and make sure that parents and professionals took the concerns of the social work service seriously.

During focus groups, some staff raised concerns about the waiting list that was in place at present for children that required a child protection case conference. An inspector

viewed this waiting list and found that some children waited on average eight to 12 weeks for an initial case conference to be convened, such was the demand for the service. The chairpersons were aware of this issue and had entered it as a risk on their own risk register maintained by them in their office and they had notified the area manager accordingly. Together with the area manager they put in place a set of procedures to control this risk such as liaising closely with the principal social workers involved in determining which children were to be prioritised for a conference, they addressed system issues and made changes in some aspects of the administration process, all of this helped to control the risk. These efforts were confirmed by principal social workers. In addition, the chairpersons met principal social workers regularly to share information and both parties told inspectors that they found this a useful forum for feedback and communication.

At the time of the inspection there were 93 children placed on the Child Protection Notification System (CPNS), all of whom had an allocated social worker. Each office had a comprehensive record of the children who were listed on the CPNS with the named allocated social worker. The electronic CPNS list was managed by an information officer within the service. There were some children that were placed on the CPNS prior to the introduction of the child protection case conference system but these children were then subject to the same review process and there was then an opportunity for them to remain or to be de-listed from the system. Inspectors viewed evidence of relevant parties being informed of the decision to place a child on the CPNS. At the time of the inspection, a review took place every six months for all children on this system and this helped to ensure that actions agreed at conferences were revised and assessed for their effectiveness, and the progress or lack of was recorded in the minutes of the review conferences.

Welfare services

A community based approach to prevention, partnership and family support (called Meitheal by the Child and Family Agency) was in the process of being rolled out across the service and was at an early stage of development. The ^{iv}Meitheal service was being implemented across this service by identified individuals. Inspectors met a number of these staff and they were clear about their role, positive about the philosophy and model of the proposed service and fully aware of the need to liaise with the wider community across the entire service area to create partnerships. They had already successfully created partnerships with professionals in the wider community. The lead co-ordinator described the timelines involved in the roll out of this service which were still at a preliminary stage. In the interim, referrals from the public about welfare issues were still being received by each office but a small number of cases were being trialled in this system by a social worker and project workers reporting directly to the lead coordinator. Not all staff were clear about the service and the timelines involved, but

inspectors were informed that this was because training to all staff had not yet been rolled out. This was planned for 2015. However, there were some professionals external to the service who were confused about this service and its start date, with some thinking that the process had already commenced and that referrals of a welfare nature were no longer being accepted by the service.

While Meitheal was being developed social workers followed the business processes and guidance in Children First (2011) and accepted referrals of a welfare nature. Not all aspects of the family support planning process as set out in the standard business processes were in place in all offices and this hindered the effectiveness of the intervention. Inspectors viewed a number of case files for which the primary categorisation was determined to be welfare-orientated and some files had evidence of clear plans in place to address the needs of the child and family. However, family support plans were often not fully completed unless there had been a family welfare conference and not all families had been offered or attended such a conference. This meant that plans to address the needs of children and families were not clearly set out and measured over time. An inspector observed part of a family welfare conference. This conference was chaired by a qualified and experienced person and was of good quality. The parent and family members were aware of the purpose of the meeting. The voice of the child was considered and the chair had met the child before the meeting and sought the child's views.

The four offices in the area had different levels of family support services available to them as a key resource in this area. Some offices had access to an in-house family support service. Other offices had access to local family support services which provided resources such as a parenting support service.

There were a number of fully funded or part-funded projects across the county which specialised in family support, operating under different models of delivery and specialising in different areas. Inspectors met three parents and two young people who were linked in with a community-based family support project in their area and they gave very positive feedback about the relationships they had built with the project workers and the range of services with which they were engaged. It was clear that they valued the service. An inspector met with the co-ordinator of this service who described a close working relationship with the local social work office and the area manager. This helped to ensure that the service s/he managed met the needs of the child protection and welfare service.

A service for children who were homeless or at risk of becoming homeless operated within the area. This was managed by a principal social worker with a team of social workers. An inspector viewed a sample of case files of young people receiving services

from this social work team and found the interventions of the social work team were well set out in the case files with positive outcomes for some children recorded.

Support and specialist services

There were effective systems in place to identify referrals that required prioritisation but the waiting list system required improvement. Each office had regular allocation meetings where team leaders discussed the needs of children and families and prioritised them for allocation to a social worker or placed them on a waiting list. Team leaders regularly reviewed their waiting lists. Some reviews of the waiting lists included the use of a risk assessment tool. Other reviews were conducted through the use of a record sheet placed on the front of the file to record a comment on the referral when it was reviewed. Some waiting lists contained open cases previously worked by a social worker which were in need of closing rather than allocating. The date of placement of a referral on a waiting list was not always recorded which meant that not all staff could quickly check the length of time that a referral was placed on a waiting list. Thus there was a risk that cases could be overlooked and waiting lists skewed by inaccurate or hard to use information.

During the inspection, 21 children in one office were awaiting allocation to a social worker following their initial assessment. This was concerning as these children had been determined by the duty social worker as having highly complex and acute needs, which was the highest threshold of need that could be applied.

