Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# OVERVIEW REPORT

## Inspections of Child Protection and Welfare Thematic Programme 2019 - 2021

**November 2021**


*Safer Better Care*

## About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

# Table of Contents

## About monitoring of child protection and welfare services

The Health Information and Quality Authority (HIQA) monitors services used by some of the most vulnerable children in the state. 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 services.

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 8(1)(c) of the Health Act 2007 to monitor the quality of services provided by the Child and Family Agency (Tusla) to protect children and promote their welfare. HIQA monitors Tusla's performance against the *National Standards for the Protection and Welfare of Children* and advises the Minister and Tusla.

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

- **assess** if Tusla, the service provider, has all the elements in place to safeguard children
- **seek assurances** from service providers that they are **safeguarding children** by reducing 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 HIQA's findings.

HIQA inspects services to see if the national standards are met. Inspections can be announced or unannounced.

# 1. Executive Summary

## Introduction and Background

In 2018, the Health Information and Quality Authority published a statutory report, *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* (June 2018). This programme of thematic inspection was developed out of a commitment made by HIQA in the statutory report, to work in consultation with Tusla and relevant stakeholders to develop a programme of thematic inspections focused on the improvement of quality in child protection and welfare services.

The statutory investigation identified three systemic risks in the management of referrals of child sexual abuse, namely; screening and preliminary enquiry of referrals, safety planning and the management of allegations of retrospective abuse. The thematic programme of inspection incorporates two of these risks; screening and preliminary enquiry of referrals and safety planning. Unlike the statutory investigation, the management of referrals of all child protection and welfare concerns were reviewed during thematic inspections. The third risk, the management of allegations of retrospective abuse, was not included in this programme as Tusla were reviewing and developing a new process to manage these allegations. HIQA continues to monitor risks associated with the management of retrospective abuse.

An external advisory group was established in 2019 with representation from Tusla, advocacy organisations, Trinity College Dublin, the Department of Children and Youth Affairs and Medway Council (UK) to provide advice on the methodology and content of the inspection programme

A guidance and assessment judgment framework was developed to provide information on the programme to services, children and their families and inspectors. As part of the programme, services were required to evaluate their own performance by completing a self-assessment questionnaire against the above national standards. The purpose of this approach was to enable services to identify areas for improvement and to develop a service improvement plan to implement these changes.

Twelve of Tusla's child protection and welfare services were initially selected to participate in this programme. These areas were chosen based on their assessed capacity, based on previous inspection finding, to improve and apply any learning arising from the thematic programme, in the interst of improving the quality and safety of their services. Tusla had specific plans to improve services in the five

remaining areas. In parallel to this programme, HIQA continued to monitor these five areas. One of the five, the Midlands, was included in this inspection programme in 2021 as it was judged to have come within the remit of this programme. The inspection of the Cork child protection and welfare service became a risk-based inspection in April 2021 and the findings of that inspection are not included in this overview report.

Inspections commenced in October 2019 and the programme concluded in April 2021. Due to COVID-19-related restrictions, all routine inspections by HIQA, including those as part of the thematic programme of inspections, were paused from mid-March 2020 until August 2020.

The methodology for inspections completed during COVID-19 restrictions was amended to ensure that public health measures were observed, with some inspection activities conducted remotely. Significantly, service directors were requested to complete a questionnaire in relation to a sample of staff recruitment files in their area in order to provide assurances that appropriate recruitment practices were in place. Other changes to to inspection methodology included face-to-face contact with children and parents were replaced by telephone conversations and video conferencing was used to conduct interviews and focus groups with Tusla staff.

## Overview of findings

Over the course of this programme, it was evident that Tusla is striving towards achieving consistency and equity in service provision. The organisation and its skilled staff were committed to quality improvement and this was reflected in the 12 individual service areas.

Overall, services made progress in achieving compliance with standards. Of the twelve areas inspected, six service areas (Mayo, Sligo/Leitrim/West Cavan, Dublin South East Wicklow, Donegal, Mid-West and Midlands) were compliant or substantially compliant in all but one standard, which was assessed as partially compliant. Two service areas (Galway/Roscommon and Louth/Meath) were compliant/substantially compliant in five standards and partially compliant in two. Of the remaining four areas, all but two of the areas had varying levels of compliance in all standards. The Cavan/Monaghan and Kerry service areas were both non-compliant with standard 5.1 recruitment of staff. Appropriate assurances were received by HIQA.

## What children, parents and family members told us about the service

Throughout the programme, inspectors heard directly from 65 children and 110 parents who were in receipt of a child protection and welfare service. They told us about the positive relationships they had with social workers, how social workers engaged with them, listened to them and improved their lives. We also heard from a small number of children and parents who had less positive experiences. They told us of the negative impact that changes to their social worker had on them. They said that social workers could be better at listening to them, considering their needs first and make it easier to access supports, including those in the community. The inspection programme found that eight service areas were fully complaint, with the remaining four substantially complaint in how they communicated with children and families.

## Governance

An overarching finding throughout this programme was that the effective delivery of child protection and welfare services and the implementation of a quality improvement agenda was significantly influenced by two factors:

- the strength of leadership shown by managers across all levels
- the effectiveness of the governance arrangements and managerial systems that were in place.

The inspection programme found that these factors were present in the majority of areas and the majority of services promoted a child-centred culture, where learnings both positive and negative were shared and improvements were made. In essence, quality improvement was central to the governance of the service so continuous improvement was part of the culture of the service.

Good governance in these areas were illustrated through effective:

- service planning
- communication
- quality assurance systems
- risk management
- transfer of learning and implementation of quality improvement initiatives
- effective use of resources
- analysis of data.

Over the course of this inspection programme, Tusla remained committed to building on and sustaining progress. This level of commitment at national and regional levels was particularly evident in the implementation of its national

approach to practice and aligned training, its national electronic information system, and in implementing ongoing staff recruitment initiatives.

