Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Mid-West
Name of provider:	Tusla
Type of inspection:	Thematic
Date of inspection:	5 and 6 August 2020 10 and 11 August 2020
Lead inspector:	Sharron Austin
Support inspector(s):	Erin Byrne Sue Talbot Lorraine O'Reilly Olivia O'Connell

About this inspection

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

This inspection report, which is part of a thematic inspection programme, is primarily focused on defined points along a pathway in child protection and welfare services provided by Tusla: from the point of initial contact or reporting of a concern to Tusla, through to the completion of an initial assessment.

This programme arose out of a commitment made by HIQA in its 2018 *Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs.* This investigation was carried out at the request of the Minister for Children and Youth Affairs under Section 9(2) of the Health Act 2007 (as amended) and looked at the management by Tusla of child sexual abuse allegations, including allegations made by adults who allege they were abused when they were children (these are termed retrospective allegations).

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for the Protection and Welfare of Children* (2012). This thematic programme focuses on those national standards related to key aspects of quality and safety in the management of referrals to Tusla's child protection and welfare service, with the aim of supporting quality improvement in these and other areas of the service.

How we inspect

Inspectors reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- interview with the general manager for children and family services
- speaking with two principal social workers and nine social work team leaders

- speaking with staff
- speaking with children and families
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review children's case files
- remote observation of a Review, Evaluate, Direct (RED) process meeting
- observing duty staff in their day-to-day work whilst adhering to social distancing.

The aim of the inspection was to assess compliance with national standards related to managing referrals to the point of completing an initial assessment, excluding children on the child protection notification system (CPNS).

Acknowledgements
The Authority wishes to thank children and families that spoke with inspectors during the course of this inspection in addition to staff and managers of the service for their cooperation.

Profile of the child protection and welfare service

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

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

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

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

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

Service area

Tusla Mid-West is one of five areas in the West region. The area has responsibility for the operational management of all child protection and welfare services across three counties Limerick, Clare and North Tipperary). The service area is noted as having a mix of urban and rural areas which impacts on service accessibility for a significant portion of the population due to the centralised location of services and lack of rural transport in a number of rural communities. Based on the 2016 census of population, the area had a population of 385,000 of which 96,266 are children representing 25% of the area's total population.

The Pobal Deprivation Index indicates that levels of deprivation in the Mid-West vary with a number of areas classified as either 'disadvantaged', 'very disadvantaged' or 'extremely disadvantaged'. The Mid-West area is a complex area to analyse as a whole due to the very distinct features of each of the three counties and the level of deprivation in Limerick city which has more areas of deprivation than of others nationwide.

The area is under the direction of the service director for the Child and Family Agency West Region. The senior management team is comprised of an area manager, five senior managers, eight principal social workers and three senior Prevention Partnership & Family Support (PPFS) Managers overseeing the operation of services across Duty, Child Protection, CPNS, Welfare, Children in Care and PPFS.

The intake and initial assessment work was completed by dedicated duty teams across three counties in the Mid-West service area. Two duty and intake teams covered the Limerick area; one team covered the Clare area; and one team covered the North Tipperary area. Each team comprised of social workers which also included senior social work practitioners and was managed by a social work team leader who reported to their respective principal social workers. These teams completed all stages of a referral up to the completion of an initial assessment. Once completed, the case was then transferred to the long term protection team where required. If a re-referral on a child was made within three months it was re-allocated to the previous social worker and did not go back through the duty system.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant	Substantially compliant	Partially compliant	Non-compliant
The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.	The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.	Some of the requirements of the standard have been met while others have not. There is a low risk to children but this has the potential to increase if not addressed in a timely manner.	The service is not meeting the standard and this is placing children at significant risk of actual or potential harm.

In order to summarise inspection findings and to describe how well a service is doing, standards are grouped and reported under two dimensions:

1. Capacity and capability of the service:

This dimension describes standards related to the leadership and management of the service and how effective they are in ensuring that a good quality and safe service is being provided to children and families. It considers how people who work in the service are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

The quality and safety dimension relates to standards that govern how services should interact with children and ensure their safety. The standards include consideration of communication, safeguarding and responsiveness and look to ensure that children are safe and supported throughout their engagement with the service.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
5 August 2020	10:00 to 16:00 (Onsite)	Sharron Austin Erin Byrne Sue Talbot	Inspector Inspector Inspector
	10:00 to 16:00 (Remote)	Lorraine O'Reilly Olivia O'Connell	Inspector Inspector
6 August 2020	10:00 to 16:00	Sharron Austin Erin Byrne Sue Talbot	Inspector Inspector Inspector
	10:00 to 16:00 (Remote)	Lorraine O'Reilly Olivia O'Connell	Inspector Inspector
10 August 2020	10:00 to 16:00	Sharron Austin Erin Byrne Sue Talbot	Inspector Inspector Inspector
	10:00 to 16:00 (Remote)	Lorraine O'Reilly	Inspector
	14:00 to 16:00 (Remote)	Olivia O'Connell	Inspector
11 August 2020	09:00 to 16:00	Sharron Austin	Inspector
	10:00 to 16:00	Erin Byrne Sue Talbot	Inspector Inspector
	10:00 to 16:00 (Remote)	Lorraine O'Reilly Olivia O'Connell	Inspector Inspector