The waiting lists viewed in all other offices consisted of referrals which were determined to be at a lower level of need. Incoming referrals of higher priority or threshold were consistently prioritised over referrals on waiting lists, which meant that children inevitably remained on waiting lists for long periods of time. In some offices, the length of time waiting was taken into consideration by staff as a key factor when determining allocation of a social worker but this consideration did not feature as predominantly in other offices. For referrals categorised as level three (out of four levels of priority, four being the highest and one being the lowest), the longest time that a child was awaiting a social worker to be allocated to them was since 2010. Most children and families had been waiting since 2013, which was still a significant period of time. The service did not assess the impact of these delays on the safety and welfare of children. An immediate action plan was issued to the area manager on foot of these concerns and the Authority received assurances from the area manager in this regard.

There was delayed access to specialist services experienced by children and families. Inspectors found from a review of files and interviews with social workers that the delays were predominantly relevant to child and adolescent mental health services. This was concerning as these children were assessed by social workers to be in need of

these specialist services and may not have their therapeutic needs met in a timely fashion.

Interagency co-operation

There was evidence of good quality information being sought from and shared with agencies to inform child protection screening, assessments, planning and interventions.

There were good examples of inter agency working between the service and other statutory services such as An Garda Síochána, the public health nurse service and the child sexual abuse assessment unit. Inspectors attended professionals meetings and found that there was good coordination of services and multi-agency involvement. Children discussed at these meetings received a co-ordinated service and quality plans were put in place for them. These meetings were attended by a wide range of professionals such as representatives from schools, psychiatry services and An Garda Síochána. The area manager and representatives of the service met An Garda Síochána twice a year to discuss business processes between both services. An inspector observed one of these meetings which was well attended and effective in helping everyone to understand the business processes of both services. In addition to the meeting, there were monthly meetings organised by one office with An Garda Síochána and a centre for assessment of child sexual abuse to discuss cases open to all three services. An inspector observed one of these meetings and found it to be an efficient and timely process as a number of joint open cases were discussed at this meeting.

However, there were also examples of fragmented relationships between the service and other services outside the Child and Family Agency. This was reported by social workers and by professionals in questionnaires returned to the Authority. During a focus group with principal social workers, they told an inspector that relationships with agencies outside of the Child and Family Agency were often dependent on individual relations between professionals working within the area but when these broke down, formal processes in place to facilitate the rebuilding of partnerships were not in place. Some staff and managers described to inspectors their attempts to develop closer relationships with staff in services outside of the Child and Family Agency in an effort to build partnerships, understand each other's service better and address waiting lists. A principal social worker showed inspectors evidence of a positive partnership s/he had developed at local level with psychology services in an effort to address waiting lists for these services. This was effective as it meant that there was communication between social workers and the staff and they knew the status of the child's place on the waiting list.

However, staff across the service told inspectors of the difficulties they experienced when they tried to access psychology services and most were of the opinion that

relationships between the services were fractured. The service was unable to produce data which showed how many children were awaiting psychology services. Social workers in one office told an inspector that they no longer referred children to psychology services that operated out of the same building as them due to the length of the waiting lists and a lack of specialised psychology services to meet children's needs. Staff in other offices told inspectors that psychology services in their area were patchy and often depended on where the child lived rather than their needs. The area manager had escalated concerns of this nature to the service director in 2014.

Organisational and institutional abuse

Cases of retrospective abuse(s) regarding persons known to have a conviction of a sexual nature or suspected to have committed an abuse were not all assessed in line with Children First (2011).

A national policy in relation to retrospective disclosures was disseminated by the Child and Family Agency to staff during the inspection period. Just prior to the inspection, the area manager had appointed a principal social worker to take the lead on the management of retrospective disclosures and s/he was in the process of compiling accurate information in each office on the numbers and types of retrospective abuse allegations and the status of each concern. At the time of the inspection, figures returned to the Authority showed that there were 199 concerns of this nature across this service and this changed to 316 shortly after the inspection, following completion of the review by the principal social worker. Despite systems in place, the Authority issued an immediate action plan to the area regarding this issue as inspectors were concerned that not all risks to children had been identified following receipt of concerns. The Authority received assurances from the area manager in this regard.

Referrals of organisational abuse and institutional abuse were managed by a childcare manager within the area manager's office. An inspector met with this manager who described the systems in place for dealing with these types of concern and found them to be robust. There had been no referrals of organised abuse or institutional abuse made over the previous 24 months to the service. A national lead was appointed in the Child and Family Agency to coordinate notifications regarding clerical and religious orders and the childcare manager was responsible for liaising with this lead in this regard. Interagency meetings took place between the service, An Garda Síochána and representatives from the Bishop's office twice a year to share information regarding these notifications, as recommended by the Ferns Report. Along with the Diocesan designated liaison person, each religious order had a designated liaison person who was responsible for the monitoring and oversight of the safety plans put in place to minimise risk.

The childcare manager had responsibilities for the review of these plans along with these professionals and at the time of the inspection there were seven open cases. An inspector viewed a sample of information relating to these notifications and found that information was appropriately shared, safety plans were robustly monitored and reviewed by the childcare manager and those involved during interagency meetings.