## Management of referrals

There has been significant improvement in many aspects of the management of child protection referrals from receipt to completion of initial assessment, but there are aspects of service provision to children that requires improvement. Inspectors found that when children were referred to child protection services that referrals were screened. Staff were child-centred in their approach to preliminary enquiries and initial assessments. Initial assessments were of good quality. The majority of children were met with by social workers during the completion of initial assessments. This meant that children were given the opportunity to tell their story through words or pictures about themselves, their interests and their family. Many children were also observed in their home environment which greatly assist social workers in reaching decisions about the safety of a child. Routinely, social workers consulted with children's families and key professionals and their views were taken on board. Social workers undertook good quality analysis of all the information that they gathered and children who required further input from a social worker and or service were appropriately identified.

However, there are aspects of service provision to children where further improvements are required in order for all areas to achieve full compliance with the national standards. These improvements include:

- adherence to Tusla's timelines in commencing and completing preliminary enquiry and initial assessment
- timely notification of suspected abuse to An Garda Síochána
- consistency in approach to safety plans
- consistency in the monitoring and oversight of cases awaiting allocation to a social worker
- the timely recording and uploading of children's records onto the National Child Care Information System (NCCIS).

## Challenges

There remains an ongoing challenge for Tusla to recruit and subsequently retain an adequate workforce in order to deliver a consistent and equitable service to children who use child protection and welfare services. Safe recruitment practices were reviewed as part of this inspection programme in 11 out of 12 service areas and some shortcomings were identified. There were some gaps in key documentation on some staff files such as references, photographic identification or curriculum vitaes. Assurances were sought and provided from regional service directors responsible for the Kerry and Cavan/Monaghan service areas that safe recruitment practices, specifically in relation to vetting and professional registration, were in place.

Service areas supported by their regional and national office implemented a range of initiatives to recruit and retain staff. Despite this, vacant posts were evident in eight out of 12 service areas at the time of inspection and six of those areas operated waiting lists of medium and low risk referrals. These vacancies limited service areas' capacity to meet demand. Service areas were utilising a range of contingencies such as employing social care workers to complete preliminary enquiries and or business support staff to assist social workers and agency staff. A stable workforce is needed to achieve the required improvements outlined throughout the inspection programme and in this report.

Individual staff supervision was identified as one of the central systems that was in place to ensure accountability and support for staff, but improvements were required to ensure a consistent approach in line with Tusla's supervision policy. Regular good quality supervision is essential to support staff working in the pressurised environment of child protection and welfare services. Two areas (Midlands and Donegal) were in full compliance with this standard, six areas were substantially compliant and four partially compliant. Improvements were required, especially in the frequency of supervision and the recording and tracking of decisions.

Despite improvements being required in staff supervision, staff told inspectors they felt supported by their managers. A range of other supports were available to staff such as employee assistance programmes, complex case forums, group supervision and many local areas had developed bespoke staff wellbeing supports.

COVID-19 significantly impacted on children, their families and services over the last 12 months. Inspectors found that some service areas such as Dublin North City had to pause some quality improvement initiatives during this time, as they focused on managing their front line service. Service areas put effective risk management plans in place which were regularly reviewed in order to continue to deliver front line services to children and families.

In conclusion, in well-governed services, managers do not lose sight of the fact that they hold primary responsibility for the quality of their service and for

demonstrating compliance with the relevant requirements, they are the first line of defence. Therefore, it is the responsibility of each service area to implement ongoing quality improvements in their service under the governance of the Child and Family Agency Tusla's national office.

## 2. Introduction

This overview report summarises the key findings of the Health Information and Quality Authority's (HIQA's) thematic monitoring programme of child protection and welfare services, including the views of children and young people and their parents during 2019-2021. This programme arose out of a commitment made by HIQA in its statutory investigation report, *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* (June 2018). This HIQA thematic inspection programme incorporates a review of two out of the three systematic risks identified by HIQA's Investigation Team in 2018, namely; screening and preliminary enquiry of referrals and safety planning. The third risk, the management of allegations of retrospective abuse, was not included in this programme as Tusla were reviewing and developing a new process to manage these allegations. HIQA continues to monitor risks associated with the management of retrospective abuse.

This programme of inspection focused on the following National Standards for the Protection and Welfare of Children (2012) (the "Standards"):

| **Capacity and Capability Dimension** |
|---|
| **Theme 3: Leadership, governance and management** |
| **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<br><br>**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 |
| **Theme 5: Workforce** |
| **Standard 5.1:** Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare<br><br>**Standard 5.2:** Staff have the required skills and experience to manage and deliver effective services to children<br><br>**Standard 5.3:** All staff are supported and receive supervision in their work to protect children and promote their welfare |

| **Quality and Safety Dimension** |
|---|
| **Theme 1: Child-centred services** |
| **Standard 1.3:** Children are communicated with effectively and are provided with information in an accessible format. |
| **Theme 2: Safe and effective services** |
| **Standard 2.1:** Children are protected and their welfare is promoted through the consistent implementation of Children First. |

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of children receiving services. These inspections 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. All types of reports to Tusla's child protection and welfare service were examined during these inspections. [1]

Service areas inspected under this programme were areas that demonstrated high level of compliance with the standards. In 2019, five of the 17 Tusla service areas were initially not included in this thematic programme, as they were subject to service improvement plans developed by Tusla arising from self-identified risks related to service delivery. HIQA continued to monitor these services in parallel to the thematic inspection programme. One of these areas, the Midlands, showed substantial progress and was included in the programme in 2021. In another service area (Cork), the inspection changed focus from a thematic inspection to a risk based inspection due to specific risks identified during inspection. This meant that, in total, 12 of the 17 Tusla service areas were inspected as part of this thematic programme.

Inspections commenced in October 2019, and four were completed that year. Seven inspections were completed in 2020 and the final inspection was completed in March 2021. The inspection reports of these inspections are published on www.hiqa.ie.

HIQA would like to thank children, parents, family members, Tusla staff and members of the external advisory panel for their contribution to the inspection programme.

[1] Child abuse can be categorised into four different types: neglect, emotional abuse, physical abuse and sexual abuse. A child may be subjected to one or more forms of abuse at any given time.