Views of people who use the service

HIQA inspectors spoke with seven children individually over the phone. When asked about their contact with their social worker, children said:

- *"She keeps me up to date. She keeps up with my wellbeing, what mood I'm in and if I'm ok. I can give my opinion on things. She listens and tries to work around it."*
- *"She's easy to talk to. It's what I like most."*
- *"You can have an easy conversation with her. She listens and understands".*
- *"I meet her on her own. She collects me and we go for hot chocolate or something"*
- *"She asks for my opinion and involves me in meetings. She supports me and makes a difference."*

Children appeared to value the support they received from their social workers. They were also asked if they had any suggestions as to what social workers could do better. All stated that there was nothing they wished to change at present. One child outlined:

- *"I don't want to change anything. The last time I had social workers they didn't tell me anything. She helps me and asks me how I feel about things."*

Inspectors also had telephone discussions with twelve parents whose children were currently in receipt of a child protection and welfare service. The parents were for the most part very positive in their comments about social workers and the service they received. Ten out of 12 said that social workers spoke to them very clearly about the reason they became involved with the family. While two parents expressed dissatisfaction at the service received as they felt that the communication was poor and inconsistent. One said: "If you work with them, they work with you". Others spoke about how available social workers were to them: "She's always available." "She returns calls within the hour". The majority of parents felt the service had improved theirs, and their children's lives: "They have helped me a lot and they know how to do their jobs. I would rate them 10/10."

Parents were clear that their children's needs came first and spoke about social workers visiting their homes and meeting with their children: "She was very good engaging with my seven year old and used three houses". One parent explained that they felt judged when a re-referral was made: "It felt like I was being questioned but

I understood why." Both children and parents advised that regular contact had been maintained despite Covid-19, albeit more over the phone than in person.

When asked what social workers could do better, most parents outlined that they felt that wasn`t anything that could be improved on.

Capacity and capability

As part of the thematic inspection programme, a self-assessment was submitted to HIQA in September 2019 by the service area's management team. The self-assessment is part of the methodology for this inspection and it required the management team to assess their own performance against the five standards relating to leadership, governance and management, and workforce which in turn helps to identify where improvements were required. Arising out of the area's self-assessment, a quality improvement plan was developed prior to the inspection fieldwork.

Inspectors largely agreed with the management team's judgments and the quality improvement plan demonstrated initiatives being undertaken in relation to service improvement and moving into compliance with the standards. The area manager was satisfied that over 70% of the areas identified as requiring improvement had been achieved. Inspectors found that the evidence identified by the self-assessment to support these judgments were in place. At the time of inspection, the area's quality improvement plan was comprehensive and at an advanced stage.

At the time of inspection, the governance structures in place supported the delivery of a good service to children and families by the Mid-West service area. Inspectors found the service area to be proactive and responsive from the point of initial reporting of a concern to Tusla, through to the completion of an initial assessment.

The area manager had significant experience of managing and planning services including at a national level within the organisation. In the past two years she had established new governance arrangements and management structures to enable the service to effectively safeguard and promote the needs of children and families. A general manager post was created with responsibility for child protection social work, prevention partnership & family support (PPFS) and Children and Young People's Service Committee (CYPSC). As outlined in the area's quality improvement plan, this had enabled significant integration of services to ensure that children's needs were central to all planning. Two other general manager posts had been created to support a knowledge management and governance and a performance support function respectively. The area manager outlined that these roles supported service improvement for the management of the child protection and welfare service and operational service delivery through a range of activities such as audits, research and quality improvement initiatives.

As well as a comprehensive quality improvement plan, a Mid-West service plan for 2020 had been developed. Both clearly demonstrated the significant progress made by the area to date and key areas identified for improvement. The area's service plan was aligned to Tusla's corporate plan 2018 – 2020 using seven strategic objectives to set out the actions that the service area was committed to for 2020. In the context of this inspection, the main objective was to achieve compliance with Children First Act, 2015. The key performance indicator (KPI) outlined that 95% of preliminary enquiries to be completed within five days and 95% of initial assessments to be completed within 40 days. The completion date was recorded as quarter three 2020 with a current in progress status.

The majority of the management systems in place were effective, but improvements were required in the monitoring of key performance indicators as these were not routinely analysed at governance meetings. Tusla's published metrics for May 2020 outlined that the area had completed 43% of preliminary enquiries within five days and 13% of initial assessments within 40 days. This illustrated that the service had substantial progress to make in achieving their target of 95% completion within the timelines. It was evident that the area was successfully reducing the number of cases awaiting allocation. The senior management team met fortnightly and provided strong leadership to staff and service planning was of good quality. A review of minutes of these meetings demonstrated good oversight and the discussions held in relation to key areas of service provision such as caseload management, resources, data management, unallocated cases, interagency working and risk registers through these regular forums. The area manager was satisfied with the assurances that she received from her team.