Learning

Serious incidents and adverse events were reported appropriately to the area manager's office and from there to the Child and Family Agency national office in a timely manner. The service investigated and reviewed these incidents and events in accordance with national policies. However, it was not clear how learning was implemented across the service area to staff and the procedure for dissemination of information to the area for learning purposes.

During focus groups with social workers, team leaders and principal social workers they were aware of published inquiries applicable to their work, the results of which they told inspectors informed their day-to-day practice.

Oversight of the child protection and welfare system

At the time of the inspection, there was no formal caseload weighting management system in place to ensure that caseloads were of a manageable size but staff were expecting a caseload weighting management policy containing national guidance in this area from the national office shortly after the inspection. Inspectors met some social workers based in one office who had caseloads of over 100 cases. These social workers worked on duty teams. A caseload of this size was clearly not sustainable long term and meant that cases allocated in this manner were unlikely to receive a safe social work service. There was some consideration given to the complexity of cases allocated to social work staff, as evidenced by staff describing this to inspectors during focus groups but the recording of these decisions was not always documented and there was no set procedure followed by team leaders and/or principal social workers in this regard.

The service had systems in place to manage and monitor cases. Case work was monitored by team leaders who in turn were supervised by their principal social workers. Team leaders monitored casework through formal one-to-one supervision. They also supervised the work that social workers did on a day-by-day basis by checking in with staff about their case planning, helping staff to prioritise their work, quality assuring court reports and other documents and helping staff to form judgments.

The monitoring of case files was supported by an audit system that was in the process of being revised nationally in 2014, this meant that the quantity of case file audits completed across the service area in 2014 was low, but the area manager told inspectors that the number of case files that would be audited in 2015 would be much higher. One office in the area had access to an electronic information system and two audits of information on this system had taken place, one in 2014 and one in 2013.

Systems in place to close cases required significant improvement. Cases were not closed in a timely fashion. Inspectors viewed a sample of cases that required closing and these cases were left on waiting lists while the allocated social worker focused on other priorities. This meant that cases remained open to the social work service for much longer periods of time than was required sometimes due to the lack of a letter being sent to them informing families that their case was no longer open to the service.

An inspector viewed a document that had been developed in one office entitled 'review of cases on intake not currently being actively worked' and this document stated that 'due to demands on the service, letters to parents and professionals advising of the case closure will not be sent'. This document was dated 2013. This was of concern as it meant that parents and children might not know that they were no longer receiving a service. In addition, parents might not be clear that their children were no longer considered to be at risk. The area manager assured inspectors that this was not the current practice within the service area.

Theme 3: Leadership, Governance and Management

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

Inspection findings

This service had clear lines of accountability and staff were aware of their responsibilities. Risks within the service were identified and controlled locally where possible or escalated if not. The quality assurance of the service required improvement and there was no service area statement of purpose in place. Services provided on behalf of the area needed to be monitored more robustly.

Statement of Purpose

There was no service area statement of purpose in place although the area manager did have a detailed knowledge of the service that it provided and the population the service catered for.

The area manager told inspectors that his office was awaiting a statement of purpose template to be issued by the Child and Family Agency in late 2014 and this would be put in place for the service in 2015. In the interim, the service worked to national strategic priorities, which were viewed by the inspector. The objectives of the service were set out in the area strategic planning document 2014 to 2017 and this document tracked the progression of the service against these priorities.

There no document in which the model of service delivery specific to the area for 2014 was set out and distributed to staff, professionals and the public to describe the work carried out in the area, the way in which it would be done and its aims and objectives in protecting the safety and welfare of children. The majority of staff whom inspectors met were clear about the statutory functions of the service but were less clear about deployment of resources and some aspects of the proposed model of delivery for services currently being developed. Professionals who completed questionnaires were mixed in their feedback, some well informed about the functions of the service and others were not clear about how the service was delivered.

Management structures and systems

There were management structures in place which aimed to ensure that the service was safe and appropriate to children's needs. However, improvements were required in a number of areas.

The area manager provided an organogram which showed how the service was structured and managed. During focus groups, staff were able to describe the line management and reporting structure and they knew to whom they were accountable. Inspectors spoke to professionals in the wider community who had a good understanding about who was accountable for the service and some told inspectors that they had very good working relationships with the area manager. They gave examples of when they went directly to the area manager for advice and told inspectors that he responded and listened to them.

There were systems to promote a safe service. National policies and procedures were in place and widely shared with staff, evidence of which was seen by inspectors at staff meetings. There was oversight of all aspects of the service by the area manager's office. The area manager had an excellent knowledge of the services in his area and met those with responsibilities for those services regularly. There were formal management meetings where principal social workers, the childcare manager and the area manager met to discuss and make decisions on a wide range of issues such as governance, health and safety and service delivery.

Managers displayed leadership, were experienced in child protection and had an excellent knowledge of the legislation and the standards for child protection services. The majority of staff with whom inspectors met had confidence in their team leaders, principal social workers and the area manager. In some offices, staff expressed a high level of appreciation for what they described as an open door policy with their team leaders, meaning that staff had ready access to their team leaders when required. Staff also told inspectors that there was an appreciation by managers of their workload and the complexity of their work.