# 3. Overview of the thematic programme methodology

As part of the thematic programme an external advisory group (EAG) made up of key stakeholders and academics was established by HIQA in 2019 for the purposes of consultation and comment on the proposed inspection programme.[2] An assessment-judgment framework and guidance document was published prior to the commencement of the inspection fieldwork. This document provided supporting information to inspectors and providers on assessing compliance with national standards and offered guidance on reviewing individual standards.

## Self-assessment

A self-assessment questionnaire and a template for a Quality Improvement Plan were developed and made available on the HIQA website to assist service areas to prepare for the child protection and welfare thematic programme of inspections.[3] The purpose of the self-assessment and quality improvement plan was for Tusla service areas to identify where improvements were required and to develop a plan to implement these improvements. HIQA found that service areas engaged well with this process.

All areas completed self-assessments on their service and submitted them to HIQA in September 2019. They subsequently developed their service improvement plan.

## Inspection fieldwork

HIQA used the self-assessment questionnaires along with Tusla's published data on unallocated cases to inform the schedule of inspections. Initially, HIQA scheduled inspection fieldwork in service areas that had either low or no numbers of children waiting for a service, and who had self-assessed their performance highly. Therefore, services areas that had to implement substantial improvements had time to do so. Secondly, it was hoped that positive findings and learnings from earlier inspections would be shared and contribute to further improvements in services.

The key activities of each of these inspections involved:

- the observation of practice
- the analysis of data submitted by the area and the area's self-assessment
- meeting with or telephone conversations with children and their parents and or family members

[2] For membership of the EAG - See Appendix 1
[3] See Appendix 2

- interviews and meetings with area managers, principal social workers and other managers
- focus groups with social workers
- the review of the relevant sections of the files of children as they related to the focus of the inspection
- the review of documentation including the area's service improvement plan relating to the management of referrals.

Due to COVID-19-related restrictions, all routine inspections by HIQA, including those as part of the thematic programme of inspections, were paused from mid-March 2020 until August 2020.

The methodology for inspections completed during COVID-19 restrictions was amended to ensure that public health measures were observed, with some inspection activities conducted remotely. Significantly, service directors were requested to complete a questionnaire in relation to a sample of staff recruitment files in their area in order to provide assurances that appropriate recruitment practices were in place. In addition, focus groups and interviews were conducted remotely, either by telephone or video conferencing. Face-to-face interactions between Tusla staff and inspectors were kept to a minimum. Parents and children were consulted by telephone where they agreed to participate in the inspection.

It was the responsibility of area managers to implement the quality improvements identified during this inspection process.

# 4. 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:

## 4.1. Capacity and capability of the service

This dimension describes standards related to the leadership, governance 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.

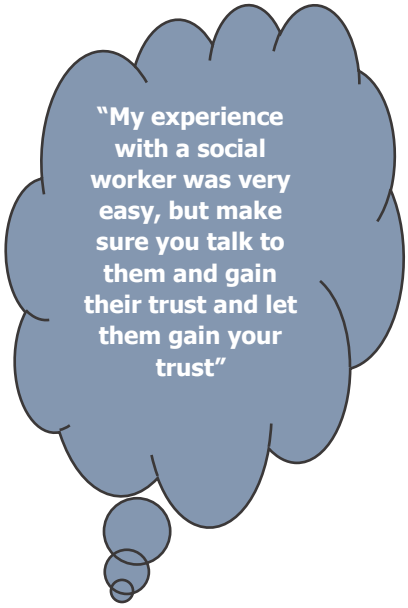
## 4.2. Quality and safety of the service

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.

## 5. What children, parents and family members told us

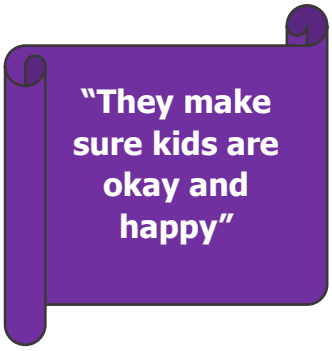
The views of children, parents and family members were essessential to the programme. Inspectors met or spoke with a total of 65 children and 110 parents and family members. Forty-five of the 65 children consulted were met with in person, both individually and in groups. From 16 March 2020, when the COVID-19 public health restrictions were introduced, inspectors were no longer able to meet children, parents or family members in person. However, inspectors spoke to a further 20 children by telephone.

Overall, children were positive about their experience of the social work service they received. Children and families expressed a lot of satisfaction in relation to their experiences of the child protection and welfare services. Children's comments included:






Children expressed satisfaction with the level of contact they had with their social workers. Many children felt their social worker cared about them and was trustworthy. They said:





Children said that they were informed about the services and the supports that were available to them. Children said they had been provided with written information on the service and the available supports and so they understood the role of the social worker. Children described how their social workers routinely consulted them by asking their opinion, listened to them and involved them in decisions. Feedback from children to inspectors included:


Many children said they were helped by the service. For example:


They also said that social workers acted on what they had said and that this helped their families.

Other children expressed their satisfaction with social workers interventions:

When asked what social workers could improve on, the majority of children said that no improvements were needed:

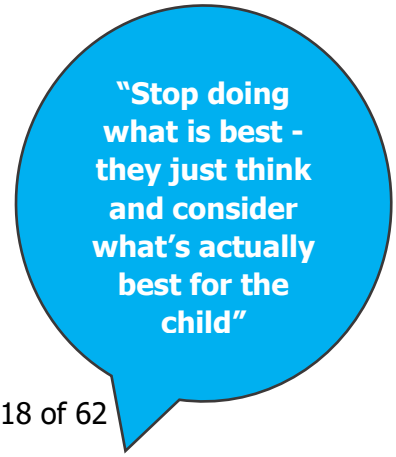


However, some children had a different view of the service. These children were in the minority in five service areas and felt there were some areas that required improvement. A child in one service area said that social workers could be better at:


In another service area, some children gave suggestions as to how social workers could be better at listening to them, including:



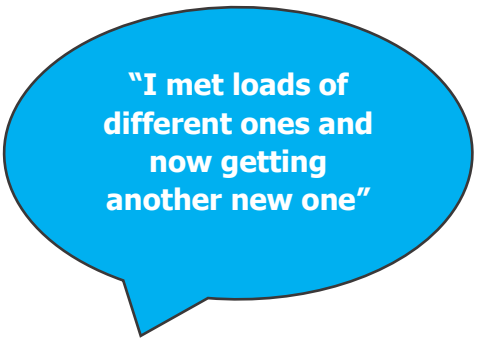
They suggested social workers should:

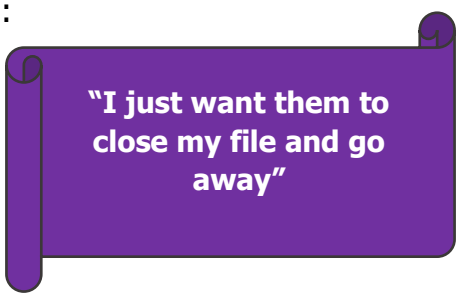
Children in this area also added:



One child in one service area did not completely agree with the safety plan put in place for them, while two children in another service area said that there had been a number of staff changes and that was something that could be improved. They said:


In a different service area, one child who did not want any involvement from the child protection service said:




Parents were generally complimentary and positive about their experiences of the child protection and welfare service. One parent said "everything is great now thanks to social work". They felt the service had improved their lives and that of their children.

Parents said that they were given information about the service so they were clear about why social workers were involved with their family. For example, one parent said "social workers were straight down the line and there was no beating around the bush" which was very much appreciated and valued. Another parent was clear

that "the incident had to be investigated. They had a job to do and they were clear about this."

Parents said that social workers communicated well and were sensitive, professional and courteous. They felt listened to and involved in the planning for their family. As one parent said, "If you work with them, they work with you." Many parents commented on the fact that social workers were quick to respond to referrals, were accessible and returned calls to parents. Parents were clear that the child's needs came first with the social worker and said that social workers visited their children at home and spoke with them.

Parents found that social workers were helpful, and offered "positive suggestions in times of crisis" and advice and support in a non-judgemental way. Most parents welcomed the help and support of the social worker. They were "very understanding of the situation and very supportive". Another said the social worker worked on solutions with them: support services were put in place and they were involved in the assessments that were conducted and the plans that were put in place to address the concerns for their children.

The majority of parents spoken with by inspectors expressed satisfaction with the service they received and, when asked, could not suggest any improvements for the service. However, a small number, 13% (15 out of the 110), of parents spoken with in seven of the 12 inspections expressed dissatisfaction with the service they received.

Parents told inspectors that there were not satisfied with the level of support they received from child protection and welfare services. For example, five parents felt it was difficult to access services, including services in the community. Parents told inspectors "when you have it, it's good". Another parent felt that more support could be offered after initial contact.

Other parents expressed dissatisfaction with how staff in the service engaged with them. In the Mid-West service area, two parents said they felt that the communication with them was poor and inconsistent. In the Kerry service area, two parents said that social workers could have been more sensitive to their needs and views. In the Waterford/Wexford service area, two parents told inspectors that while they had negative experiences with previous social workers, both were happy with the current service they were receiving.

The other suggestions that parents made included:

- to shorten the time that Tusla was involved with families, and
- to have better inclusion of fathers in the social work process.

The majority of parents told inspectors that they did not recall being asked for their feedback on the service they had received, despite some service areas having a system in place to consult with parents and children.

# 6. Key findings of the child protection and welfare thematic inspections

## 6.1 Capacity and capability

Good governance is essential to delivering a safe and effective service. In a well-governed service, overall accountability for the service is clearly defined and the governance arrangements ensure a safe, sustainable service is delivered within a child-centred culture. The leadership, governance and management arrangements in place provides assurance at local, regional and national level that the service is meeting their legal requirement to protect children. The components of good governance include clear lines of accountability, good planning and decision-making and successful risk management, quality assurance and performance assurance systems, which are underpinned by effective communication among staff.

Five standards relating to the theme of leadership and governance were inspected against as part of the child protection and welfare thematic programme.

All service areas completed a self-assessment questionnaire and used it to rate their performance. The majority of service areas had developed a service improvement plan, which incorporated specific actions to achieve improvements.

Inspectors agreed with, or substantially agreed with, the senior managers' self-assessment of their service's performance relating to governance of the service in seven out of twelve service areas and found that inspection findings supported these ratings.

Inspectors partially agreed with the Midlands and Waterford/Wexford service area's self-assessment of their compliance with the standards on governance. This meant that inspectors did not agree with the areas' self-assessment for all the governance standards inspected against in this programme. For example, the Midlands service area assessed themselves as compliant in all five standards and inspectors found they were substantially compliant in two of these standards. Inspectors did not agree with the Kerry, Dublin North City and Cavan/Monaghan service areas' self-assessments; that is, they found lower rates of compliance than in the self-assessment questionnaire for some standards.

**Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards**

| Judgment | No. of areas | Service areas |
|---|---|---|
| **Compliant** | 3 | Mayo, Sligo/Leitrim/West Cavan, Dublin South East/Wicklow |
| **Substantially Compliant** | 5 | Galway/Roscommon, Donegal, Mid-West, Louth/Meath, Midlands |
| **Partially Compliant** | 4 | Cavan/Monaghan, Kerry, Waterford/Wexford, Dublin North City |
| **Non-compliant** | 0 | |

This standard is focused around the service's governance arrangements. Overall, eight service areas were either compliant or substantially compliant with this standard. The remaining four areas were compliant in some aspects of the standard but required improvement to achieve full compliance. Findings under this standard are outlined below.

## Policies and procedures

Tusla is required to deliver their services in line with legislation, *Children First National Guidance for the Protection and Welfare of Children* (2017) and national policies and procedures.

