

**Health Information and Quality Authority
Regulation Directorate**



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

Name of Service Area:	Donegal	
Service Area ID:	100-204-308	
Dates of inspection:	13 May 2014 – 22 May 2014	
No. of Fieldwork days:	6	
Lead inspector:	Bronagh Gibson	
Support inspector(s):	Orla Murphy Eva Boyle Paul Tierney	Helen Donovan Maureen Burns Rees
Type of inspection:	<input checked="" type="checkbox"/> announced <input type="checkbox"/> unannounced	
Inspection ID:	682	

About monitoring of compliance

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 compliance of the Child and Family Agency with the National Standards and advises the Minister for Children and Youth Affairs and the Child and Family Agency as to the level of compliance.

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 and take place:

- to monitor compliance with standards
- arising from a number of events including information affecting the safety or wellbeing of children

Summary of compliance with Health Act 2007 and National Standards for the Protection and Welfare of Children for Child and Family Agency

This inspection report sets out the findings of a monitoring inspection:

- to monitor ongoing regulatory compliance with National Standards
- following receipt of solicited and unsolicited information
- following notification of a significant incident or event

The table below sets out the themes that were inspected against on this inspection.

<p>Theme 1: Individualised Supports and Care</p> <p>Services for children are centred on the individual child and his/her 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.</p>	<input checked="" type="checkbox"/>
<p>Theme 2: Effective Services</p> <p>Effective services ensure that the proper support mechanisms are in place to enable children to lead a fulfilling life. Personal planning is central to supporting children to identify their goals, needs and preferences and what supports need to be put in place by the service to ensure that each child maximises his/her personal development.</p>	<input checked="" type="checkbox"/>
<p>Theme 3: Safe Services</p> <p>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 people from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities.</p>	<input checked="" type="checkbox"/>

<p>Theme 5: Leadership, Governance and Management</p> <p>Effective governance in services for children is accomplished by directing and managing activities using good business practices, objectivity, accountability and integrity. In an effective governance structure, overall accountability for the delivery of services is clearly defined and there are clear lines of accountability at individual, team and service levels so that all people working in the service are aware of their responsibilities and who they are accountable to.</p>	<input checked="" type="checkbox"/>
<p>Theme 6: Use of resources</p> <p>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.</p>	<input checked="" type="checkbox"/>
<p>Theme 7: Responsive workforce</p> <p>Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children’s services organise and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.</p>	<input checked="" type="checkbox"/>
<p>Theme 8: Use of Information</p> <p>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.</p>	<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 compliance with the National Standards, an awareness of the Health Act 2007 and the UN Convention on the Rights of the Child. The inspection focuses initially on one particular part of the child's journey: the point at which the child is referred to children's social care services because they are believed to be at risk of, or actually suffering, harm or have welfare needs.

During this part of the inspection, the inspectors will evaluate the:

- timeliness and management of referrals
- effectiveness of assessment and risk management processes
- provision of immediate help where required
- extent of focus on the child or young person's needs and
- effectiveness of multiagency work at the point of and immediately following referral.

The remainder of the fieldwork focuses on all other aspects of the child's journey.

The key activities of this inspection involved:

- the interrogation of data
- the review of local policies and procedures, minutes of various meetings, 19 staff files, audits and service plans
- the review of 120 children's case files by both tracking and sampling information contained within their files
- meeting with eight children and young people, meeting or telephone interviews with five parents
- meeting with 13 social workers, four team leaders, two principal social workers – one of whom was chair of child protection conferences – one child care leader, one family support development worker, two administrators and a human resources manager

- questionnaires from 17 external stakeholders and meetings or telephone interviews with 20 external professionals including (members of An Garda Síochána, health services and educators)
- observing staff in their day-to-day work
- observing practice in one child protection conference review, one family support planning meeting, one multiagency meeting and one management meeting.

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.

Acknowledgements

The Authority wishes to thank the children and parents and or guardians for their participation in the inspection process. Inspectors also wish to acknowledge the cooperation of the staff and senior managers of the Child and Family Agency in the Donegal area.

2. Profile

2.1 The Child and Family Agency

Child and family services in Ireland are now the primary focus of a single dedicated State agency, the Child and Family Agency, overseen by a single dedicated government Department, the Department of Children and Youth Affairs. The Child and Family Agency Act 2013 (No. 40 of 2013) established the Child and Family Agency. The Agency was established 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 service areas and are managed under area managers.

Child protection and welfare services are inspected by the Authority at service area level with governance inspected at an area manager level.

2.2 Service Area

Donegal is one of 17 service areas in the Child and Family Agency. It is situated in the northwest of the country and borders Northern Ireland and County Leitrim. It is the fourth largest county in the State covering 4,859.51 square kilometres.

Donegal is ranked one of the most deprived areas in the country and the *State of the Nation's Children* report, alongside the Central Statistics Office (CSO) Census 2011, indicate that Donegal is underachieving across a range of areas including educational attainment. Data related to levels of unemployment and one parent households are above the national average.

The overall population for the area based on the 2011 population Census was 161,137, which included 43,732 children.

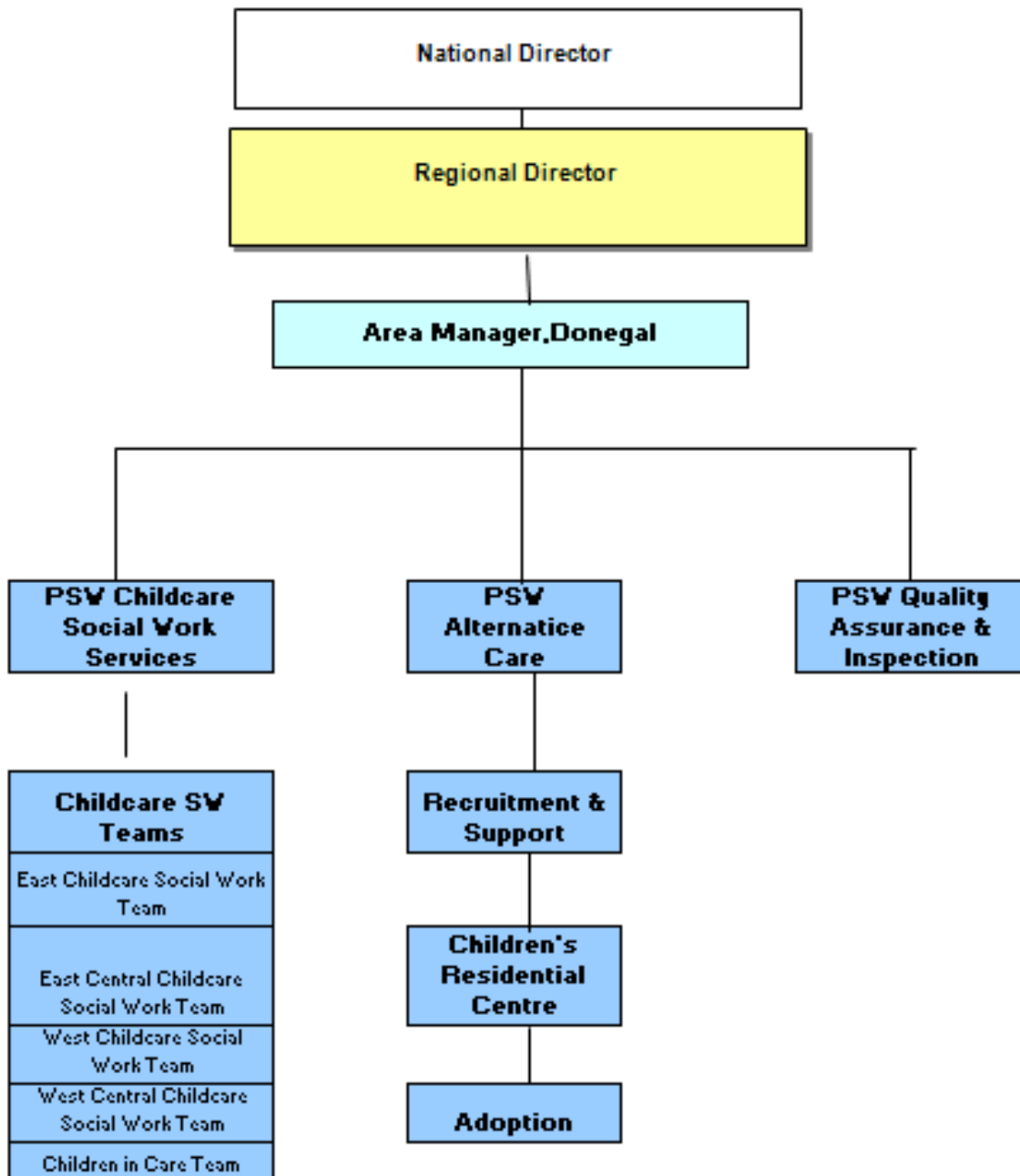
Regionally, the area was under the direction of the service director for the Child and Family Agency West Region.