Within the context of Covid-19, a contingency plan was developed to ensure service delivery. The purpose of the plan was to manage the risk of the service area fulfilling its statutory duties within a changing environment. It was designed to illustrate the different levels of service priorities and how they could be configured as staffing restrictions presented; to identify the associated risks and the actions to mitigate those risks. Initial scoping of scenarios in relation to assessing workforce risks from staff absences was undertaken through a mapping exercise to assess the impact on operational delivery from 75%, 50% and 25% capacity. In order to ensure the availability of staff and promote business continuity, core processes were identified with corresponding actions. Relevant to this inspection, these included responding to referrals into duty and child protection, children identified as particularly vulnerable, duty and intake visits and visiting protocol, strategy meetings and performance support. The plan demonstrated strong governance arrangements with managers well-sighted on the management and sustainability of the organisation's capacity and resources.

The intake/duty and child protection service was overseen by three experienced and competent principal social workers who reported to the general manager for children and family services. Staff who spoke with inspectors were competent and knowledgeable in carrying out their statutory responsibilities so as to ensure children received a timely service. There was a lot of experience on the teams and staff outlined that there was a good, open culture within the service which allowed for reflection and discussion.

The service area had successfully transitioned to electronic records for the child protection and welfare service, children in care and child protection conferencing in April 2019. However, the area manager was aware that further improvements were required by staff and managers in recording their work in a timely manner on the system. This is essential in order to have complete and accurate data on the system, which is essential as the area manager used the National Child Care Information System (NCCIS) as a system to monitor the area's progress. The area manager's report for 2020 outlined that the NCCIS data quality improvement process was implemented locally. In order to continually make improvement, the area manager reviewed key data quality indicators on a monthly basis locally in order to monitor and improve data quality. In addition, in order to maximise data quality and improve data entry, local NCCIS staff facilitated regular meetings with social work staff. Additional practice notes were developed by the area's NCCIS practice lead when required. Inspectors found that accessing information relating to referrals on NCCIS was good. Where required, key records in relation to screening, preliminary enquiry and initial assessment processes were on the system, however, improvements were required in management oversight of children's records on NCCIS to ensure that records accurately reflected the decisions and work being completed by social workers in a timely manner. In addition, records of completed case supervision demonstrating discussion and direction on individual cases were not consistently uploaded or recorded on NCCIS.

The area manager had a number of effective quality assurance systems in place and was committed to implementing quality improvement. As part of its quality improvement plan, the area had identified that the quality assurance of the management of child protection and welfare referrals in the service area required improvement. On foot of this, Tusla's Quality Assurance Directorate undertook a series of audits which included an audit of the delivery of the child protection and welfare service from the point of initial reporting to Tusla through to the completion of initial assessment. This audit was completed in February 2020. Seven issues requiring action were identified and an action plan was completed. Overall, inspectors found that the area had implemented actions to improve consistency in the management of referrals. The area manager also identified that the implementation of the revised national standard business process in July 2020 would address specific practice issues such as to achieve a timelier response. Part of the area's response to the finding of the audit, was the development of local guidance documents on governance protocol for multiple referrals with long term involvement, guidelines for closing cases and a safety planning practice note. Staff who spoke with inspectors identified these documents as useful and how they were applying them in practice. Subsequent to this audit, there was evidence that the findings and recommendations from the report were discussed by the senior management team.

An annual audit plan was signed off by the area manager in May 2020 and submitted to the service/national director which outlined 21 planned and or ongoing audits. Relevant to this inspection, audits included monthly NCCIS compliance checks on case records, quarterly audit and analysis of cases awaiting allocation and a planned social work self-audit of individual caseloads to ensure compliance with legislation, regulations and standards in quarter three 2020.

The national quality assurance framework which focused on the provision of a well led, safe and child centred service was in place. The child centred aspect of this framework had been identified in the service area's quality improvement plan for completion with a review date for September 2020. Tusla's practice assurance and service monitoring team undertook a follow up audit of the implementation of the national approach to practice in December 2019. The report demonstrated that the service area had met their targets in terms of the implementation of the approach to practice at intake and initial assessment stages and scored high in their level of compliance.

Communication systems were reported to be good by staff. Staff felt supported and were kept up to date by managers. Senior managers communicated well with each other and with their teams. Team meetings were held regularly and were well attended. A review of these demonstrated that there was good discussion on agenda items related to the duty team, as well as service development, standard business processes and shared learning from serious case reviews, complaints or incidents. Team briefings were held for staff across each county in December 2019 and January 2020 to look at what was working well and what needed to improve. Common emerging themes included the impact on service delivery due to staffing vacancies. There was a process called a 'Need to Know' which was used by staff to escalate information and issues of concern to the area manager and the national office. Inspectors reviewed a number of 'need to knows' and found they were used appropriately. As part of its strategic plan to raise awareness of child abuse and neglect and to promote the service's response, targeted briefings to key stakeholders and public events were held. Incident learning notices were discussed at team meetings and regularly shared with staff. Examples of these included a data breach, investigation of a complaint and interviewing children as part of a section 3 assessment. As a result of the findings, recommendations were considered and the action taken by the line manager on receipt of the learning notice was recorded. Inspectors found that these learnings were implemented in practice.