National policies and procedures are an essential component in achieving a consistent delivery of service. It is the responsibility of managers in each service area to ensure staff adhere to the organisations policies and procedures in order to meet the statutory obligations of the organisation, which are to:

- support and promote the development, welfare and protection of children
- support and encourage the effective functioning of families, and
- provide for the protection and care of children in circumstances where their parents have not given, or are unlikely to be able to give, adequate protection and care.

This programme of inspections found that improvements were required as some service areas were not always adhering to all national policies. This is referenced throughout this report.

## Governance structures

A stable management team that demonstrates strong leadership enables the delivery of a service that is safe and sustainable. Inspectors found that all the service areas had defined management structures in place. Area managers were responsible for service delivery and reported to regional service directors who in turn reported to Tusla's national office. Area managers were supported by business support personnel and managed teams of principal social workers responsible for providing child protection and welfare services, which include duty and intake teams.

Duty and intake teams were the dedicated point of contact for processing new referrals on concerns about children. These teams received new referrals by phone, electronically, in writing or in person and screened this information.Team leaders managed duty and intake teams and this ensured that lines of accountability were clear to all staff. Duty and intake teams were comprised of social workers and social care workers and there was some variation in how these services were organised. For example, in the Sligo/Leitrim/West Cavan service area there were dedicated staff who completed the screening of new referrals and then passed them on to other staff to complete the preliminary enquiry. In the Mayo service area, only senior social work practitioners responded to new referrals in the first instance at the "front door".

## Leadership

Strong leadership shown by managers across all levels plays a critical role in the delivery of good quality and safe services to children. The thematic inspection programme found that in many areas, management teams provided strong leadership and helped to align staff to the area's quality improvement agenda. All areas had management teams in place who demonstrated a committment to improving the quality of service delivery. The inspection programme found that while achievements in quality improvement varied, where it was embedded in practice it led to children and families receiving a better service. Examples of good leadership included:

- the management team in the Midlands service area used strong messaging about professional accountabilities and the quality of practice and services provided in a range of senior management communications
- the management team in the Mayo service area were planning to develop a customer charter which would set out to all stakeholders the behaviours, attitudes and actions they should expect in their interactions with the service

- the area manager in the Kerry service area held consultations with staff to determine what the service was doing well and what the service could do better
- the management team in the Dublin South East/Wicklow service area held a service planning day to map out what was working well, what was of concern or worry to the team and what needed to happen to ensure the service could do better
- the management team in the Louth/Meath service area demonstrated they had professional knowledge and that they were committed and experienced.

Inspectors found that, where changes had occurred in service area's, these transitions were well managed. In the Sligo/Leitrim/West Cavan service area, there had been some recent changes to the management team and the transitions had been seamless. In the Cavan/Monaghan service area, there had been significant changes to leadership in the previous two years. In this service area, the management team was highly motivated and had achieved significant improvements in the 10 months prior to the inspection. In the Kerry service area, the area management teams were evolving at the time of the inspection and had identified that the functioning and operations of the duty and intake team required improvement.

### Management systems

A good and well-thought-out service plan provides the vision, direction and support so that services can effectively promote a quality service. The majority of areas had their own local service plan in place which was aligned to Tusla's corporate plan. These plans promoted a a quality improvement agenda and to ensure services were child centred.

Service areas had implemented Tusla's national service objectives, to varying degrees, including the national approach to practice and the National Child Care Information System (NCCIS) during the time frame of the child protection and welfare thematic inspections. Service plans were in place in 10 out of the 12 service areas inspected.

Common local strategic objectives for the areas included:

- improving children's participation and ensuring the voice of children was heard
- improving leadership and governance skills of management including risk management and promoting quality improvement
- objectives relating to workforce planning, retention and supervision and restructuring of teams to ensure implementation of service objectives.

Inspectors found that where good quality service planning was in place, they included the area's vision for their service such as in the Sligo/Leitrim/West Cavan service area, whose stated vision was to ensure that all children were protected from harm in an environment that helped them to reach their potential. In the Mayo service area, the concept of the 'Mayo child' was developed. This concept recognised that each child is the responsibility of the whole service, irrespective of which part of the service that is working with them at a particular time. Completed service plans generally contained clear actions and targets to strengthen the responsiveness and impact of social work interventions.

Two service areas (Kerry and Donegal) did not have service plans for 2020 at the time of their respective inspections. This meant that their vision for the service and how it would be delivered was not clear. Donegal had not yet finalised its 2020 service plan at the time of its inspection in March 2020 but it was in progress. In the Kerry service area, the area manager provided inspectors with the area's commissioning plan and told inspectors of local service priorities. However, these priorities needed to be clear with time-limited plans in place to achieve them. In addition, inspectors found that improvements were required in achieving the objective of service improvement plans in the Cavan/Monaghan and Dublin North City service areas; for example, a reduction in the cases awaiting allocation and improving adherence to standard business processes time frames. However, in the Dublin North City service area, staff shortages were identified as affecting the areas ability to achieve these objectives.

### Assurance systems

The oversight and monitoring of services requires good systems that managers can rely upon to assure themselves about the service being delivered. Area managers had a range of systems in place to provide them with information on service delivery. Inspectors found that the eight areas which were compliant or substantially compliant with this standard had regular, well-attended governance meetings, which included senior managers and business support personnel. Reports on the performance of the service were discussed, which provided assurances to area managers that a quality, safe and effective service was provided to children and their families.

The following areas were on the agenda at governance meetings in all eight service areas:

- staffing, complaints, finance, risk management, quality assurance and training
- review and monitoring of monthly and quarterly metrics for the service including the area's performance against key performance indicators,

unallocated cases, numbers of referrals and notifications to An Garda Síochána
- interagency working.

Senior managers also assured themselves of the quality and safety of the service through their supervision with principal social workers and through regular review of the implementation of service plans. Area managers were accountable to their regional service directors on the performance of the service and provided metrics on a monthly basis to Tusla's national office. Where there were issues with meeting key performance indicators, area managers were required to set out how they were addressing these.