Staff were fully aware of their roles and responsibilities. There was evidence of good relationships between staff and their team leaders. Some team leaders who met inspectors displayed strong leadership skills and were consistently revising their internal processes in an effort to make them more efficient and effective. Staff directly involved in the roll out of the Meitheal model of service were positive in their attitude to its implementation.

There were sufficient communication systems in place in the service. Information on aspects of service delivery was shared with staff at team meetings and an inspector

observed a staff team meeting where information was shared. All staff had access to email.

Planning the service

The service was planned at national and local level but was not informed by a formal analysis of need.

The three year strategy for the service was mapped out in the area strategic plan 2014 to 2017. This strategy contained details of how key performance indicators as set out by the national office would be achieved, but did not allow for information on all developments taking place locally to be recorded. Each principal social worker in the area had been assigned a lead role in line with the 'National Service Delivery Framework (NSDF) and inspectors saw evidence of developments that they had made in each of the areas assigned to them. There was no service delivery plan which sufficiently addressed key challenges such as the steady increase of referrals received over the previous years and the ability of the service to respond to these referrals. During interviews with staff, not all were aware of the plans for the service in the coming years.

Risk Management

There were effective formal management systems in place to manage aggregated or organisational risk but some improvements were required.

A regional quality assurance and risk management manager had been appointed in 2014 who was aware of the risks in the service at the time of the inspection. Principal social workers each maintained live risks register in their offices and these informed the area manager's risk register. Training in risk assessment was offered to all staff in 2014 by the regional workforce development unit and there was evidence that some staff attended this training. The area manager had appointed duties to an administrative staff member in his office for the upkeep and on-going maintenance of the area risk register.

Operational risks were set out in risk registers viewed by inspectors and were appropriately risk assessed, risk rated and controls had been put in place where possible. Inspectors reviewed the minutes of the principal social workers and area manager meetings which confirmed that risk was considered at all meetings and local solutions put forward wherever possible. When the level of risk was assessed as being high, these concerns were then escalated to the area manager's office. These risks ranged from issues pertaining to children in need of disability and psychology services, due diligence issues^{vi}, waiting lists, staff shortages, and the child protection case

conference system. It was not clear from the risk registers the current status of each risk after it had been escalated to the area manager's office and it was difficult to see if the risk had been reduced or increased following controls being applied. During interview, not all staff were aware of the risk register in their office and they did not always know if their concerns were acted upon formally by their principal social worker or by the area manager's office.

Serious incidents were reported to the area manager's office appropriately by principal social workers and then to the national office of the Child and Family Agency and the Authority. There were 13 entries in the serious incident register, five that were closed, seven which were open and one entry without a recorded status. Of the 13 entries, five of these were child death notifications and all were appropriately notified to the Authority and one adverse incident that took place in 2014. There was no log of near misses kept by the area manager or principal social workers, but their knowledge of these was gathered through the day-to-day contact they had with their teams but not recorded formally. Near misses were on occasion documented on office risk registers if a pattern of these events became evident. An early warning system known as 'need to know' was in place and this acted as an early notification system for managers.

Quality assurance and monitoring

There were mechanisms in place to monitor the quality of the service but they required improvement.

The national three year strategic plan contained key performance indicators which were reported to the national office. A service area wide system for the auditing of files was due to commence in 2015.

Monitoring by team leaders of services was informal but rigorous although not always recorded sufficiently when day-to-day decisions were made about cases outside of the formal supervision process.

There were systems in place for learning at all levels of the service but this was not always formalised. Staff showed a good awareness of the learning they had gained from published inquiries such as the Roscommon inquiry (2010). There were some missed opportunities for learning. For example where serious incidents or adverse events had taken place in the service, the information was not always shared (where appropriate) with staff at all levels in order that practice could be examined and improved.

There were no service level agreements (SLAs) in place for 2014 and monitoring systems for services delivered on behalf of the service were based on good

relationships with the area manager. Responsibilities for SLAs lay solely with the area manager and his office since 2014. During interview, he told inspectors that financial responsibilities transferred to his office in 2014 for all funding of contracted services. Those working in his office had since created a database of funding recipients, evidence of which the inspector viewed. The area manager had close relationships with some of these projects historically and this was confirmed by a number of professionals working in these projects. There was less involvement by the area manager with recipients of smaller amounts of funding and insufficient oversight was provided. A number of funded projects pro-actively forwarded to the area manager's office copies of their annual reports, copies of evaluations and statistics on their service delivery.

SLAs were not in place for 2014 but plans were in place to address this in 2015. The area manager told inspectors that new national funding applications were due to be issued in 2015, along with nationally approved SLA templates. In addition, the area manager had four community workers now reporting to him since quarter two of 2014 and he had assigned duties to these workers to build and establish more formal relationships with all funded projects. The absence of SLAs for 2014 meant that the area manager could not assure himself that the funding was used effectively by these services in addressing the needs of children and families in the service area. Questionnaires were issued to a representative sample of these funded agencies. Despite the lack of SLAs, a number of these agencies reported a clear understanding based on contact with the area manager's office regarding their service commitments. Other agencies were less clear.