Donegal child protection and welfare services had four office bases within the service area: two in Letterkenny, one in Buncrana and one in Donegal town. There were four social work teams who were directly line-managed by team leaders who reported to the principal social worker for child welfare and protection. There was a principal social worker responsible for alternative care and a principal social worker who was chair of child protection conferences. Each team had two intake workers and social workers who had mixed caseloads, including children in care. At the time of the inspection, one office did not receive incoming referrals on a temporary basis so that it could address backlogs in initial assessments. Teams also included community workers, family support workers and administration staff.

There were 968 cases open to the service prior to the inspection, 379 of which were child protection cases and 589 were welfare cases. The area had received 1,151 referrals in the 12 months before the inspection and identified that 614 required initial assessments and the remainder were closed. The area had 79 children on the Child Protection Notification System (CPNS) at the time of the inspection.

The organisational chart in Figure 1 on the following page describes the management and team structure as provided by the area.

Figure 1: Organisational structure of the Child Protection and Welfare Service, Donegal 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. Such 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 the area complied with five out of the 27 standards assessed, had a minor non-compliances with 10 standards, while there were moderate non-compliances with 12 standards. The area had no major non-compliances with any of the standards. The findings are set out in Section 4 of this report and the action plan is published separately.

Children received a child protection and welfare service which supported and protected them. There was a strong management team providing good leadership and direction, and children were supported by committed and resilient staff. However, during the inspection, the management team and staff struggled to manage the levels of risk within the service due to low staffing levels that affected several aspects of the service, particularly its capacity to allocate social workers to cases or to carry out assessments of children's needs. These risks were escalated by the Authority to the service director and national director during the inspection. In spite of these challenges, this inspection found that the service had been moderately successful in reducing waiting lists for assessment in the two months prior to inspection.

The Authority found that the rights and welfare of children were promoted and consultation with children was good. They were included in decisions about their lives and their wishes were acknowledged. Children and families understood the roles and responsibilities of social workers as well as other agencies and professionals who were involved with them. There was good interagency work with both An Garda Síochána and other agencies and professionals.

The area was not always compliant with *Children First: National Guidance for the Protection and Welfare of Children (2011)*, referred to in this inspection report as Children First. Many of its requirements were being implemented in order to protect

children. All concerns regarding children were screened effectively and social workers based their decisions on strengths and risk and protective factors within families and their social networks. There was a system to ensure child protection conferences took place in a timely manner, but this was not effective for all children. Child protection plans were developed on a multidisciplinary and multiagency basis, but their quality varied. The Child Protection Notification System (CPNS) was not available on a 24-hour basis to relevant parties including An Garda Síochána and healthcare services.

A number of children were on waiting lists for the child protection service and although every effort was made to manage risk in these cases, there were inconsistencies. There were 15 children prior to inspection placed on the Child Protection Notification System with no allocated social worker and these children were not visited by social workers with the regularity required for children with this level of need and risk. All of these children were allocated a social worker by the end of the inspection. Children experienced delays in their needs being assessed as both initial and further assessments were not always completed in a timely manner. Waiting lists were also in place for family support workers, psychology and assessments of alleged and convicted offenders in the community.

Although efforts were made to identify, assess and manage risks posed by alleged or convicted offenders in the community, early warning systems to identify organised abuse were not robust enough. Delayed risk assessments meant that immediate risks to children may not have been identified and managed by the service.

The majority of children and families knew how to access their information. There was a complaints process in place and child-friendly information was available and distributed to children.

There were other deficits in the management of child protection and welfare concerns. Not all children who required a social worker had been allocated one. The service had some systems in place to measure progress but they were not sufficient and there was no systematic analysis of all complaints or learning to improve practice. Improvements were also required in information management. The management team did not have ready access to relevant information including the number of referrals of alleged organised or retrospective alleged organisational or institutional abuse.

4. Summary of judgements under each standard

Theme	National Standards for the Protection and Welfare of Children	Compliant Non-compliant – minor, moderate, major
Theme 1: Individualised Supports and Care	Standard 1:1 Children’s rights and diversity are respected and promoted.	Compliant
	Standard 1:2 Children are listened to and their concerns and complaints are responded to openly and effectively.	Minor non-compliance
	Standard 1:3 Children are communicated with effectively and are provided with information in an accessible format.	Minor non-compliance
Theme 2: Effective Services	Standard 2:4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	Moderate non-compliance
	Standard 2:7 Children’s protection plans and interventions are reviewed in line with requirements in <i>Children First</i> .	Moderate non-compliance
	Standard 2:8 Child protection and welfare interventions achieve the best outcomes for the child.	Minor non-compliance
	Standard 2:9 Interagency and inter-professional	Minor non-compliance

Theme	National Standards for the Protection and Welfare of Children	Compliant Non-compliant – minor, moderate, major
	cooperation supports and promotes the protection and welfare of children.	
	Standard 2:10 Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.	Moderate non-compliance
Theme 3: Safe Services	Standard 2:1 Children are protected and their welfare is promoted through the consistent implementation of <i>Children First</i> .	Moderate non-compliance
	Standard 2:2 All concerns in relation to children are screened and directed to the appropriate service.	Minor non-compliance
	Standard 2:3 Timely and effective action is taken to protect children.	Moderate non-compliance
	Standard 2:5 All reports of child protection concerns are assessed in line with <i>Children First</i> and best available evidence.	Moderate non-compliance
	Standard 2:6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	Moderate non-compliance
	Standard 2:11 Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes	Minor non-compliance

Theme	National Standards for the Protection and Welfare of Children	Compliant Non-compliant – minor, moderate, major
	effectively inform practice at all levels.	
	<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>	Moderate non-compliance
Theme 5: Leadership, Governance and 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>	Compliant
	<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>	Moderate non-compliance
Theme 5: Leadership, Governance and Management	<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>	Moderate non-compliance
	<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</p>	Moderate non-compliance

Theme	National Standards for the Protection and Welfare of Children	Compliant Non-compliant – minor, moderate, major
	child protection and welfare policy and standards.	
Theme 6: Use of Resources	Standard 4:1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.	Compliant
Theme 7: Workforce	Standard 5:1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.	Minor non-compliance
	Standard 5:2 Staff have the required skills and experience to manage and deliver effective services to children.	Moderate non-compliance
	Standard 5:3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	Minor non-compliance
	Standard 5:4 Child protection and welfare training is provided to staff working in the service to improve outcomes for children.	Compliant
Theme 8: Use of Information	Standard 6:1 All relevant information is used to plan and deliver effective child protection and welfare services.	Minor non-compliance
	Standard 6:2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	Compliant

Theme	National Standards for the Protection and Welfare of Children	Compliant Non-compliant – minor, moderate, major
	Standard 6.3 Secure record-keeping and file-management systems are in place to manage child protection and welfare concerns.	Minor non-compliance

5. Findings and judgments

Section 8(1) (c) of the Health Act 2007

Compliance with Health Act 2007 and National Standards for the Protection and Welfare of Children for the Child and Family Services

Theme 1: Individualised Supports and Care

Services for children are centred on the individual child and his/her 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.

National Standards for the Protection and Welfare of Children

Reference:

Standard 1.1 Children's rights and diversity are respected and promoted.

Standard 1.2 Children are listened to and their concerns and complaints are responded to openly and effectively.

Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.

Inspection findings

This inspection found that the service took a child-centred approach, which promoted the individual rights of children and their families and valued their participation in and contribution to decisions made about their lives. Children and families were made aware of their rights and supported to exercise them, particularly the right to be heard, make a complaint and have access to advocacy services when required. There was a need to ensure case records consistently reflected the voice of the child and that the central register of complaints recorded all complaints received by the service. There was also a need to further develop literature for children and families and the general public on social work services in the area.