Four service areas were judged partially complaint with Standard 3.1. In these service areas, oversight and assurance of the quality and safety of the service required improvement. For example:

- improving the frequency and structure of management meetings in the Cavan/Monaghan service area
- ensuring good quality information and key data analysis in the Waterford/Wexford, Dublin North City and Cavan/Monaghan service areas
- service planning in the Kerry service area
- consistently adhering to policies, procedures and guidance.

### Communication

Effective communication among staff underpins accountability, decision-making and risk management, in order that a service meets its strategic and statutory obligations. Good quality and regular communication is essential for ensuring that teams work together to achieve their service's overall objectives.

Communication systems were effectively used in 11 of the service areas inspected. For example, in addition to the regular governance meetings outlined above where key information was shared, clear lines of communication between staff and managers ensured that information was shared efficiently and in a timely manner in person, by telephone and by email. Regular team meetings between the various teams as well as integrated service area meetings ensured good communication between staff and management. Inspectors found that staff knew how to raise concerns or make protected disclosures which is an important safeguard of every service that ensure the timely reporting of concerns about the effectiveness and safety of the service.

Good liaison with external stakeholders who made referrals to the service and extensive interagency collaboration with An Gárda Síochana was evident in many service areas. Good communication supported:

- effective interagency cooperation with community support services and referring agencies and professionals
- good working relationships between teams
- the appropriate identification and addressing of issues
- good guidance to staff on matters relating to practice.

In the Cavan/Monaghan service area, communication required improvement, specifically in the frequency and structure of management meetings and consistency in team meetings across the entire service area.

**Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service delivery**

| Judgment | No of areas | Service areas |
|---|---|---|
| **Compliant** | 0 | |
| **Substantially Compliant** | 9 | Mayo, Sligo/Leitrim/West Cavan, Galway/ Roscommon, Dublin South East/Wicklow, Donegal, Mid-West, Waterford/Wexford, Louth/Meath, Midlands |
| **Partially Compliant** | 3 | Cavan/Monaghan, Kerry, Dublin North City |
| **Non-compliant** | 0 | |

Overall, this inspection programme found that the majority of services were effectively managing risks associated with their service area. They were also proactively working on the implementation of quality improvement plans, albeit with room for further improvement. Tusla service areas participating in this inspection programme embraced the concept of quality improvement, with the majority of areas close to achieving compliance with this standard. Nine service areas were substantially compliant and three were partially compliant. Management teams were committed to quality improvement and good governance supported the drive to improve service delivery.

### Risk Management

Effective management of risk is a key aspect of good governance, as the safety and wellbeing of children, as well as the functioning of the organisation, can be compromised where risk is poorly managed. This thematic programme found that where service areas were well managed, an effective risk management system was in place to structure the identification and appropriate response to manage, mitigate or eliminate the identified risks to children and families and the service.

Tusla had a national organisational risk management policy and procedure to guide service areas, however, it was not consistently implemented. Good systems for timely and effective identification, management and review of organisational risk were in place in seven of the 12 service areas inspected. In these areas, reporting systems including the 'need to know' system was appropriately used to escalate risks in relation to individual children. Risks to the child protection and welfare service were assessed, risk rated and recorded on risk registers. Mitigating actions were identified to minimise and control the potential impact of the identified risks on service provision. For example, the risk register in the Dublin South East/Wicklow service area reflected that file audits routinely carried out by the principal social worker did not happen as required, due to the capacity of managers and work demands. This was to be addressed by the commencement in post of another principal social worker. The area manager was satisfied that this measure, alongside the quality assurance audit processes already in place, would mitigate against the identified risk.

However, despite the best efforts of area managers, some risks persisted and could not be managed within the service area and these were appropriately escalated to regional and national risk registers.

For example:

- in the Donegal service area, risks related to staff shortages which led to delays in providing services to children was on the risk register and had been escalated to the regional service director and the Tusla national office. As stated, the area manager told inspectors that while a business case had been made for the posts, there was no funding available at the time of the inspection for these posts
- in the Dublin North City service area, staff shortages and issues related to staff retention and inexperienced newer staff was escalated to the regional service director
- in the Midlands service area, risks associated with the non-adherence to timelines for preliminary enquiries and initial assessments, in addition to staffing vacancies, had been escalated to the regional service director.

These risks had supportive measures in place, including workforce development and planning and data review forums.

In five service areas (Galway/Roscommon, Dublin North City, Cavan/Monaghan, Kerry and Waterford/Wexford), however, basic improvements were required in the management of organisational risks. Two service areas, Galway/Roscommon and Dublin North City, had not identified all risks to the service, such as the non-adherence to the timelines set out in Tusla's standard business process and in the risk associated with staff not having full information on a child due to inadequate recording on National Child Care Information System (NCCIS). In the Cavan/Monaghan service area, the risk register was not being used in line with its purpose, as all risks known to the management team were not reflected in the risk register nor were they managed in line with Tusla's national risk management policy. In the Kerry service area, while the risk register was not regularly updated and risks were not routinely escalated, there was a plan in place to review the risks on a monthly basis going forward. In the Waterford/Wexford service area, the process for addressing risks that required a regional or national response was not effective and contingency planning for long-term risks required improvement.

Throughout this thematic programme of inspections, it became clear that the main organisational risks identified by Tusla services were:

- staffing vacancies and the impact on Tusla's capacity to provide services and manage referrals efficiently
- cases that were not allocated to a social worker and were awaiting a service
- non-adherence to the timelines set out in Tusla's standard business process, the impact of which was that some children and families did not receive a timely service
- from March 2020, managing the risks associated with the COVID-19 pandemic.

## Response to COVID-19

Overall, HIQA found that the impact of the COVID-19 pandemic on service delivery was well managed in the five service areas inspected after March 2020. Tusla's national office issued guidance and procedures on the management and delivery of services throughout the pandemic. This nationally agreed response identified the areas of service provision that were a priority. Risks to provision of services were routinely identified, reviewed and addressed promptly. Service areas prioritised service provision for children of the highest level of risk and utilised partner agencies in the monitoring of at risk children. In the Midlands service area, staff and managers adapted well to the impact of the COVID-19 pandemic on service delivery

and complied with Tusla's national policies and procedures in the management of risk.