Theme 4: Use of Resources

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

Inspection findings

The service was not sufficiently resourced to meet the needs of children and families in a child-centred, safe and effective manner. Notwithstanding this, the available resources to the area manager were well managed and deployed to meet prioritised need. Improvements were required to establish agreements with funded projects to ensure that they met the prioritised needs of the service in a planned manner. A comprehensive needs analysis for the service had not been carried out.

Resources

The area manager had not carried out a formal needs analysis but service needs were documented by the area manager and principal social workers in the 12 months prior to the inspection.

There was evidence of the area manager consulting with professionals from a wide range of statutory and voluntary community services to identify the needs of children and families. A children and young people's services committee, although relatively newly formed, was led by the area manager and one of its aims was to ascertain the needs of children in the area. In 2014, the area manager had consulted with a funded project about a service need which led to an access facility being provided for children and families.

The child protection and welfare service had re-configured earlier on in the year into one service area. Prior to this, services had been provided by four distinct offices and as such resource allocation was traditional, for example, some offices traditionally had a suite of services to which children and families could be referred while other offices did not have the same level of services available to them. This meant that for some children and families, there were inequities when they sought help and support from the service.

The systems in place to allocate and monitor the use of resources were not sophisticated enough to demonstrate outcomes for children and families. The service was unable to analyse the effect of resources allocation. Risk registers highlighted poor outcomes as a result of resource deficits, such as waiting lists.

The area manager and other managers deployed resources at their disposal to meet the needs of children and families as effectively as they could. The area manager was sanctioned to recruit a number of agency social workers in 2014 to address the issue of staffing deficits and these staff were recruited accordingly. A principal social worker was assigned responsibilities for the processing of concerns of a retrospective nature by the area manager prior to the inspection. Staff in the service were observed responding quickly to changing needs of children and families and responded to emergency situations appropriately.

There were a number of key resource issues raised by staff as concerning throughout the inspection. Staff at all levels expressed concern about what they considered to be inadequate staffing numbers in place to respond to the level of concerns reported to the service. Principal social workers told inspectors that there were not enough staff to complete initial assessments in a timely fashion. There was evidence that team leaders and principal social workers regularly took on caseloads to compensate for limited resources by carrying out social work duties. This was confirmed by social workers during interview and observed by inspectors. Inspectors viewed evidence that principal social workers raised their concerns about unallocated cases frequently to the area manager over the past year during meetings, the forwarding of emails and conversations recorded by both parties. Principal social workers recorded concerns regarding unallocated cases requiring initial assessment or their inability to assign an allocated social worker to a child after an initial assessment had been completed and this had been recorded appropriately on risk registers. These concerns were escalated to the area manager's office. The area manager was also concerned about the number of unallocated cases in his service and had escalated this issue to the regional service director in October 2014 formally through the risk register and earlier in the year through correspondence.

Staff expressed concern about the physical state of the buildings in which some of them worked. The service had some offices with colourful waiting rooms and toys for children to play with while they waited to meet their social worker. These offices had appropriate rooms for facilitating access between parents and children or sibling groups and meeting rooms. However, one office was significantly poorly resourced in this area and had dated furnishing, poor bathroom facilities for visitors, no baby changing facilities and cramped meeting rooms. Some staff working at this office told an inspector that parents had on occasion attended to the toileting needs of babies on tables in meeting rooms. Inspectors met staff in an office who did not have their own desk or chair and used the desks and chairs of staff who were not in the office that day. Inspectors noted that one office had air conditioning which was out of service for more than two years and staff had to use portable heaters to keep warm during colder weather. This was not a suitable work environment.

Inspectors met the service director to discuss resource issues which had been escalated to his office. He told inspectors that the national service was in a state of financial constraint. He acknowledged that some of the resource issues experienced in the area required further examination and others were in varying stages of progression. He was in the process of preparing a business case on the issue of staffing to the national office once he received the findings of a study conducted by the regional quality assurance and risk management manager. He told inspectors that agency staff had been appointed in 2014 across the service to address some of the staffing deficiencies. Inspectors were concerned that despite the allocation of staffing resources in this regard there still remained extensive waiting lists across the service which had not been significantly reduced by the allocation of these staff.

The service director confirmed to inspectors that he had limited finances available to him but did have the means to address some of the buildings issues in 2015 and had plans in place. He told inspectors that a considerable amount of money was spent each year on the funding of services in the community in the area and he wanted managers to focus on this aspect of the service in 2015 to ensure greater value for money, efficiency and effectiveness.

Theme 5: Workforce

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

Inspection findings

This inspection found that the service was provided by a skilled and supported staff team that were organised and managed in such a way to ensure that they had the required skills, experience and competencies to respond to the needs of children. Improvements were needed to ensure that evidence of safe recruitment practices was fully maintained in all personnel files, including those of agency staff.

Recruitment

The majority of social work staff were recruited in accordance with legislation, standards and policies but improvements were needed to ensure that the required documentation was in place for agency staff.

The service had a whole time equivalent of 90.9 social work staff and 31.75 clerical/administrative staff. At the time of the inspection, there were 16.94 vacant social work posts. There were 11 temporary agency social workers employed at the time of the inspection and this was in response to the 16.94 vacant social work posts.