Operational risks were set out in the service area risk register viewed by the inspector and were appropriately risk assessed and risk rated. Eleven risks were recorded on the risk register which had been reviewed by the area in July 2020. The Mid-West service plan for 2020 provided an opportunity for the area to identify its strategic direction, objectives and approach to the management of risk. A review of this document demonstrated that the area had identified three risks that were deemed to be of the highest priority. These related to the non-filling or funding of key posts, insufficient and inappropriate accommodation for staff in a number of locations and lack of access to suitable and appropriate care placements. Mitigating actions had been identified to ensure that their potential impact was minimised and controlled. These risks were also placed on the regional risk register after escalation by the area manager. While risks were being proactively addressed so as to minimise the impact on service provision, they reflected significant ongoing challenges in social work capacity. Overall, the risk register appropriately recognised the barriers and challenges to continuous service improvement and control measures may take some time to be sustainably addressed.

As part of the inspection methodology, staff files were not reviewed by inspectors. Instead, the Service Director was required to complete a questionnaire (staff file review form) for a sample of staff. Eighteen staff files were selected as part of the sample. The questionnaire focused primarily on updated Garda vetting and professional registration. A review of the returned questionnaires demonstrated that the regional service director was satisfied that safe recruitment practices were in place and provided assurances that all staff files contained evidence of vetting by An Garda Síochána and where required were in the process of re-vetting as well as evidence that professional registration was renewed on an annual basis.

Managers and staff told inspectors that shortfalls in staffing capacity remained and that this risk had been escalated to the regional/national office as it impacted on the service area's ability to provide a safe and effective service. The area manager told the inspector that the Mid-west had 40% of social work activity in the west region but was not resourced to reflect this. This had resulted in the numbers of cases awaiting allocation and higher than national average caseloads. In response, the service managers temporarily re-assigned staff to meet service needs in critically affected teams. Staff vacancies within the child protection and welfare service at the time of inspection included eight senior social work practitioners, two social workers and two family support practitioners. The area manager outlined that the capacity to recruit in a timely manner was impacted by national resource allocation decisions. However, a business case had been presented and agreed which would see the development of a new team with oversight of complex child sexual abuse work led by a principal social worker, with a dedicated specialist social worker and play therapist. Good practice was demonstrated in the area's contingency plan in response to the current pandemic in the context of the initial scoping of scenarios in relation to assessing workforce risks from staff absences. A mapping exercise was carried out to assess the impact on operational delivery from 75%, 50% and 25% capacity which included plans to move staff across teams if required.

The Mid-West's service plan for 2020 outlined that a bespoke human resources (HR) crisis management team was established in response to very high vacancies that occurred at different points of the year in 2019 for different teams. The overall aim of this group was to identify any possible actions that could be progressed to address vacancies. Their analysis of staffing vacancies at the end of 2019 indicated that there had been a considerable slowing down of staff turnover. Eight actions were prioritised in the area's service plan of which some had been completed. These included targeting new graduates through university roadshows. Bi-monthly meetings with the regional HR manager and local child protection and welfare and business managers took place and an action plan was developed. Arising from this initial action plan, the senior management team were addressing a number of initiatives to improve retention. These included engagement with third level colleges to progress local social work courses, supporting staff induction, training and development needs, exit surveys and responding to any issues arising.

Staff had the required skills and knowledge to efficiently perform their duties in the management of referrals. The area had developed an induction programme in March 2020 for inducting new social workers. This outlined that induction took place over a 12 month process within a learning and reflective practice environment. Induction training courses were completed online and certificates were maintained on the supervision file. Key achievements outlined in the area's quality improvement plan within the past 12 months outlined that new staff were assigned a 'buddy' and orientation and induction was designed by their immediate line manager within the staff supervision process and developed as part of the professional development plan. At the time of inspection, one new staff member had been recruited and had commenced in March 2020. Inspectors spoke with experienced and competent staff members across the duty and long term child protection teams who were committed to the implementation of the national approach to practice and had a wealth of experience to ensure progress on same. The service area had experienced and committed managers to ensure implementation of the national child protection strategy across the service. The senior management team were developing a training strategy for the Mid-west which outlined a range of accredited training for first time managers to more senior management training and coaching. The area manager told the inspector that this was due to commence in September 2020.

There were a number of good initiatives in place to support staff, but the area had identified areas for improvement in order to further promote staff well-being. Managers supported staff to engage in a range of awareness raising and learning opportunities through updates and e-learning programmes. Staff wellbeing was addressed at team days. Staff support and well-being was a specific agenda item at a staff team meeting in December 2019. A presentation on key achievements to date and challenges for 2020 were addressed which included input from an external wellbeing organisation. In response to specific issues arising from the management of a serious case, specialist bespoke counselling and support was put in place for staff.

A staff well-being survey had been completed in June 2020 and 13 areas for improvement were identified. The findings of this were shared with the Mid-West senior management team and an action plan had yet to be developed. This survey took place alongside a wider West region staff survey and the findings of both these reports were to form part of the work of a newly established 'Values & Behaviour' sub-group on the Mid-West senior management team. A communications group was also established with responsibility for producing a newsletter to keep staff updated and informed.