Service areas developed local contingency plans to ensure continuity in service delivery. The Mid-West, Waterford/Wexford, Dublin North City and Louth/Meath service areas conducted impact analyses of COVID-19 on service provision. In the Mid-West service area, the purpose of the contingency plan was outlined as ensuring service delivery and managing the risk of the service area fulfilling its statutory duties within a changing environment.

During the COVID-19 pandemic where public health guidance placed restrictions on the movement of people, Tusla service areas maintained good communication through remote and electronic means as well as by telephone and in person. Management teams met weekly specifically regarding the impact of COVID-19 on services and were proactive in ensuring this was kept to a minimum. Assessments were conducted on workforce risks of staff absences. For example, the Waterford/Wexford service area was proactive in identifying potential risks associated with the lifting of restrictions and had contingency plans for redeployment of staff to the area of service delivery most impacted. All five service areas had practical measures in place which included staff attending offices on a rota basis, use of video calls, regular contact with other community services and increased check-ins with staff. This ensured that children and families who most needed a service received one and that staff were supported throughout the restrictions to adhere to public health guidance.

### Quality assurance systems

Quality assurance is another key aspect of good governance. Service areas that are well governed proactively assess and evaluate the service delivered to children to improve services. This information provides assurance to senior management that a safe service is provided to children and families in line with the organisation's policies and procedures.

The inspection programme found there had been significant development of quality assurance audits, and there was a commitment to quality improvement in all areas.

Tusla has a national quality assurance framework that was implemented throughout all service areas. The inspection programme found that quality improvement initiatives were in place at national, regional and local levels with improvements to quality assurance systems required in eight of the 12 service areas inspected.

The Tusla national office directed audits to be undertaken on various aspects of service delivery by Tusla's practice assurance and service monitoring service (PASM),

and by individual service areas. Over the course of the inspection programme from October 2019 to March 2021, examples of nationally directed audits included:

- the Dublin South East/Wicklow and the Donegal service areas, where the PASM team conducted an audit on the implementation of Tusla's national approach to practice
- the Donegal and Kerry service areas, where the PASM team completed audits on cases awaiting allocation, and the delivery of 'front door' services
- the Dublin North City service area, where the PASM team completed an audit in on the delivery of the child protection and welfare service from the point of referral through to the completion of the initial assessment
- the Mid-West, Dublin North City, and the Midlands, where individual service areas conducted audits on their level of compliance with notifying An Garda Síochána of suspected abuse.

These audits were an effective means of identifying areas for improvement, but there were mixed findings in how service areas took action and implemented recommendations from audits. For example, in the Mid-West service area, the findings of an audit identified some cases where notifications of suspected abuse to An Garda Síochána were outstandins and they were subsequently completed. In the Midlands service area, an audit of An Garda Síochána notifications led to the principal social worker reviewing 10% of abuse and neglect referrals on a monthly basis from October 2020 to March 2021, which provided assurances that notifications were made to An Garda Síochána as required. In the Donegal service area, findings from a national audit prompted changes in how the area reviewed, evaluated and directed referrals at the front door. In the Dublin South East/Wicklow service area, a national audit on the implementation of the national approach to practice identified improvements and the inspection found actions had been taken. Another national audit in this area related to ensuring NCCIS records were updated was not fully implemented at the time of the inspection. In the Cavan/Monaghan service area, while actions identified in national audits were incorporated into the area's service improvement plan, they were yet to be implemented at the time of the inspection. In the Dublin North City service area, prompt implementation of recommendations of PASM audits was required and in the Kerry service area, findings from a national audit of cases awaiting allocation had not been fully implemented at the time of the inspection.

Local service areas also conducted their own auditing programmes. Where auditing was used effectively in service areas, it supported managers in the service to identify areas for improvement, to manage risk and to let them know if staff were carrying out roles in line with policies and procedures. Overall, service areas commonly completed review of files in order to have assurance on unallocated cases, time

frames for completion of intake records and initial assessments, and the implementation of the national model of practice.

Five of the 12 service areas developed effective initiatives as a result of audit findings which directly led to service improvements. These included:

- the Galway/Roscommon service area, where findings from the programme of audits were compiled and to identify learning for improved practice
- the Louth/Meath service area, where quality assurance audits were completed to identify improvements and led to the design of an Initial Assessment Practice Manual. This was provided to all social workers to assist with the completion of these assessments
- the Waterford/Wexford service area, where an audit on the quality of initial assessments identified the need for increased oversight of initial assessments by social work team leaders
- the Midlands service area, where audits were used to target areas for improvement, with re-audit of key areas of activity to provide assurance that high standards of practice were being maintained
- the Mid-West service area, where an annual audit plan outlined 21 planned and or ongoing audits covering areas of practice including 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.

Nonetheless, the thematic programme found that improvements could be made in how in local quality assurance was conducted. Those improvements included:

- effective implementation of quality assurance systems (Dublin South East/ Wicklow, Kerry, Dublin North City)
- conducting audits to focus on the quality of service delivery (Mayo and Sligo/Leitrim/West Cavan)
- and the timely and full implementation of action plans arising from audits (Cavan/Monaghan, Louth/Meath and Donegal).

The inspection programme found that service areas had systems in place to share learnings. Team meetings were routinely used to share learnings that arose from an analysis of: National Review Panel reports (Cavan/Monaghan), serious case reviews, complaints or incidents (Mid-West, Louth/Meath and the Midlands) and issues related to practice with children and families (Sligo/Leitrim/West Cavan, Dublin South East/Wicklow and Dublin North City). Other areas held workshops for staff on areas such as the implementation of Tusla's national approach to practice (Waterford/Wexford) and the review of cases in order to identify good practice and share learning (Galway/Roscommon). Managers in these service areas said that improvements to practice came about because of the sharing of learning.

In addition, the west region established a regional service improvement initiative. A governance group, chaired by the regional service director, ensured that actions identified to achieve greater consistency in practice across five service areas, were tracked and implemented. This initiative brought connectivity between areas to facilitate the sharing of learning.