Inspectors found that everyday practice was guided by the United Nations Convention on the Rights of the Child. This was supplemented by business processes that supported social workers to take a standardised approach to practice such as seeking the views of children and families during social work assessments, and including children in decision-making. Social workers interviewed by inspectors were aware of the rights of children and had received training in this area, including working with children from different ethnic and religious backgrounds. Children and parents who spoke to inspectors held mixed views on their participation in decision-making and the value placed on their wishes and preferred choices. Some children said that although they were consulted and fully involved in decision-making, there was sometimes an emphasis placed on the wishes of their parents. However, records reviewed by inspectors showed that social workers met children in private when they visited them and the majority of, but not all records, clearly recorded individual children's views and choices. In many cases, these were the deciding factors when access or living arrangements and alternative services were being determined by social workers. Parents said that they felt supported and respected by social workers and, when appropriate, their wishes and concerns were considered. Inspectors observed various meetings, some of which included families, and found this to be the case.

There was a high value placed on children's right to education and maintaining them in mainstream education. Individual records showed that the social work department worked in partnership with schools and other agencies to maintain children in mainstream education. Inspectors found that this was effective as an early intervention and assisted the social work department to monitor children who were at risk in the community. This was confirmed by educators who met with inspectors.

There was an open and transparent approach to complaints by the social work department but the number and nature of all complaints was not reflected on the complaints register. A standardised approach to recording complaints was required. There was a complaints policy and procedure in place and this was available in a child-friendly format. Records of complaints were reviewed by inspectors and showed that they were responded to in a timely fashion and outcomes were clearly recorded. Management meetings observed by inspectors showed that the team reflected on complaints and issued apologies to complainants when appropriate. Social workers told inspectors that they encouraged children to complain if they were not happy with the service. Case records showed that there were several routes through which complaints arrived to the social work department and there was not a standardised approach to recording them. Complaints reported through the regional complaints officer were sent to the principal social worker, who maintained a record and placed the complaint on the central register. Inspectors read monthly reports from team leaders to the principal

social worker and found that progress on complaints under investigation were reported to the principal social worker and the register was amended accordingly. Complaints reported directly to social workers were recorded on case files and were not reflected on the central register. Inspectors observed one team leader dealing with a complaint and the team leader confirmed that although the principal social worker had oversight of all complaints, many of those they dealt with were not placed on the central register. This meant that the central register was not a true reflection of the number and nature of all complaints received by the service and trending of all complaints for the purpose of responding at a service level was difficult to achieve.

Inspectors found that the service managers and social workers advocated strongly for the rights of children with a disability and children from different cultural backgrounds. Information provided to inspectors showed that plans were in place to enhance external advocacy services. The area manager and the principal social worker told inspectors that children with diverse needs were the focus of interagency and interdisciplinary meetings and protocols so that practice could be improved. Inspectors saw minutes of various meetings that showed this was the case. Individual cases were reviewed by inspectors and advocacy at this level was clearly demonstrated. Inspectors also found cases where children had court-appointed guardians ad litem⁺ to children to ensure their voice and wishes were heard in court proceedings. There was an acknowledgment by all staff interviewed that advocating for all children was central to everyday practice, but there was a need to develop this service further, particularly as a supportive mechanism at meetings where professionals were in the majority. Information provided to inspectors showed that the service planned to rectify this by the end of 2014.

There were supports in place to ensure quality communication with children and families. Records showed that these included access to various methods of communicating with children and parents with disabilities. One social work team had recently received a handheld computer to assist them in this endeavour. The service had access to disability services to assist them. Case records showed that interpreters were available when required and there were examples of meeting minutes being translated into different languages and provided to family members who did not speak English.

⁺ 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 actions 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.

There was a suite of literature available to children and families and the service had recently begun to routinely provide this information to those who required a social work intervention. Information on the service and on children’s rights was strategically placed around social work offices. The social work department had also set up information stalls at local events to educate the general public about its services. Inspectors observed an interagency meeting and heard the area manager educating others about the service, sharing various practice guidance and describing short- and medium-term service plans. It was acknowledged by the area manager and the principal social worker that literature about the service needed to be rewritten in a format that was accessible to all and that this work had begun prior to the inspection.

Judgement

Standard	Judgment
Standard 1.1 Children’s rights and diversity are respected and promoted.	Compliant
Standard 1.2 Children are listened to and their concerns and complaints are responded to openly and effectively.	Minor non-compliance
Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.	Minor non-compliance

Theme 2: Effective Services

Effective services ensure that the proper support mechanisms are in place to enable children to lead a fulfilling life. Personal planning is central to supporting children to identify their goals, needs and preferences and what supports need to be put in place by the service to ensure that each child maximises his/her personal development.

National Standards for the Protection and Welfare of Children Reference:

Standard 2.4

Children and families have timely access to child protection and welfare services that support the family and protect the child.

Standard 2.7

Child protection plans and interventions are reviewed in line with requirements in *Children First*.

Standard 2.8

Child protection and welfare interventions achieve the best outcomes for the child.

Standard 2.9

Interagency and inter-professional co-operation supports and promotes the protection and welfare of children.

Standard 2.10

Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.

Inspection findings

The requirement for services was based on the assessed levels of need and presenting risks to children. However, access was determined by limited resources at a time of increasing demands on the service. As a result, children at greatest risk were prioritised for a service and the majority of those who did not meet this threshold experienced delays. The service was making good efforts to reduce waitlists for a social work service but they continued to exist, for example, in relation to allocation of a social worker or family support worker and for carrying out initial, further and parenting assessments.

There was an equitable approach to service provision and although staff interviewed told inspectors that children and families would benefit from a broader range of community-based interventions, some of these services did exist. Inspectors found that social work services were supplemented by others, such as services relating to cultural

diversity and disability. Inspectors observed a children services committee sub-group meeting and found that existing services worked closely with the social work department to strengthen access arrangements and develop others.

Child protection and welfare procedures were carried out for many children but delayed for others. Data provided to the Authority showed that incoming concerns were screened within 24 hours. Inspectors found that this was an effective element of the system as it identified children at high risk and in need of a service immediately. This was demonstrated by a low number of cases whose priority level had increased following an initial assessment. Inspectors found initial assessments that had been completed within five days and had resulted in quick responses to children at high risk. Figures provided by the area showed that 28% (84) out of 297 initial assessments were not completed within the 20-day period expected by the Child and Family Agency. Figures provided also showed that 44% (270) of initial assessments were ongoing. Inspectors found that some of these exceeded the 20-day time frame. Inspectors found records of initial assessments that took 24 weeks to complete. Initial assessments reviewed showed that they were delayed for several reasons such as:

- limited and stretched social work resources
- delays in gathering information from external sources
- lengthy initial assessments that exceeded their purpose.

Several managers told inspectors that comprehensive initial assessments reduced the need to refer a case on for a further assessment and prevented larger waiting lists for further assessments. They also said that delays in moving cases from initial to further assessment stage effectively was a work in progress with social work teams following the introduction of standard business processes. Inspectors found that this was not an effective way to manage cases as it contributed to bottlenecks at initial assessment stage and increased workloads on duty intake teams. All staff interviewed said that the needs of children could not be fully determined or met when initial assessments were delayed.

The social work department had waiting lists for assessments and allocation to a social worker, but these were not verifiable or consistently managed. The managers were aware of this and were supporting social workers to use national thresholds for social work interventions. Figures provided to the Authority indicated 47 cases were awaiting an initial assessment, however, inspectors were provided with a printed waiting list from one team leader that showed a figure of 106 cases. Another team leader estimated a waiting list of 72 cases. Data returns to the Child and Family Agency were provided to inspectors and they showed that in March 2014 a total of 169 cases were awaiting allocation to a social worker. A sample of cases on these waiting lists were

reviewed by inspectors and showed that duty social workers made regular contact and monitored children and families at higher levels of need or risk. There was also good use of other agencies and professionals such as family support services and schools. This provided an early warning system about escalating risk. Other case records showed minimal or no contact with social work or other agencies. Team leaders told inspectors that they were not confident that all children had been visited while awaiting a social work service and acknowledged that these cases were not effectively monitored and that children's needs went unmet or unidentified. This was confirmed in cases reviewed by inspectors.

Inspectors found that there were systems in place to review waiting lists for allocation to a social worker, but this was not always effective. Reports provided to inspectors showed that cases on waiting lists were reviewed routinely by the area manager, principal social worker and team leaders. Escalated risk was considered and cases were re-prioritised for allocation following review. Data provided to the Authority indicated 15 children placed on the Child Protection Notification System were not allocated a social worker. This figure had reduced to nine at the time of the inspection. This was not in accordance with national policy as it did not ensure all children at risk of significant and ongoing harm were consistently prioritised for allocation of a social worker. The principal social worker acknowledged the requirement for guidance on managing waiting lists effectively and has developed a local guidance in response to this need. This was accompanied by a risk assessment tool for team leaders when prioritising or re-prioritising cases for allocation. This was implemented in one social work office before the end of the inspection. This was a positive finding.