Staff received regular supervision but improvements were required in the recording of supervision sessions. The area's quality improvement plan identified that there was room for improvement in relation to staff supervision. The area had last completed an audit of supervision in 2018. A review of a sample of 17 staff supervision records by the inspector found that while the majority of recommendations from previous audits were in place, the quality of recording, progress made in implementing actions from the previous supervision session as well as clear decision making required further improvement. The frequency of supervision was generally in line with Tusla's supervision policy. Staff were positive about the level of supervision and support they received, both from their line managers as well as peer supervision. Group supervision was also in place in the area. These sessions were used for mapping cases, developing danger statements and safety goals, drawing up safety plans and assisting families to develop networks. Staff reported that supervision was regular and of good quality in relation to both case management and support. Managers told inspectors that each staff meeting and supervision routinely started with a "check in" on staff and asking how they were. However, this was not reflected consistently in supervision. While supervision was viewed by staff as being good overall, staff told inspectors that the area of debriefing was an area that required improvement. This was primarily linked to the expanding role of social work team leaders with limited time to undertake this. While staff told inspectors that caseload management was discussed in supervision, not all supervision records evidenced this and therefore improvements were required in relation to adherence to the caseload management policy.

Managers and staff told inspectors that there had been a focus on completing personal development plans in the past twelve months. With the exception of two staff, all supervision records sampled had these plans on file. However, the review of these plans required improvement as there was little or no evidence to demonstrate progress against individual identified needs.

Staff had their training and development needs identified through supervision, personal development plans and a training needs analysis (TNA). Although staff told inspectors there was a culture where training was promoted and supported, inspectors found that there was no consistency between the identified needs of staff in professional development plans and in the training provided. A progress report was completed in November 2019 regarding the 2018 training needs analysis. The top five priority needs and an update on how they were being met were clearly set out. A review of this was actioned in the area's quality improvement plan to produce a revised training needs analysis by October 2020. In light of Covid-19, a learning and development priority needs analysis was completed just prior to the inspection. The top identified need related to the revised standard business processes and implementation of same across all service teams. Staff told inspectors that they were provided with a list of training opportunities at the start of the year and were also given the time and space to complete e-learning modules. Examples of training received included child abuse substantiation procedure (CASP) briefings and workshops, forensic interviewing and practice intensive workshops for intake and initial assessments. Accredited training for first time managers to more senior management training and coaching was due to commence in September 2020. A number of staff were supported to engage in a range of learning opportunities, for example, leadership and management development programmes and Empowering Practitioners and Practice Initiatives (EPPI).

While some improvements were required, collectively these aspects of leadership, governance and workforce informed the quality of service which is set out in the next section of this report.

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.	**Judgment** Substantially Compliant

The governance structures in place supported the delivery of a good service to children and families by the Mid-West service area. Inspectors found the service area to be proactive and responsive from the point of initial reporting of a concern to Tusla, through to the completion of an initial assessment. Improvements were required in the management of performance specifically the lack of adherence to key performance indicators.

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.	**Judgment** Substantially compliant

A number of internal and external quality assurance systems were in place. The area's quality improvement plan was comprehensive and at an advanced stage. A suite of locally devised policies and procedures were developed on foot of findings within these audits and were reflected in practice. Improvements were required in management oversight of children's records on NCCIS to ensure that records accurately reflected decisions and work completed by social workers in a timely manner.	
Standard 5.1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.	**Judgment** Substantially compliant
Safe recruitment practices were in place. At the outset of 2020 the service area continued to carry vacancies across a number of grades. In response, a bespoke human resources (HR) crisis management team was established to very high vacancies that occurred at different points of the year in 2019 for different teams. An appropriate action plan was developed and the senior management team were addressing a number of initiatives to improve capacity.	
Standard 5.2 Staff have the required skills and experience to manage and deliver effective services to children.	**Judgment** Compliant
Staff had the required skills and knowledge to efficiently perform their duties in the management of referrals. Inspectors spoke with experienced and competent staff members across the duty and long term child protection teams who were committed to the implementation of the national approach to practice and had a wealth of experience to ensure progress on same. The service area had experienced and committed managers to ensure implementation of the national child protection strategy across the service.	
Standard 5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	**Judgment** Substantially compliant
Staff reported that they were well supported and supervision at individual and group level was in place. However, the quality of recording, progress made in implementing actions from the previous supervision session as well as clear decision making required further improvement. The review of professional development plans also required improvement as there was little or no evidence to demonstrate progress against individual identified needs.	

Quality and safety

Overall, the service area appropriately managed child protection and welfare referrals in line with Children First 2017: National Guidance for the Protection and Welfare of Children.

In relation to the themes of child centred services (standard 1.3) and of safe and effective services (standard 2.1) inspectors found that 14 areas of improvement identified in the service area's quality improvement plan were implemented with various review dates scheduled to assess progress. Some examples included, more effective communication with children and young people and their involvement in service design, improving the management and governance of child protection and welfare cases awaiting allocation as well as standardising a number of practice approaches. Cases awaiting allocation had reduced which meant that some children and families were receiving a more timely service. The national approach to practice was well embedded within the duty and intake teams. A suite of locally devised policies and procedures had been implemented to support staff. Senior managers regularly reviewed and adapted internal systems to improve the management of child protection and welfare cases. Case closures were managed effectively. While there was evidence of good practice across screening, preliminary enquiry and initial assessment processes, the timelines for completion of these processes were not in line with the national standard business processes. This was mainly related to a delay in completing the associated records and not in the work being undertaken by practitioners.