Systems were in place to recruit staff. The recruitment of permanent staff was managed through the national recruitment panel. Personnel files were held in a central location and local personnel files containing staff supervision and training records were held in each office. National policies were in place and included a staff induction policy, a staff supervision policy, policies on lone working and dignity at work and guidance on protected disclosure.

During this inspection, inspectors viewed the personnel details of permanent members of staff and a number of social workers employed through a recruitment agency. The majority of permanent staff were recruited in accordance with legislation, standards and policies. Personnel files contained key information such as the staff member's full name, date of birth, evidence of identity, references, An Garda Síochána vetting, qualifications and records of previous employment. The vetting of staff with An Garda Síochána had taken place at the time of recruitment and as such, staff had not had a repeated vetting of their background since their date of appointment in compliance with the Child and Family Agency's own policy. This meant that there were staff working in the service whose An Garda Síochána vetting was more than ten years old. There was no evidence

of a rolling programme of vetting in place. Prior to the inspection, the area manager returned figures that showed that all staff were registered with the relevant professional body but inspectors found that not all staff had submitted evidence of their registration status with their professional body. Inspectors identified some gaps in the personnel files of permanent members of staff. Some contained only one written reference on file. It was unclear if the gaps were the result of poor filing systems or whether the required information had been obtained and held by the recruitment service of the Child and Family Agency.

There were gaps identified in the personnel records of agency social work staff. There was one recruitment agency used by the service to supply agency social workers. Principal social workers and/or team leaders interviewed these applicants prior to them commencing in their role. There was no specific procedure to guide the principal social workers in the recruitment of agency staff. Inspectors viewed a sample of agency personnel files in local offices. Not all files had the required number of references, confirmation of An Garda Síochána vetting nor confirmation of references in place.

An induction process for new members of staff was in place and a national policy guided team leaders and principal social workers in this regard. Inspectors met a number of new staff members and agency staff during the inspection who confirmed that they had been in receipt of orientation and induction programmes. Team leaders demonstrated a strong awareness of the need to closely supervise and support newer members of staff in their teams.

Sufficient staff and skill mix

There were experienced and qualified staff in place to deliver services. However, there had been a considerable rise in the number of referrals over the previous years and considerable waiting lists were in existence. In spite of the use of agency workers, staff were not able to address or reduce the size of the waiting lists.

There was a high ratio of experienced social work staff along with a smaller ratio of newer members of staff. The majority of staff described their team leaders as valuable, experienced support persons who had a wealth of experience in child protection services. In addition to social work staff, there were both childcare leaders and family support workers in some offices. A public health nurse specialising in child protection was employed at one office. The area manager had a team of staff who worked with him in non-social work posts. This team included a Children First (2011) implementation officer and a research officer.

Staff turnover was low as evidenced by the figures provided to the Authority and there was consistency in staffing in place in the area. Although this was positive in terms of a

consistent service being provided to children and families, some staff expressed frustration in what they felt was an inability or limited opportunities to move or transfer to other services within the Child and Family agency.

There were concerns raised by all staff across the service about the levels of staffing in place to cope with the daily demands of the service. Inspectors found evidence of communication to the area manager by principal social workers of these concerns in the 24 months prior to the inspection. Principal social workers also documented their staffing concerns as organisational risks on their office risk registers. The area manager shared these concerns and had escalated this issue accordingly to the service director. The service director said he was aware of the concerns which had been escalated to his office by the area manager and told inspectors that although the service was not fully staffed, it was operating at 92% (including agency) of what he considered to be an agreed national figure and therefore not operating at excessively low levels but accepted that the rate of referrals was growing year on year and that the service area was the largest recipient of referrals in comparison to other service areas around the country.

Managers had significant line management experience and direct experience for the type of service they delivered. They had qualifications in management or were in the process of acquiring such qualifications. Training in leadership was being rolled out during the inspection and a number of managers were attending this training. The majority of staff reported a high level of satisfaction in the way in which they were managed.

Support and supervision

Staff were supported and supervised appropriately in their work through formal supervision and informally on a day-to-day basis.

Supervision practice was guided by a national supervision policy. Inspectors observed staff receiving day-to-day support and guidance from their line managers. During focus groups, staff told inspectors that they valued formal supervision and they received it regularly. Inspectors viewed a sample of supervision records across the service and found that it was provided regularly although decisions from one supervision meeting were not always followed up at the next. The training requirements of staff were not always set out in their supervision records. Principal social workers received group supervision from the area manager and a written schedule of supervision was in place for 2014. Not all of these supervision sessions were recorded which meant that some decisions made could not be tracked over time.

An appraisal system of performance management was not yet in place in the service. This meant that there was no formal mechanism in place for the review of staff members' performance and any professional development needs that they might have.

Staff were facilitated to make protected disclosures and appropriate guidance was provided in the Children First (2011) practice handbook for practitioners. Staff at all levels who met inspectors were confident in voicing their concerns about aspects of the service and had done so through meetings and other correspondence viewed by inspectors. These concerns related predominantly to the number of unallocated cases and concerns regarding staffing numbers.

Training

Training opportunities were available for all staff in the service but this was not informed by a robust training needs analysis.