There were waiting lists for other services provided by the social work department. Information provided to the Authority indicated that the majority of children referred to family support services received an intervention. Team leaders told inspectors that family support workers were valuable elements of the social work service and every effort was made to ensure children in greatest need received a timely and effective service. Referrals to family supports were made via team leaders who liaised with family support workers to prioritise cases for intervention. Families accessing this service demonstrated practical interventions that were beneficial to them. There were 230 children were awaiting allocation of a family support worker or child care leader and three were awaiting a family welfare conference. There were also children and families who were awaiting services not directly provided by the Child and Family Agency including child mental health services. There was a waiting list for the assessment of alleged or convicted offenders who may pose a risk to children in the community. Inspectors found that although efforts were being made to expedite access to externally-provided services, they too were faced with the challenge of limited

resources and access was prioritised. Records showed that the service did access private forensic psychology on occasion, but staff interviewed said there were few alternatives to these services when lengthy waiting lists existed. There were arrangements in place with external agencies to provide supports to children and families with lower levels of need and risk, but social workers said that these were limited and not accessible to all children and families who would benefit from them.

The area placed a high value on early interventions and services available were accessed and used effectively, but more resources were required. Social workers had access to a choice of family support services. Inspectors reviewed cases that had received early interventions from family support workers and external agencies which included parenting programmes, educational and youth programmes and domestic violence services. Some of the parents told inspectors that they found these interventions to be of benefit and some identified delays in receiving a service. External agencies said that they received appropriate referrals and the needs of children and families were clearly identified by the social work department. A review of cases closed at either screening or initial assessment stage showed that children and families were appropriately redirected to community-based services and closed to the social work department. There was also evidence in case records of good quality collaborative working between these services and the social work department when a case remained open to social work. The area manager and principal social worker told inspectors that there was a need for more resources and a more effective use of available resources. For example, appropriate resources were required to have initial assessments of welfare concerns carried out by professionals other than social workers. Managers told inspectors that this was part of the development of the service in line with the local area pathways model.

There were family support plans in place but they varied in quality and some required more detail. Case records showed that some family support plans were developed in conjunction with other plans in place in the area. For example, a recommendation of one child protection conference was to have a family support plan in place that would support parents to develop social and community-based networks. Inspectors attended a planning meeting and found that the plan was developed within a respectful, inclusive and strengths-based process. Inspectors found that some plans were of a high quality, including detailed actions required with identified time frames and persons responsible. They included a multiagency approach to working with families such as supports from a public health nurse, addiction services, housing supports, afterschool projects and child minding services. Other plans reviewed by inspectors were not of the same quality and lacked detail and appropriate actions to be taken. Other records indicated that a family support plan was recommended but was not on file. A standardised approach was

required to writing family support plans that would provide clear direction in each case.

National guidance on caseload management including the management of complex cases was not yet in place, but there was an effective local system in operation. Information provided to the Authority showed that Donegal had the second highest rate of court activity in the country. The principal social worker said that this was indicative of the complexity of cases they dealt with, the demands placed on individual social workers and the service, and the continuous learning it provided for front-line staff and managers. Reviews of complex cases were carried out by the service and used for the purpose of learning. One such report was provided to inspectors. Social workers said that complex cases were identified by them and their team leader through supervision and case management processes. Once identified, support and monitoring was provided by the principal social worker. Inspectors sampled several of these cases and found supervision notes contained guidance and direction from managers, and actions to be taken were identified. Social workers said that they felt supported by their managers. One social worker requested a second social worker to be co-allocated a complex case as a means of support and this was provided by their manager.

Cases were managed through the case management process which was built into staff supervision. Inspectors read a sample of staff supervision records and found that case discussion and the decision-making processes were well represented in file notes. There was evidence of good standards of guidance and direction in cases discussed. Team leaders and social workers said that it was not possible to discuss every case in each session. They described a process that concentrated on high-level or complex cases and said that this was not an effective system for all cases as it may have contributed to short periods of drift for lower risk cases. They were also of the view that joint decisions, for example, in relation to closing cases, were sometimes delayed.

The child protection conference system was effective and timely for many children but delays in assessment meant that other children experienced a delayed response. Practice was improving and was being aligned with standard business processes. Information provided to the Authority showed that 98 child protection conferences were held about 264 children in the year before to inspection. Inspectors reviewed records of cases that showed individual children's needs and risks were considered when sibling groups were involved. Others showed that conferences were held shortly after a concern being made to the social work department to ensure a timely response to immediate risk. Inspectors found that many child protection conferences were based on reducing risks while strengthening families. For example, inspectors reviewed a case where a family support plan was recommended at a child protection conference in order

to build social and professional networks for parents who were experiencing isolation. Parents and professionals said they were provided with minutes of child protection conferences and plans emerging from them. The chair of child protection conferences said that conferences were not timely for some children who had experienced delays at initial assessment stage. This was confirmed in some cases sampled by inspectors.

Child protection plans were developed for children at risk and they were reviewed in line with standard business processes by an appropriately trained person. Child protection plans were developed at child protection conferences. There was a chairperson of child protection conferences whose substantive post was principal social worker. The chairperson had received specific training to carry out the role of conference chair. The quality of child protection plans varied. Most plans reviewed by inspectors were of a good standard in that they were developed with families and other professionals and were comprehensive with clearly identified safety measures to protect children. Others were vague and did not adequately detail the actual concern or the actions required to reduce the risks involved. One child protection plan in relation to siblings placed on the Child Protection Notification System was reviewed, although social workers had not met the children for approximately three months. Family support staff had met the children, but this was inadequate. The child protection plan for these children did not deal sufficiently with the fact that there was no allocated social worker. This case was brought to the attention of the principal social worker who acknowledged the deficiencies in the plan. Recording mechanisms varied and some plans were in meeting minutes while others were stand-alone documents. Some meeting minutes were not on file and the chairperson of the child protection conferences said there were delays in recording due to reduced administrative supports.

Systems for closing cases were not always effective. The area had taken a strategic approach to closing cases in the year prior to inspection and it was in the process of developing more effective systems. In addition the National Office for the Child and Family Agency had recently established thresholds for accessing social work services. This was being applied systematically to all cases during the inspection, with the aim of closing cases that did not meet newly defined thresholds. The principal social worker told inspectors that this had assisted the service to close cases in one office, and the process was being replicated across the other offices.

There were systems in place to close cases based on agreement between social workers, team leaders and the principal social worker. The majority of cases reviewed by inspectors were closed in a timely manner but others were not. For example, some cases remained open when there was no requirement for a social work intervention, but

the outcome of an investigation by An Garda Síochána was still awaited. One case remained open in order to provide emotional support to a young person, when a referral to long-term supports from a community-based service would be more appropriate. Another case was open and allocated although the family had moved out of the area. There was also a case that remained open to the system for six months due to an administrative delay. There were anomalies in the electronic system in place and this meant that a closed case had to be re-opened when an information request was made under freedom of information legislation.

There was a significant rate of re-referrals (40%) in relation to children previously known to the social work department. Inspectors reviewed some of these cases and found examples of cases that were opened and closed on multiple occasions over long periods of time. For example, one case was opened and closed five times over a five year period and had escalated from a welfare to a child protection concern during that time. The allocated social worker and case records showed that although the cumulative effect on the child was part of the current social work assessment, it had not been considered previously. Another case was closed following family supports being put in place but was opened and closed on two more occasions following similar concerns being reported. The principal social worker told inspectors that a project was under way to examine case closures and this was demonstrated in meeting minutes provided to inspectors.

Significant efforts were made by the service to work collaboratively with other agencies to improve outcomes for children. There was a high emphasis placed on interagency working for the protection of children and families and good working relationships existed between the area and other agencies such as adult mental health, disability, education and An Garda Síochána. However, levels of engagement by some professionals and agencies with the social work department in planning and decision-making processes varied and were not consistent. The service had good working relationships with An Garda Síochána, schools and mental health services. There was a children's services committee with three sub-groups at which high-level relationships were formed and interagency working was promoted and facilitated. Inspectors observed a children service committee sub-group meeting and found this to be the case. The area had a family support advisory forum, a local area pathways planning group and a clinical oversight group that further promoted interagency working and improved integrated service delivery. Strategy and family support meetings were convened for individual cases and external professionals and agencies were invited to attend. Core group meetings were convened every six weeks so professionals could share information about children. This was confirmed by external professionals to inspectors. Inspectors reviewed various plans developed for children and found that

attendance by external professionals was not consistent at planning meetings and although this was not in the control of the social work department, it diluted the effectiveness of multiagency and or disciplinary planning and decision-making processes.