Inspectors found a high standard of child centred practice. An open and transparent approach was taken to encourage the family's engagement with the service. Records reflected consultation with families during the respective processes. Age appropriate tools and approaches were used by staff to engage with children. Examples of good listening and reflection on children's feelings and responses as part of a holistic assessment of risks and consideration of the child's development was evident on case files reviewed by inspectors. The views about what the child wanted and why this was important to them was embedded within the assessment practice with clear decisions about next steps required. Good consideration was given to children with additional needs, for example, children with a disability or mental health issue. Careful consideration was given to children's identity and cultural heritage in informing direct work undertaken. This ensured their voice was reflected within the work to both challenge and enhance the protective capacity of parents. As indicated in the service area's quality improvement plan, communicating more effectively with children and young people had been actioned. Of note, a project team involving staff from the child protection and welfare service, children and young people's service committee (CYPSC) and prevention, partnership and family support (PPFS) had been

established to work in conjunction with the local institute of technology to produce of a series of child friendly animations. These would provide children and young people with information about the service particularly in relation to children's rights and safety plans. Senior managers told the inspector that children and young people from the locality were involved in the recording of the voiceovers for the animations and the project was near completion. The animations would be shared with children and young people when a social worker was allocated to a case.

Child protection and welfare referrals were made to Tusla, in writing, over the phone or through the Tusla portal. Dedicated duty and intake teams operated across the three counties in the Mid-West. These teams received and processed all new referrals on unknown and closed cases. Inspectors found that national business processes were followed and the national approach to practice was embedded in all aspects of screening, assessment, planning and decision-making. An effective quality screening and preliminary enquiry gives social workers the appropriate information to decide what action is required to progress the referral and to protect children at immediate risk. Inspectors found that there were appropriate systems in place to ensure that screening was prioritised by social workers. The observation of duty staff in their day-to-day work by an inspector whilst adhering to social distancing during fieldwork found practice to be in line with Tusla's standard business processes. Staff who spoke with the inspector presented as professional, well informed and competent in their interactions with the public.

Screening was recorded in a number of different ways across the three counties. For example, in Limerick and Clare, either the garda notification or child protection and welfare report form was signed, dated and assigned a priority level. While in North Tipperary, a screening note was recorded under the referral details on the integrated information system or as an email attachment noting the categorisation and threshold. While screening was prioritised by social workers, a consistent recording approach across the three counties should be implemented pending a nationally agreed formal screening tool. Tusla's intake record did not lend itself to evidencing that screening took place within 24 hours. As such, unless an intake record was signed off by the social work team leader within 24 hours, it was difficult to evidence if screening was completed within that timeframe for some cases.

For the referrals that met the threshold for a social work intervention, they were appropriately prioritised and categorised. Of the 48 referrals sampled by inspectors for screening, 45 or 94% of cases had recorded evidence of screening, of which 31 or 81% were completed within 24 hours. Tusla's integrated information system does not currently allow managers to 'run a report' to track screening being completed within 24 hours.

There was good evidence of social workers analysing previous referrals in their consideration of new referrals or further referrals of issues previously highlighted. Inspectors found that where there were multiple reports of the same concern, the referral was linked to the open intake record before closure. Referrals that did not meet Tusla's child protection and welfare eligibility criteria did not require an intake record to be completed. In such instances, the referral was launched but no intake record was required and the social worker recorded the reason for the purposes of closure.

Almost all records reviewed evidenced that referrals were acknowledged. Referrers were informed that the child protection or welfare threshold was met, and that preliminary enquiries would ensue. Following receipt of a referral, parents were advised that a record had been set up in relation to their child, unless doing so posed a safety concern. Inspectors found that generally, parents and professional referrers were informed of the outcome of the screening and preliminary enquiry in writing.

Tusla's standard business process sets out a five day timeframe for screening and preliminary enquiries to be completed and recorded on an intake record. However, the timescale for completion of preliminary enquiry was not always achieved in a timely manner and the rationale for prioritisation following screening was not always explicit. A Tusla quality assurance audit completed in February 2020 indicated that intake records were taking an average of six point five days to complete. Staff told inspectors that "managing the child took precedence over managing the system". A number of cases reviewed by inspectors indicated significant drift from the date of referral to the intake record commencing or from it being completed as well as initial assessments commencing or being completed. Formal records of management and oversight were not consistently available or uploaded in a timely manner in these instances. This was recognised by staff who spoke with inspectors and recent work indicated improved performance in this area in terms of completion. Notwithstanding, it was as an area that required further improvement.

Forty-six cases were sampled by inspectors for preliminary enquiries, of which 17 or 37% were completed within five days in line with the national business processes. Of the remaining 29 cases, delays on the completion of the intake record being completed were found in 18 or 62% of cases. Often the delay being the review and approval of the social work team leader. These delays ranged between two and three weeks up to over two months and in one case a period of six months before sign off. Despite delays in completing some intake records, records contained good quality analysis of available information, internal checks were routinely undertaken by the social workers and in the majority of cases, details were clarified with the referrer prior to completion. The records also demonstrated consultation with parents or guardian where appropriate. Clarification on a number of cases was sought from individual social work staff during the inspection fieldwork. However, the reasons for the delays in completing preliminary enquiries within the timeframe was not consistently recorded on children's files.