Training was offered to staff from the regional workforce development unit, whose schedule for 2014 was viewed by an inspector. There was a range of courses offered. A total of 55 training opportunities were scheduled in the southern region in 2014. Some of these courses were offered on an interagency basis and external staff also had the opportunity to attend. In three offices in the area, staff training was well documented but one office did not record adequately the training completed by their staff. Staff and managers were aware of this training schedule and that they could access these courses subject to the approval of their line managers. In addition, the regional workforce development unit organised places on paid external courses for small numbers of staff when possible, subject to budget considerations. Staff confirmed the availability of these external paid training opportunities in the twelve months prior to the inspection. Staff also had access to courses provided by the training office of the Health Service Executive training department in 2014. During focus groups, staff told inspectors that they were supported to attend specialised courses which they themselves paid for.

The service returned data to the Authority that indicated that all staff were trained in Children First (2011). Training in this area was a regular feature on the yearly training schedule co-ordinated by the regional workforce development unit. During focus groups, staff had a very good knowledge of these guidelines and their responsibilities in relation to it. There was insufficient evidence to show that all agency staff had completed training in Children First (2011). This was concerning given that their day-to-day work required them to follow the guidelines set out in Children First (2011).

One office in the area had written training plans in place for 2014 and was exemplary in its positive approach to continuous professional development of staff in times of

financial restraint. At this office, there were training opportunities for all staff in a variety of formats throughout the year, for example existing staff who had developed expertise in specialist areas trained their colleagues. Staff sourced on occasion professionals external to the Child and Family Agency who they approached and these professionals on occasion delivered short courses at no charge to the service.

A number of long serving staff members told inspectors that despite the availability of continuous training and development in 2014, not all courses met their training needs. These staff told inspectors that the courses organised by the regional workforce development unit did not change considerably from year to year and as such they had already completed the majority of these courses in previous years. There was no training needs analysis carried out to inform the design of the training programme.

An inspector met with the regional manager of this regional workforce development unit who showed written plans for how the service would be operating in 2015. A more comprehensive system of training needs analysis and personal training objectives for all staff would be commencing in 2015. Course evaluation would be a key feature of service delivery in 2015 to reflect the needs of those working in the service.

Theme 6: Use of Information

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

Inspection findings

Systems were in place in the service for the gathering of data for the purposes of submission to the national office and analysis of some aspects of the services. Not all offices in the services had electronic information systems and data was counted manually. This impacted negatively on the capacity of the service to analyse data to improve the quality of services for children. Children and families' personal information was kept on paper files and was mostly kept secure but there had been a small number of files that had been mis-placed.

Collection and analysis of information

Data was collected on a wide range of issues affecting the service but the system in place was limited in its capacity to gather information in an accurate and timely manner.

Some data in the area was collected through manual counting systems and given the high number of referrals received by each office in the area, there was a risk that a manual count would be inaccurate. The area manager told an inspector that the roll out of a national information system was set to commence in 2015 and the offices in his area currently without an electronic system would be prioritised in this regard. The inability of the area to accurately collect and collate data meant that the totality of information was not always known and could therefore not give the clearest picture of the situation in the area.

Data was used by managers to inform decisions on issues such as caseload allocation. It was used by principal social workers and the area manager to form judgments on the service and the ability of the service to respond to the needs of children. Data was analysed at monthly management meetings attended by the area manager and principal social workers but generally in the context of identifying risks, rather than as a tool for driving improvement. Principal social workers had raised concerns during the 24 months prior to the inspection regarding the number of referrals and the difficulties that

they had in allocating these referrals to staff for initial or further assessments. This concern was based on data they had collected in each of their offices. Decisions were made based on this data and some offices were sanctioned to receive agency staff to help address this issue.

The information system

The information systems in place were not sufficiently robust to support the management of child protection and welfare concerns.

One of the offices had an electronic information technology system in place. The remaining three offices in the service did not have an electronic information system yet in place and their systems were limited to paper based systems and information systems created individually by staff members using basic information technology packages such as spreadsheets. This system posed a challenge to the collection, validation and analysis of data. At the time of the inspection, the number of re-referrals to the service and the number of children awaiting services in psychology was not known. It was difficult for managers to retrieve information for the purpose of the data set requested from the Authority. Prior to the inspection, data were revised and re-submitted to the Authority but it was not possible for managers to do this in the time frames required.

The information systems were not being used in compliance with good information governance practice. Staff at one office had escalated an organisational hazard to the area manager's office as there were some newer members of staff without a username and password. In the interim, they were using the passwords of their team leaders to access the information system. The information officer in the area was aware of this breach of policy as it had been highlighted at the local Governance Group meeting for the system. The Information Officer told the inspector that this issue had been escalated through the risk management process from the service manager to the area manager's office and then to the service director. There was an issue about who was now responsible for the creation of usernames and passwords since the service separated from the HSE. At the time of the inspection, the regional service director was not aware of this specific issue but acknowledged that some activities that had previously been the responsibility of the HSE were not as clear since the formation of the Child and Family Agency.

Record keeping

There was evidence of good quality records in place for children but improvements were required to ensure that there was better consistency and a high standard of record keeping in line with Children First (2011).