There were protocols in place between the service and An Garda Síochána. The social work department and the service was in the process of developing protocols with mental health services provided by the Health Service Executive (HSE). Members of the Garda Síochána who completed questionnaires and talked with inspectors said there were good working relationships with the service. Some said that some out-of-hours placements for children entailed long distance travelling for them and indicated the draw this had on their resources. The principal social worker had oversight of all notifications received from An Garda Síochána and was in the process of refining the process of acknowledging these and moving them through the intake system. There were members of the Garda Síochána identified locally to liaise with the social work department, and team leaders met them routinely to discuss specific cases. Issues such as delays in notifications being made to or by An Garda Síochána were dealt with directly by team leaders and their Garda Síochána liaison person. Inspectors also observed this happening at a children's services committee sub-group meeting. Social workers told inspectors that working with other disciplines and agencies for the purpose of monitoring cases was particularly valuable to them. The social workers looked forward to improved protocols in relation to information sharing with services provided by the HSE.

Training was provided on a multiagency and multidisciplinary basis. Inspectors were provided with a training schedule that confirmed this. The area manager was observed offering places on training courses for social workers to other agencies, particularly those who received funding from the area.

Judgement

Standard	Judgment
<p>Standard 2.4 Children and families have timely access to child protection and welfare services that support the family and protect the child.</p>	<p>Moderate non-compliance</p>
<p>Standard 2.7 Child protection plans and interventions are reviewed in line with requirements in Children First.</p>	<p>Moderate non-compliance</p>
<p>Standard 2.8 Child protection and welfare interventions achieve the best outcomes for the child.</p>	<p>Minor non-compliance</p>
<p>Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.</p>	<p>Minor non-compliance</p>
<p>Standard 2.10 Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.</p>	<p>Moderate non-compliance</p>

Theme 3: Safe 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 people from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities.

National Standards for the Protection and Welfare of Children Reference:

Standard 2.1

Children are protected and their welfare is promoted through the consistent implementation of Children First.

Standard 2.2

All concerns in relation to children are screened and directed to the appropriate service.

Standard 2.3

Timely and effective actions are taken to protect children

Standard 2.5

All reports of child protection concerns are assessed in line with Children First and best available evidence.

Standard 2.6

Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.

Standard 2.11

Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels.

Standard 2.12

The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

Inspection findings

The area took measures to promote the safety of children in accordance with Children First (2011) and staff were aware of their responsibilities. There were standard procedures in place to respond and manage child protection and welfare referrals and these complied with Children First (2011). There was an effective system in place to screen and prioritise incoming reports of child protection and welfare concerns, but

there were delays to the progression of some cases through the initial and further assessment stages. Delays meant that children at greatest risk and highest levels of need were prioritised, whilst others were placed on a waiting list. Prioritisation of cases on an ongoing basis was not always effective. Although some children on a waiting list had input from other services, this was not the case for all children.

Reports of child protection and welfare concerns were effectively screened. Comprehensive preliminary enquiries were carried out in a timely way. Inspectors found that this aspect of the system was effective in the identification of children in greatest need of a social work response. Figures provided to the Authority showed that the area had received 1,151 referrals in the 12 months prior to inspection, 306 of which were closed following screening. The area did not gather information on how many of these closed referrals were redirected to another agency for a service. Initial assessments were recommended for 614 incoming referrals, 297 of which were completed, 270 were ongoing and 47 had yet to commence. Inspectors observed duty social workers dealing with incoming concerns and found that they responded promptly and appropriately to them. Preliminary enquiries were found by inspectors to be well recorded, comprehensive and supported safe decision-making about children. Duty social workers were observed providing practical and useful information and advice to members of the public and other professionals. Inspectors found that there was a collaborative approach to responding to incoming concerns that indicated immediate risk to a child and saw evidence of this in case records they reviewed.

The Child and Family Agency had recently established national thresholds for referrals to social work services and this was in the process of being implemented. The majority of social workers interviewed confirmed to inspectors that they continued to be guided by the *Framework for measuring, managing and reporting social work intake, assessment and allocation activity* to support their professional judgment on prioritising referrals for social work services. The principal social worker, team leaders and social workers said that there may be some cases that may not require a social work service once they have been reviewed and aligned with new thresholds. The priority level assigned to each case was clearly recorded in case files and there was managerial oversight of these cases.

Prioritisation of cases for a service was ineffective. Inspectors found that prioritisation did not ensure all high risk cases were consistently allocated a social worker or while allocated that the service received by the children was adequate. Figures provided to the Authority showed that there were 15 children placed on the Child Protection

Notification System without an allocated social worker. This number had reduced to nine during the inspection period.

These were children assessed as at risk of significant and ongoing harm. One team leader reviewed case notes with inspectors and confirmed that four children were not visited for up to five months prior to inspection. Another team leader was not confident that all those children on the Child Protection Notification System in their office – who did not have an allocated social worker – had been visited within safe time frames. This was a situation that had been expected to have been resolved within three weeks but had gone on for over two months. Lack of social work contact and visits to children did not allow for a full assessment of the children's current situation including any further risks to which they were exposed. This was not safe practice and as such, the Authority requested immediate actions to be taken regarding these cases to ensure all children on the Child Protection Notification System were allocated a social worker, and that safety visits were carried out. Inspectors were provided with written assurances that this had happened. Managers told inspectors that this was a direct result of reduced social work resources.

There was a timely and appropriate response to the majority of children who had been determined to be at immediate and serious risk. Inspectors found examples of cases where initial assessments were carried out within three days where risks to children were high. Case records showed that unannounced home visits were carried out in many of these cases and this provided social workers with a better view of the actual circumstances of the family. Several pre-birth cases were reviewed by inspectors where core meetings, strategy meetings and multidisciplinary reports had resulted in a pre-birth child protection conference to ensure the safety of the children. Inspectors also reviewed cases where emergency care orders were pursued when children were at immediate risk.

Inspectors observed social workers responding immediately to concerns reported by a hospital about one child. However, cases reviewed showed that there were unallocated cases related for example, to domestic violence. These showed that although high levels of need and risks were identified, some community-based interventions were time limited and once they ceased, risks and needs either escalated or returned. One team leader gave inspectors additional examples of where this had happened. These cases were found to be re-referred to the service over protracted periods of time. Inspectors reviewed a sample of cases where children were removed by An Garda Síochána for reasons of risk under Section 12 of the Child Care Act, 1991, and found that the majority had not been previously known to the service. One case was known

previously but inspectors found that there was no requirement for a social work service and that the family had been referred on to an appropriate service.

The quality of initial assessments varied. Inspectors reviewed a sample of completed initial assessments and found many that were of a high standard. They were detailed, assessed risk and need, and covered a broad range of areas such as the child's health, education, family context and previous history of engagement with services (when appropriate). The recommendations from these assessments were based on information gathered from several sources including family members and other professionals and agencies. They were well recorded. Other initial assessments were not up to an adequate standard as they lacked detail, did not clearly record the actual concern, and the child's needs or voice were not evident. For example, some recorded 'no concerns' under each heading with no information on who was contacted or had been consulted with as part of the assessment. These initial assessments did not contribute to quality recommendations in relation to the children involved. Some initial assessments were completed for up to six days and not signed off by a team leader, and it was difficult to determine if this was a recording or process issue. Other professionals told inspectors that they were contacted as part of the assessment process. Data provided by the area manager and case records reviewed by inspectors showed that An Garda Síochána were notified promptly of incidences of suspected or confirmed abuse. However, team leaders said that delays in carrying out initial assessments meant that notifications to An Garda Síochána might not always be timely and as a consequence children could remain at unnecessary risk for a period of time.

Further assessments also varied in quality. Inspectors reviewed a sample of further assessments and found that specific assessment frameworks were drawn on by social workers to assist them with this process. The framework used was recorded on most files but not all. The majority of further assessments were of good quality. They were comprehensive assessments of children's ongoing needs. Family strengths were noted and areas of support were identified. There was good consultation with other professionals and agencies in these assessments. Others reviewed were not as detailed and did not adequately outline the needs of the child. There were reports on file that said a further assessment was required but no further assessment was on file. The area manager did not provide exact figures on how many further assessments were delayed or had yet to begin, but social workers said that there were delays in completing some of these assessments.