Network checks are conducted to find out if other agencies involved with the child and their family have concerns about the care of the child. When information is sought from other agencies as part of network checks, the information should normally be sought with the consent of the child's parents unless there is a clear child protection concern that requires checks to be completed in the absence of consent. However, it was not always clear from the records whether parents consented to these checks where appropriate. Where required, children and families were visited in their homes and safeguarding measures were identified and agreed at this stage. Of the 46 referrals sampled by inspectors for network checks, 18 or 39% demonstrated that network checks had been completed.

The first consideration for the duty and intake teams when receiving a report, is the immediate safety of a child and whether action is required to urgently respond. The Mid-West had implemented a draft practice note for safety planning including standard templates for various stages in the case process. Alongside this guidance, they had also developed a chronology template which focused on safety planning. Inspectors found that referrals that required immediate attention were prioritised over other referrals and there was a good standard of practice in relation to embedding 'immediate safety planning' responses within the intake record; with positive examples of effective work by some social workers in virtually engaging parents and children given the current public health restrictions. Examples included, but were not limited to, the response of social workers to a number of cases where An Garda Síochána removed children to a place of safety under Section 12, to young children at home alone and children at immediate and serious risk of harm. In these situations there was good co-operation between the social work teams and An Garda Síochána in taking protective action to ensure that children were safe.

Children can be waiting allocation to a social worker at any point within the system. Inspectors found that social work team leaders managed waitlists and reviewed them regularly and in line with policy. However, the existence of a waitlist meant that some children did not receive the service they required in a timely manner. At the time of inspection, there were 23 children on the waitlist for preliminary enquiry and 93 on a waitlist for an initial assessment. Of these, five were catergorised as high priority. Inspectors found that high risk cases and those where there had previously been child protection concerns were attended to promptly, with comprehensive analysis of risks and checks of progress. Some cases that were awaiting allocation to a social worker were prioritised for key tasks to be completed on them. Inspectors saw evidence of this on a sample of files that were 'active on duty'. As identified in the area's quality improvement plan, an interim protocol on the management and governance of cases awaiting allocation within the service was approved in February 2020. The aim of this protocol was to provide guidance to staff with a definition of an unallocated case and with the knowledge of the systems in place to manage, review and monitor these cases in a standardised and consistent basis across the service area. Inspectors reviewed 16 cases awaiting allocation and found 15 or 94% of cases were reviewed by the social work team leader. Five or 33% had been subject to multiple reviews, none of which required the priority level to be changed. Inspectors were told that one case awaiting an initial assessment since mid-July was due to be assigned to a senior social work practitioner the following week.

Cases awaiting allocation were also reviewed through the Review, Evaluate and Direct Action (RED) process. These meetings were a collaborative approach with community stakeholders for decision-making which endeavoured to ensure that interventions to children and families were proportionate and timely. The remote observation of a RED process meeting was undertaken during the inspection. Inspectors found that the process demonstrated good implementation of the service area's protocol around the application of this process. Cases were considered and discussed where there was an unmet and uncoordinated child welfare need which was connected to parenting.

Joint Working between Tusla and An Garda Síochána is crucial to ensure effective, timely and consistent responses to allegations of abuse and forms an integral part of the child protection and welfare service. The introduction of the Tusla and An Garda Síochána Children First joint protocol in December 2017 clearly sets out the requirements in relation to formal communication, notification and recording of joint-working and decision-making. Following a notification of suspected child abuse by either agency, regular contact and information sharing was carried out in line with the protocol. Records of strategy meetings and or discussions with An Garda Síochána on individual cases were evident on a number of case records reviewed by inspectors.

A national audit of Tusla notifications of suspected child abuse to An Garda Síochána self-assessment questionnaire was completed as part of a planned two phase national assurance review in June 2020. The purpose of the audit was to assess where notifications met the threshold for notification to An Garda Síochána in line with the joint working protocol, that these took place in a timely manner. The findings for the Mid-West demonstrated that of 118 cases of suspected child abuse, 21 cases or 18% required a garda notification. The audit found that 10 or 48% of the 21 cases did not evidence that a garda notification had been made of which four cases required immediate follow up. Inspectors sampled garda notifications and found that they were responded to in a timely manner, and officers were advised of the social worker allocated to the case. Four referrals reviewed by inspectors where a garda notification was required demonstrated that notifications were made for three cases in a timely manner. One case awaiting allocation at the time of inspection had identified that a garda notification was required but had yet to be made. Following clarification and update with the social work team leader, an assurance was provided to the inspectors and the notification was completed during the inspection.

Social work managers were confident that An Garda Síochána were appropriately notified of cases where a crime was suspected. There was now a prompt to assist staff in the revised intake and initial assessment forms on the integrated information system. Generally information sharing and checks of progress of investigations was good. However, the combination of Covid-19 and the capacity of An Garda Síochána to undertake specialist interviews meant that initial assessment timescales could be protracted.