In accordance with a national policy on record management, data was collected for the purposes of:

- creating records of the social work involvement with individual service users and families,
- to support workers in the processes of assessment, planning, review or investigation,
- to show how decisions were made and who was involved in making them
- to provide a record of the services or interventions
- to show how service users (children and families) have been involved in their assessment, support planning, review or investigation.

This data was viewed by inspectors in case files, spreadsheets, electronic information technology systems and other filing systems. Information was placed on standard business templates used across the service and was used by a variety of professionals in the service area. When social workers were allocated a case, they reviewed the information collated by the previous social worker to inform their decision-making.

Guidance outlined in Children First (2011) and a national policy on record management (2012) was available to guide staff on record management. Policies relating to freedom of information and data protection were also available for staff to consult when dealing with concerns and queries from service users. A significant number of files viewed by inspectors were factual, accurate, legible and well organised. Standard business processes such as intake records, initial assessments and further assessments were used consistently throughout the service. These documents along with standard report forms, case notes, court reports and supervision notes provided a comprehensive picture for children of their circumstances and interventions, though not always in chronological format.

Some records viewed by inspectors required improvement as the quality of these records varied. They were not always dated or signed and not all children had their own individual file as required by Children First (2011) and the record management policy. Where families were known to an office for significant periods of time prior to the roll out of the standardised business processes, the journey of the child through the system was not clear especially in relation to the plans put in place and progress against these plans. A chronology of events was not always compiled to explain the history of the case. The priority status or threshold of need status was not always recorded on the case file or intake record, therefore the social worker did not always have a quick reference to the priority or status of need assigned to the case following receipt of referral.

There were effective local systems and procedures in place for filing and storage of case files in offices but there were examples of inconsistencies in this area. Each office had their own system for filing records and these systems were viewed by inspectors and found to be appropriate. Some offices had a dedicated administrator available to them who had responsibilities in this area and had established in-house procedures that were effective. During the inspection period an inspector in one office identified a small number of cases that had been misplaced temporarily. A team leader in another office told inspectors that one file had been lost within their service.

There was an effective process to accommodate freedom of information requests but not all children and families were aware of this process. Requests by young adults or families were made through freedom of information requests and a dedicated freedom of information officer working in the service had responsibilities in this area. Social workers dealt directly with requests from children for their information if the cases were open to the service. They told inspectors that they would ask the child what information they required and decide if this could be provided without a freedom of information request. Staff told inspectors that requests of this nature were not a frequent occurrence from children and families that they worked with in the community. Children and families with whom inspectors spoke with did not know their rights in this area, which might be a contributing factor in the low rate of requests.

The system of auditing files had been finalised in 2014 and there was evidence of some file auditing that had taken place in 2013 and 2014. The file audit system was described by the area manager as having been in a developmental stage in 2014. Staff in the service had contributed to the development of a national file audit template in 2014, a copy of which was viewed by the inspector. The area manager outlined plans to roll out the nationally approved audit template in 2015. A risk management and quality assurance manager with regional responsibilities confirmed the roll out of the approved file audit to commence in 2015. Given the low number of file audits that had been carried out in 2014, managers could not be assured of the quality of record-keeping in the service.

ⁱ Section 26 of the Child Care Act, 1991 makes provision for the courts to appoint a guardian ad litem for a child. A guardian ad litem is appointed to protect the rights and best interests of the child. The 'guardian ad litem service' is a service that in most cases provides children involved in family law with an independent voice in court. This means that appropriate people, called 'guardian ad litem', are appointed by the court to talk with the child, their family and other organisations who know the child and their family during this process. They then consider all that they have heard and advise the court on what is in the best interest of the child concerned. They will include the child's own wishes.

ⁱⁱ Children and Young People's Services Committees (CYPSC) are the key structure identified by the government to plan and co-ordinate services for children and young people in every county of Ireland. The Office of Children and Youth Affairs (DCYA) provides the policy and lead for CYPSCs. (Children and Young People's Services Committee leaflet)

ⁱⁱⁱ Threshold of need. The aim of the threshold guidance is to promote clarity and consistency of response to referrals to Tusla under Children First Guidance and legislation. Within this guidance 'four' levels of intervention are described. These are indicators to assist professional judgement. Level One: no additional needs/child achieving expected outcomes. Level Two: Children with additional needs. Level Three: Children with multiple (complex) additional needs. Level Four: Children with highly complex, acute and/or immediate risk of harm. (Child and Family Agency, Threshold of need guidance for practitioners in Tusla social work services, April 2014)

^{iv} A national practice model for all agencies working with children, young people and their families. Meitheal is about preventative support where children have unmet additional and/or complex needs that need to be responded to but a referral under Children First is not required. Tusla (2013) Prevention, Partnership and Family Support National Guidance and Local Implementation.

^v The development and implementation of a single, transparent, consistent and accountable National Service Delivery Framework (NSDF) focused on improving outcomes for children, is a key component of the Child and Family Agency. The NSDF seeks to deliver services within a coordinated, multi-disciplinary and multi-agency framework, from universal and community services through to secondary and tertiary level services. Tusla (2013). Prevention, Partnership and Family Support National Guidance and Local Implementation.

^{vi} Due Diligence is the process to look closely at the operations of an entity prior to incorporation, amalgamation, merger etc. Health Service Executive (2011) National Financial Regulation