The Child Protection Notification System was not being used effectively. A review of the list of children placed on the System, and case records, showed that some children

were brought into the child protection conference system in 2007 and remained there. Potentially this meant that children remained at significant and ongoing risk for seven years. The chairperson of child protection conferences told inspectors that these cases were under review to either close or take alternative actions, and that this issue was an historical one related to practices before standard business practices were introduced. Inspectors found that some cases had been reviewed and closed to this system but electronic records had yet to be updated. The area had a Child Protection Notification System which was managed in accordance with Children First (2011). Records showed that it was up to date and held all the relevant information. The area manager had the overall responsibility for managing the system and had delegated administrative tasks associated with it to the chairperson of child protection conferences. Access to the system was limited to key personnel and it was monitored regularly by the area manager. The Child Protection Notification System was not accessible on a 24-hour basis but it is acknowledge by inspectors this is a national issue facing social work departments all over the country.

Child protection conference reviews were generally held in a timely manner, but inspectors found that this was not always the case. Inspectors observed one child protection conference review and saw that it was well chaired and attended. Reports from social work and other professionals were presented in a sensitive way, and the chairperson made every effort to support a parent during this process. Minutes of other reviews showed progress in some cases was slow due to delays in having children and families assessed by other professionals. Attendance varied and social workers said that this very much depended on the professionals involved. Children on the Child Protection and Notification System who did not have a social worker experienced delays in having review conferences. The chairperson of child protection conferences said that this was to allow more time for actions to be implemented before the review took place. Inspectors were of the view that this was not a safe or effective use of child protection conference reviews, as delayed action was a risk in itself and this should have been addressed within the review process.

National policies and procedures in relation to serious incidents were implemented by the area. Information provided by the area manager showed that serious incidents were reported and reviewed in line with national policy. Reports, meeting minutes and written communication between managers and staff demonstrated that learning from these events was identified and disseminated.

The area did not routinely collect data in relation to retrospective disclosures or allegations of institutional or organised abuse. The area manager and principal social

worker said that this data was not requested by the National Office of the Child and Family Agency and social work activity related to this area was not represented in data returned to the national office by it. Inspectors reviewed a sample of retrospective cases and found that when retrospective cases were made by young people they were dealt with appropriately.

This inspection found that good efforts were made to identify and manage the risk posed by convicted and alleged offenders in the community but that systems in place were not robust or safe enough. This included systems to identify potential organised abuse in the locality. The principal social worker told inspectors that there was no national guidance, policy, procedures or assessment framework in place to support social workers to assess and monitor this risk. The area maintained individual case files on alleged and convicted offenders and this system of recording adults provided the area with a way of identifying convicted or alleged offenders already known to services. It was helpful information to have when new referrals were received about children with whom these adults had contact with. Adults who potentially posed a risk to children were allocated to a social worker so that the level of risk they posed could be assessed and monitored but there was a waiting list for allocation. Strategy meetings were held regularly with An Garda Síochána on this issue, but the principal social worker said that they needed to be developed more as they dealt mostly with individual cases. Team leaders told inspectors that there was minimal contact between the social work department and probation services. The area did have access to an assessment service that carried out assessments on adults, but this was a reduced service and waiting lists existed. One case showed that an assessment of one convicted offender was delayed for six months. Inspectors reviewed a number of adult cases awaiting an assessment and were concerned that the immediate risk to children was not known. One case did not demonstrate that potential organised abuse was considered. The Authority issued an immediate action plan to the area during the inspection period. This required the service to review one case to ensure potential organised abuse was considered, and to develop a plan to review all cases on the waiting list so that immediate risks to children could be identified and managed. This work was in progress at the end of the inspection.

The area had an early warning system in relation to allegations of clerical abuse. There were communication systems in place between the social work department and religious orders to ensure cases were reported and dealt with appropriately. There were no new cases of clerical abuse notified to the service in the 24 months prior to this inspection.

Judgement

Standard	Judgment
<p>Standard 2.1 Children are protected and their welfare is promoted through the consistent implementation of Children First.</p>	<p>Moderate non-compliance</p>
<p>Standard 2.2 All concerns in relation to children are screened and directed to the appropriate service.</p>	<p>Minor non-compliance</p>
<p>Standard 2.3 Timely and effective actions are taken to protect children.</p>	<p>Moderate non-compliance</p>
<p>Standard 2.5 All reports of child protection concerns are assessed in line with Children First and best available evidence.</p>	<p>Moderate non-compliance</p>
<p>Standard 2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.</p>	<p>Moderate non-compliance</p>
<p>Standard 2.11 Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels.</p>	<p>Minor non-compliance</p>
<p>Standard 2.12 The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.</p>	<p>Moderate non-compliance</p>

Theme 5: Leadership, Governance and Management

Effective governance in services for children is accomplished by directing and managing activities using good business practices, objectivity, accountability and integrity. In an effective governance structure, overall accountability for the delivery of services is clearly defined and there are clear lines of accountability at individual, team and service levels so that all people working in the service are aware of their responsibilities and who they are accountable to.

National Standards for the Protection and Welfare of Children

Reference to;

Standard 3.1

The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

Standard 3.2

Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.

Standard 3.3

The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.

Standard 3.4

Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards.

Inspection findings

The service area had a statement of purpose and function. This was a generic statement provided by the National Office of the Child and Family Agency that outlined the purpose of and vision for national services. The area manager acknowledged that it

did not reflect local service provision and that it was a decision of the national office that this statement would not be modified at a local level, but that this may change in the future.

Inspectors found that this service performed its functions in accordance with legislation, regulations and national policies and standards. Managers ensured that legislation, policies, standards and operating procedures based on these were accessible and available to all staff. This was achieved through the use of a central location on the area's information technology system, staff meetings and supervision and guidance notes. Social workers interviewed were familiar with legislation and national standards and there were clear indications that they were embedded in everyday practice. The service managers had carried out a comprehensive analysis of how the area was meeting national standards and practices that required improvement were clearly identified. Inspectors were provided with a suite of documents that made standard business processes easy to follow and social workers said this was helpful to them. Records and reports reviewed by inspectors showed that social work practice was in line with the service's legal obligations and limitations when intervening in family life, and demonstrated the high regard for children's rights.

Inspectors found evidence of good leadership across the service. This service was managed by a cohesive and solution-focused team comprising an area manager, principal social workers and social work team leaders. Records showed that managers were experienced in both social work and community-based practice. There was a clear management structure which created effective lines of authority and accountability and this was supported by defined roles and responsibilities. The service managers showed a good understanding of the shortfalls within the service that they had identified prior to the inspection. The area manager met with the principal social worker regularly to keep the principal social worker informed about the day-to-day delivery of social work services and told inspectors that this provided an early warning system in relation to any challenges to the service.

Inspectors found that managers provided guidance and direction to their staff within an open, supportive, inclusive and accountable working environment. The reporting relationships between social workers and team leaders were clear. Managers knew what their responsibilities were and these were set according to their role but also their day-to-day duties as provided in standard operating procedures. Inspectors found that managers were reflective and committed to improving services to children and families and this was consistently highlighted in meeting minutes reviewed by inspectors, and in interviews with staff and external professionals. This was particularly evident in changes

to team structures and geographical boundaries that each office was responsible for to enhance accessibility to the service and the level of service provided. It was also evident in the interagency approach that was strongly advocated for by the area manager and principal social worker.

Communication systems across the service were effective and information provided to inspectors showed that meetings were held at local, regional and national level. Staff interviewed said that they were fully informed through this process. Managers who were interviewed told inspectors that various meetings held them accountable for practice. This was evident in meeting minutes reviewed by inspectors.

There was a national service plan and the area was making progress in its implementation. The area manager provided the Authority with a copy of the Child and Family Agency Plan (2014–2017). This established a framework for the current and projected delivery of local services. Inspectors observed interagency meetings and found that the area manager and principal social worker were proactive in developing the service in line with national expectations. The area manager provided inspectors with a local service plan. This contained a list of high-level targets to be met. The area manager acknowledged that this was not sufficient.