There was good liaison between An Garda Síochána and the duty teams, through individual contact, garda liaison meetings and senior local management liaison forum meetings. Terms of reference were established for the local Garda/Tusla Liaison management team. This team had oversight responsibilities for all notifications and joint working and met every four to six weeks. Terms of reference were also established for the senior local management liaison forum. The principal social worker of each local area office and the Superintendent of the corresponding Garda District constituted the senior local management liaison forum and had overall responsibility for the management of child protection and welfare assessments and investigations in their geographical area. This team met on a quarterly basis. Minutes of these forums reviewed by inspectors reflected the discussions and information sharing between both agencies.

Tusla's standard business processes outlines that an initial assessment is completed within a 40 day timescale from the date of the initial report into Tusla. However, the service was not achieving this target with some cases drifting for significant periods. The purpose of the initial assessment is to determine whether there has been harm or potential for future danger to a child and if there is any existing safety present to address this harm. Cases on the waitlist for initial assessment were reviewed regularly by the social work team leader. Screened referrals with a determination made to proceed to initial assessment were prioritised using the post intake prioritisation system in line with Tusla's practice matters guidance for the management of cases awaiting allocation. Inspectors reviewed 34 files where a determination had been made that an initial assessment was required and found that 24 or 70% were completed. However, two of these cases marked completed on the information system did not have the actual required team leader sign off. This was acknowledged by the area during the inspection. The remaining assessments were either ongoing or waiting to be commenced. Of the 24 completed initial assessments sampled, 18 or 75% were not completed within 40 days. The timelines in these cases ranged from over 50 days to in excess of seven months. Nine or 50% were completed within a four to five month range and two or 11% took up to seven months to complete. The rationale for delays were not consistently recorded on the initial assessment form. Inspectors found that reasons were sometimes recorded in case supervision records or on case closure summaries if the outcome of the assessment was to close the case. For the majority of referrals that required an assessment, these commenced in a timely manner. Notwithstanding the delay and drift in a number of cases, overall, inspectors found that the quality of the analysis of risk and children's needs were of a high standard and appropriate recommendations for action were identified. Where required, assessments were informed by good quality sharing of information from relevant professionals. Where appropriate, social workers met and spoke with children on their own about the assessment and observed children in their own home.

Where a referral was deemed to have not met the threshold necessary for an initial assessment but there were unmet needs that required a support service for the child and their family, inspectors found that these cases were appropriately referred on to other services.

Inspectors found that safety planning was central to the work undertaken by social workers with children and families and this was evident throughout the screening and preliminary enquiry processes. While safety planning was not generally recorded in a formal record, safeguarding measures and safety plan arrangements were found to be recorded in various parts of the child's file including case notes, assessments or discussed in case supervision. Where appropriate, children participated in the development of safety plans and due consideration was given to parental capacity to safeguard the child. Their voice was effectively captured and used to inform the focus of the safety plan and expected standards of care. Most safety plans were adequately monitored and reviewed with further action taken to address issues with parents where there was limited evidence of improvements in the quality of parental care children experienced. Safety planning was embedded within family support plans for those children and families that required ongoing support. Social workers recognised the importance of children and their parents requiring an available network of support at this challenging time. As such, inspectors found that social workers made regular calls by teleconference or video to see how children and their families were coping and were alert in identifying where safety plans were not working.

Of the 19 referrals sampled by inspectors for safety planning, 18 or 95% were adequate and addressed specific risks which were of concern to the safety and welfare of the child. Furthermore, where appropriate, children were involved in developing the plan and the capacity of the protective persons identified were clearly assessed and monitored. Of the cases sampled for safety planning, one case did not have a safety plan in place as required and was awaiting an initial assessment. Adequate assurances regarding safeguarding measures were provided by the social work team leader in relation to this case during the inspection.

A standardised approach to safety planning had been identified as an area for improvement in 2020 as demonstrated in the area's quality improvement plan. This resulted in the development of a draft practice note for safety planning including standard templates for various stages in the case process. Alongside this guidance, they had also developed a chronology template which focused on safety planning.

Case closures were managed effectively. All 10 cases reviewed by inspectors were appropriately closed. Each case indicated appropriate discussion and oversight with clear recording of the history of the case and use of chronologies. The outcome of the most recent intervention was clear on all cases with the rationale for closing; including checks of ongoing support needs and other agencies' continued involvement. Inspectors found that families were informed of the decision making process.

Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.	**Judgment** Compliant
An open and transparent approach was taken to encourage the family's engagement with the service. The views about what the child wanted and why this was important to them was embedded within the assessment practice with clear decisions about next steps required.	
Standard 2.1 Children are protected and their welfare is promoted through the consistent implementation of *Children First*.	**Judgment** Partially compliant
Referrals that required immediate attention were prioritised over other referrals and there was good cooperation between the social work teams and An Garda Síochána in taking protective action to ensure that children were safe. There was a good standard of practice in relation to embedding safety planning. Case closures were managed effectively. Improvements regarding timelines across the screening, preliminary enquiry and initial assessment processes was required. There were significant delays in the completion of preliminary enquiries and as well as initial assessments commencing or being completed. Formal records of management and oversight were not consistently available or uploaded in a timely manner in these instances.	