Managers and staff made every effort to manage high level risks within the service, but these were short-term measures that could not be sustained. Minutes of management team meetings reviewed by inspectors asserted that high-level risks identified by managers were linked to insufficient staffing levels. Primarily, these risks were the capacity of the service to allocate all cases and address backlogs in carrying out initial assessments, whilst dealing with incoming concerns. These minutes showed that several decisions were made to manage or reduce these risks. For example, a decision was made by managers to re-route incoming referrals from one to other offices. The aim was to allow one team to reduce backlogs in initial assessments in high priority cases. Social work team leaders said that although this was mostly successful, it placed an additional burden on other teams that also had insufficient staffing and who had waiting lists. One team leader said that once referrals were routed back through their office they could find themselves in a similar position again. Some team leaders reported fluctuations in staff morale and strain on team leaders who were endeavouring to balance staff deficiencies. Another initiative was to change geographical catchment areas or 'patches' for each office in order to ensure each office received a similar number of referrals. Information provided by the principal social worker showed that this was based on an analysis of data and information gathered by the service. This was in progress at the time of the inspection. The restructuring of the intake system was

also being considered. Management meetings also highlighted other risks and these included lower priority level cases receiving no or limited social work service so that resources could be concentrated on higher priority level cases, resulting in some welfare cases escalating to child protection cases.

There were some systems in place to assess records and report risks through the system but they were not always effective. The area manager told inspectors that there was currently no policy on the management of risk for the service. The principal social worker had developed a system whereby social workers and team leaders could report high-level risks and risks associated with individual cases to him/her and these would be placed on the risk register or represented in figures returned to the National Office of the Child and Family Agency if appropriate. This was demonstrated in reports provided to inspectors. There was a risk register for the service and inspectors found that this recorded risks such as reduced staffing levels and waiting lists. Inspectors reviewed communication between the service director and Chief Operations Officer for the Child and Family Agency which showed risks were reported directly by the service director. The area manager and principal social worker told inspectors that although risks were reported using this system, responses from the National Office were not timely and did not always help to reduce risk.

Inspectors found that for various reasons, a number of staff across social work offices had reduced caseloads and some had caseloads that did not include key social work activities, such as home visits or carrying out assessments. Others had a reduced caseload that was commensurate with their level of experience. The principal social worker and team leaders told inspectors that skill mix and experience were considered carefully by managers when determining the composition of each team. This was evident in offices that inspectors visited and staff files that inspectors reviewed. The managers of the service told inspectors that when combined, these variables impacted on the capacity of the service to provide continuity of service to some children and families. This was evident in case records and case lists reviewed by inspectors.

The early warning notification system – called ‘need to know’ notifications – was in place in the area and used by staff when there were specific concerns arising from the management of risks in specific cases and or the service. This was in line with national requirements. There was a recording system for incidents and near misses but inspectors found that these were not routinely completed by staff. Social work team leaders could not provide inspectors with a copy of any completed incident and or near miss forms and social workers interviewed were not aware of them.

There was a system to review complaints but it was not effective. There was a system in place to formally review complaints twice a year. Inspectors attended meetings where complaints were discussed and key learning points were identified. However, complaints reviewed at this level did not include all complaints to the service, for example, complaints made directly to social workers and or team leaders. As such, all complaints to the service were not reviewed for the purpose of learning and improvements. This was a missed learning opportunity.

There were several systems in place to monitor the effectiveness and performance of the service but a whole-service evaluation which considered the views of children and families had not been carried out. Therefore, service improvements were not informed by sufficient information including, importantly, the experience of children and families who accessed the service. The area had begun the process of establishing key stakeholder groups that included children and families. Other systems in place included file audits, intake reviews and analysis of case histories. Analysis of how the service was meeting the national standards was reviewed regularly at management and staff meetings. Other data was regularly analysed to assess how the service was being delivered in light of standard business processes. The chairperson of the child protection conferences reported on data gathered for the purpose of improving that element of the service. Information provided to inspectors showed that this identified blockages in the system and areas that were working well, and that it prompted managers to make positive changes in a timely way. There were monthly performance meetings with the service director and minutes of these meetings showed that performance was assessed at senior management level. Some trending of information did occur at these meetings, for example, in relation to referrals and how they were progressed through the system. Other issues discussed included finance and the impact of staffing levels on service delivery. One family support sub-group had been evaluated based on outcomes for children. This evaluation had positive findings and highlighted the potential for improved outcomes based on a collaborative approach.

Day-to-day practice was influenced by recommendations arising from investigations and reviews of specific cases and was also influenced by regulatory bodies.

Recommendations implemented included those emanating from child death reviews, serious incidents and judicial decisions. Inspectors found that improvements made included structural changes to teams and intake systems, increased monitoring of case work and social work assessments. Learning from these events was discussed in supervision and the principal social worker and team leaders had recognised a need to hold formal workshops for staff to promote learning further. The area had a clinical oversight team that acted on gaps in provision or service quality, particularly in relation to mental health issues. The service managers demonstrated an openness to change

and make improvements as required. For example, inspectors were provided with practice guidance developed as the inspection progressed on inspection. This was also demonstrated at management meetings observed by inspectors where recommendations made by the Authority in other reports on other services were considered for implementation locally.

The monitoring of external services which received funding from the Agency was not robust enough to ensure that the service provided to children and families was compliant with legislation, regulations, Standards and national policy. Inspectors sampled service level agreements from 2013 which contained monitoring and governance arrangements. These agreements were in the process of being updated in relation to revised cuts to funding. The area manager acknowledged that other than annual reports, there were no formal systems of monitoring these services. Documents provided by the area showed that frameworks for monitoring were being developed with an expected completion date at the end of 2014. This was not sufficient to ensure these external providers were providing a safe, quality service.

Judgement

Standard	Judgment
<p>Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.</p>	<p>Compliant</p>
<p>Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.</p>	<p>Moderate non-compliance</p>
<p>Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.</p>	<p>Moderate non-compliance</p>
<p>Standard 3.4 Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards</p>	<p>Moderate non-compliance</p>

Theme 6: 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.

National Standards for the Protection and Welfare of Children

Reference to;

Standard 4.1

Resources are effectively planned, deployed and managed to protect children and promote their welfare.

Inspection findings

Resources available to the area were well managed and deployed and the service was being developed in line with the national service plan and local area pathways model. Inspectors found that managers were striving to develop services in line with national expectations. However, the area manager acknowledged that a local service plan would be of benefit in terms of measuring progress and planning services locally.

Inspectors attended meetings and were provided with reports that demonstrated how the area manager was proactive and worked collaboratively with local agencies and services to implement the national model of service delivery. Action plans to progress this were in the developmental stage. Inspectors were provided with a gap analysis carried out by managers. This assessed how the service was meeting National Standards and the principal social worker told inspectors that this provided some way for the service to measure progress. Data and information gathered by the area informed how current resources were allocated but a comprehensive needs analysis for the service as a whole had not been carried out. This would further strengthen service planning and the most effective use of resources.

The service was under-resourced, however, managers made efforts to ensure available resources were deployed effectively. Reports provided to inspectors showed that

staffing deficits were known to managers and service delivery was prioritised accordingly. This meant that children and families with a higher level of need were prioritised for a service and others were placed on waiting lists. The social work department was sanctioned to avail of a low number of agency staff and during the inspection period one vacant post was sanctioned to be filled. Inspectors found that agency staff were utilised appropriately. Inspectors found that team leaders made efforts to compensate for limited resources by carrying out some social work duties. This was confirmed by social workers interviewed. However, inspectors found that this was not sustainable.

There were effective systems in place to evaluate the financial performance and cost-effectiveness of the service. Inspectors were provided with financial performance reports and minutes of performance review meetings. These reported on areas of expenditure and cost containment measures to senior managers. The area awaited national guidance on commissioning and procuring services.

Judgement

Standard	Judgment
<p>Standard 4.1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.</p>	<p>Compliant</p>

Theme 7: Responsive workforce

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

National Standards for the Protection and Welfare of Children

Reference to;

Standard 5.1

Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.

Standard 5.2

Staff have the required skills and experience to manage and deliver effective services to children.

Standard 5.3

All staff are supported and receive supervision in their work to protect children and promote their welfare.

Standard 5.4

Child protection and welfare training is provided to staff to improve outcomes for children.

Inspection findings

Staff were safely recruited through the National Recruitment Board in line with national policy and legislation. Personnel files were held in three different locations and no personnel records – other than those related to staff supervision, training and performance – were held locally.

Inspectors reviewed a sample of personnel files held in one of these locations and found that some were incomplete. For example, the required number of references or evidence of qualifications were not on file for some staff, and although a manager of the human resource department told inspectors that they were satisfied that An Garda Síochána checks had been carried out on all staff, this was not evident. It was unclear to inspectors whether gaps in personnel files were as a result of a fragmented filing

system or whether the required information had not been obtained and held by the Child and Family Agency. Information provided to inspectors showed that the principal social worker was in the process of retrieving and auditing personnel files to ensure they contained the required information. The area had a database that recorded the registration status of social workers. Management meeting minutes read by inspectors showed that some social work staff were in the process of applying for registration through the social work registration body and that the principal social worker was kept updated on progress.

Inspectors found that there was a comprehensive induction policy and process in place that was implemented. The area manager provided the Authority with a copy of this policy. Social workers interviewed confirmed they had received an induction when they joined the social work team and said they were supported by their managers and colleagues during this process. The principal social worker told inspectors that newly inducted social workers had protected caseloads and this was demonstrated in caseload records reviewed by inspectors. One team leader said that inducting staff could be fragmented due to limited resources.

The service was provided by committed, motivated and skilled staff, but numbers were insufficient to ensure a consistently effective service. Inspectors found that teams were made up of staff with various skills and experience including working across different social work functions, community-based work and family therapy. Staff interviewed said that this mix was a strength of their team. Inspectors observed staff interacting with families and other professionals and found that there was a partnership approach that promoted the best interests of children. Administrative staff were observed as both a fundamental support and valuable members of each social work team.

There was a supportive environment for staff within the social work department, but this required formalisation. Supervision was provided by line managers throughout the service to the area manager, principal social workers, team leaders and child care leaders. There was a relatively recently developed supervision policy in place but this was not fully implemented. Supervision was viewed as central to effective practice by managers and the staff team.

Records showed that there were significant gaps and variance in the timing and quality of supervision across social work offices. Supervision records showed that the principal social worker was supervised regularly by the area manager and this included accountability for practice. Other staff records showed that that supervision of social workers related primarily to case management and was not balanced with development

and performance issues. Some social work team leaders told inspectors that this was a negative impact of staffing deficits. All staff interviewed said that although formal supervision did not routinely take place, managers were very supportive of them, particularly in times of stress and in managing complex cases. They said that managers were available at any time to provide guidance and support and this was of value to them. One social work team leader confirmed that supervision training was not provided to all staff providing supervision.

Reports and meeting minutes provided to inspectors showed that the principal social worker was monitoring the implementation of national policy in relation to supervision and was proactive at ensuring progression in this area. Personal development plans were in place and the continuing professional development of all staff was strongly encouraged by managers. This was demonstrated in staff files and recorded in staff and management meeting minutes. This was also part of the national workforce development plan. The majority of staff interviewed were confident that they would and could raise any practice concerns with their managers but all were not aware of the policy or procedure related to protected disclosures. Social workers told inspectors that they were trained and supported by managers to deal with issues such as aggression in the workplace and lone working.

The area had a programme of training for 2014. Information provided to inspectors showed that this was informed both nationally and locally. The service had begun to analyse staff training needs and had developed a template for this purpose. This template was provided to inspectors. Staff interviewed said that managers were proactive in sourcing and facilitating training and that topics covered were directly applicable to their everyday practice. A record of all training was provided to inspectors and showed that it included areas of practice such as dealing with addiction, motivating families, safe care, mental health, child protection and domestic violence. At a multiagency meeting, inspectors observed that the area manager ensured social workers were trained in groups that included other agencies and professionals.

Judgement

Standard	Judgment
Standard 5.1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.	Minor non-compliance
Standard 5.2 Staff have the required skills and experience to manage and deliver effective services to children.	Moderate non-compliance
Standard 5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	Minor non-compliance
Standard 5.4 Child protection and welfare training is provided to staff to improve outcomes for children.	Compliant

Theme 8: 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.

National Standards for the Protection and Welfare of Children

Reference to;

Standard 6.1

All relevant information is used to plan and deliver effective child protection and welfare services.

Standard 6.2

The service has a robust and secure information system to record and manage child protection and welfare concerns.

Standard 6.3

Secure record keeping and file management systems are in place to manage child protection and welfare concerns.

Inspection findings

The area gathered and used quality information about its service for the purpose of service planning and improvements. This was supported by an effective and accessible electronic information system and information governance arrangements. There was a need to gather additional information and data, and to widen the range of information analysed by the area to further inform quality service improvements.

The area had effective systems in place to manage, gather and collate data relevant to service provision. There was an electronic information system which captured information and data about all referrals to the service and key social work activities.

Inspectors observed that this system made specific data readily available to managers for analysis, such as the number and nature of incoming referrals to each office, the length of time a case remained open to the service and the priority level of each case. Social work team leaders told inspectors that figures and reports produced by this system allowed them to identify the effectiveness of social work activities, such as dealing with incoming referrals and completing assessments within the required time frames. Social workers said that the system alerted them to delays in meeting time frames and prompted them to respond. The area manager and principal social worker said that the system assisted them to identify where the service was operating adequately, identify trends and service deficiencies. Reports reviewed by inspectors showed that this data and information was routinely analysed by managers to determine how effectively the service was operating as a whole, and how each individual social work office was performing. For example, the area was not staffed to a level that could consistently meet service needs but managers made best use of information available to ensure the service operated at maximum capacity within these limitations. Inspectors found that the structure and functions of social work teams were directly informed by relevant and dependable information.

The area was required to gather and submit data on key performance indicators to external managers, and reports provided to inspectors showed that this was carried out in line with national policy. Managerial and staff meeting minutes showed that the implications of key performance indicators and additional statistics gathered and analysed by the area were communicated across the service for the purpose of quality improvements. These improvements included accessibility to the service, restructuring of teams to increase workload capacity, improved interagency and or multidisciplinary working and a concentration on developing effective pathways to mental health services provided by the HSE.

The electronic system in place did not capture information and data on all aspects of the service. Other recording systems were in place which required improvement. Reports provided to inspectors showed that the principal social worker had a system to gather information and data on An Garda Síochána notifications. The chairperson of child protection conferences gathered and reported on data related to child protection conferences and reviews, and the child protection system recorded the length of time cases remained open to that part of the system. Social work team leaders and social workers said that key information such as dates of social work visits, strategy meetings and referrals to other services and or professionals were contained in case notes. This was evident in case notes reviewed by inspectors. The dataset returned by the area to the Authority showed that the area managers did not know how many referrals required a referral to another agency nor could it identify how many of those were closed to the

social work department. The rate of re-referral to the service was known but this data was not analysed sufficiently to determine the cause of re-referral. This meant that systems in place did not ensure information was gathered, analysed and used to the best possible level.

Inspectors found that children's information was managed in line with legislation and Children First (2011). Records showed that there was a dual recording system in place, in electronic and in paper format. The majority of records were electronic. Paper records were also maintained and they contained key documents pertaining to individual cases. They were found to be stored securely. Records reviewed by inspectors showed that each child had an individual case file, the majority of which were up to date. There were some delays to updating electronic case records but this was not found to impact negatively on the level of service provided.

File audits were regularly undertaken and the area demonstrated good practice in this regard. Outcomes and recommendations of these file audits were communicated to staff and information provided to inspectors showed that overall findings informed actions to be taken to meet National Standards. The principal social worker and team leaders said that the quality of records had improved as a result, but further improvements were required such as timely updating of electronic records, improved report writing and case notes.

Managers and staff demonstrated good day-to-day practice in relation to governing and protecting information about children and families. The area managers were in the process of developing a policy on access to information held by the social work department and reports provided to inspectors showed that this was due for completion by the end of 2014. There were specific protocols on the use of the electronic recording system, and information was protected by coded access to this system. A project team was established to monitor access to information, including data protection breaches. Minutes of its meetings showed that levels of access to the system were discussed. The principal social worker and social work team leaders said that routine electronic reports were generated by managers who had accessed individual case records. Social workers confirmed they were made accountable for accessing records when it was not obvious why they had done so. Children and families could access information held about them through freedom of information legislation or directly with the social work department. Information leaflets on accessing information was also provided to them. Inspectors found several cases where information was accessed by children and families but records showed that this was not routinely recorded. Social workers interviewed confirmed this was the case. Therefore the service could not demonstrate the frequency

at which children and families accessed information held about them and did not know if improvements to practice were required.

Judgement

Standard	Judgment
Standard 6.1 All relevant information is used to plan and deliver effective child protection and welfare services.	Minor non-compliance
Standard 6.2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	Compliant
Standard 6.3 Secure record keeping and file-management systems are in place to manage child protection and welfare concerns.	Minor non-compliance