### Caseload management

Tusla had a national policy on the management of caseloads for social workers, the purpose of which was to ensure managers maintained consistent oversight of staff workload. Social work team leaders scored social workers cases, usually within the supervision process, to determine the weighting of the caseload based on specific criteria: for example, on the complexity of a case and associated work. There were three categories of caseload weighting: busy but okay, manageable and unmanageable.

The thematic programme of inspections found that in four service areas, Cavan/Monaghan, Dublin South East/Wicklow, Donegal and the Midlands, managers used caseload management to maintain effective oversight of the workload of staff. In these service areas, social worker's caseloads were assessed as 'busy but okay' or 'manageable' at the time of the inspection.

In five service areas (Mayo, Sligo/Leitrim/West Cavan, Galway/Roscommon, Waterford/Wexford, and Dublin North City), managers in the service assessed some social workers caseloads as 'unmanageable'. Inspectors found that appropriate action was taken by managers to address this. For example, in the Galway/Roscommon service area, cases were re-distributed and in the Dublin North City service area, steps were taken to reduce workloads for staff.

In the remaining three service areas, Kerry, the Mid-West and Louth/Meath, inspectors found improvements were required to ensure full adherence to the caseload management policy where that caseload management tools were not

routinely completed. In addition, in two service areas (Kerry and Louth/Meath), it was not clear what plans were in place to address unmanageable caseloads.

### National Child Care Information System (NCCIS)

A secure information technology system that has the most up-to-date records, supports the delivery of a child protection service. It provides assurance that practice is consistent and timely interventions are taken to protect children and promote their welfare.

All service areas used Tusla's electronic case records system, the National Child Care Information System (NCCIS), to record the activities and interventions with families. HIQA found well-implemented data management practices in four service areas (Mayo, Sligo/Leitrim/West Cavan, Donegal and the Midlands). For example, in the Donegal service area, the use of NCCIS was well embedded into practice and the integrity of the data inputted into the NCCIS was well managed. Inspectors saw that the data quality officer sent a data quality log to managers and to the NCCIS liaison officer. This included a summary of each team's data quality issues, which the data quality officer assisted the teams to address. In this way, a contemporaneous, accurate record was maintained. In the Midlands service area, priority was given to equipping front-line staff and managers with the knowledge and skills to make best use of NCCIS and, overall, inspectors found information about individual children was well managed and kept up to date.

However, governance of this system required improvement in order for service areas to maintain oversight of practice. A consistent finding from eight of the 12 inspections carried out in the thematic programme was that children's case files were not always updated on NCCIS. This meant that a contemporaneous record of the work completed with children and families was not available on the information system. For example, in the Kerry service area, work completed with families and decisions made were not always reflected on NCCIS. Staff supervision records were not consistently uploaded, which meant that managerial oversight of practice or decision making was not always evident. In the Galway/Roscommon service area, recording was inconsistent. For example, the intake record, which is used to capture preliminary enquiries, recorded all activities in some cases and not in others. The lack of accuracy and integrity of data was a feature of inspections in the Waterford/Wexford and Cavan/Monaghan service areas. In the Dublin South East/Wicklow, Mid-West, Dublin North City and Louth/Meath service areas, all necessary information was not recorded or uploaded to the system in a timely manner.

Additionally, procedures surrounding this required standardisation to ensure consistency in practice.

Accurate and up-to-date records are essential in order for area managers to be assured and to assure their service directors and the national office on the quality and safety of the service provided to children and their families. NCCIS was consistently used by management teams as an assurance mechanism on the quality and safety of the service provided. Monthly, quarterly and annual reports could be pulled from the system to monitor service provision, particularly on the achievement of key performance indicators such as the timeframes for completion of preliminary enquiries and initial assessments.

The inspection programme found that improvements were required in three areas in the management of data in order to ensure the accuracy of data. For example, in the Dublin North City service area, inspectors found a delay in the uploading of information to NCCIS which could potentially impact on reports provided to the area manager and the national office. In the Cavan/Monaghan service area, staff were not adhering to the standard business process in regard to the inputting of data resulting in inaccurate information on NCCIS. In the Waterford/Wexford service area, improvements were required in data management in order to ensure accuracy in the reporting of key performance indicators.

**Standard 5.1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare**

| Judgment | No of areas | Service areas |
|---|---|---|
| **Compliant** | 4 | Dublin North City, Waterford/Wexford, Louth/Meath, Midlands |
| **Substantially Compliant** | 1 | Mid-West |
| **Partially Compliant** | 4 | Mayo, Sligo/Leitrim/West Cavan, Galway/Roscommon, Dublin South East/Wicklow |
| **Non-compliant** | 2 | Cavan/Monaghan, Kerry |
| **Not assessed** | 1 | Donegal |

Safe recruitment practices are required to assure managers at all levels that the service employ staff with the required competencies to undertake duties associated with their role and responsibilities. A well-governed service area employs staff in line with employment and equality legislation and maintains contemporaneous, accurate and secure personnel files for all staff.

Findings in relation to Standard 5.1 relating to safe recruitment practices were mixed. There was room for improvement in relation to some staff files. Recruitment files were reviewed in 11 out of the 12 service areas with six of these reviews completed by inspectors prior to March 2020. Of these six areas, inspectors found

two service areas non-compliant and four partially compliant with this standard as staff recruitment files did not contain all required documents. As stated, HIQA changed the inspection methodology after March 2020 in respect of this standard. In the remaining five service areas inspected, the relevant regional service directors were provided with a sample of staff names and questionnaires detailing specific information that was required to be returned along with an overall assurance that safe recruitment practices were in place.

In the four service areas judged by inspectors to be partially compliant, some staff files did not contain a curriculum vitae, references or photographic identification, as found by inspectors in the files in the Mayo, Dublin South East/Wicklow and Galway/Roscommon service areas. In the Dublin South East/Wicklow service area, staff probationary periods were not appropriately recorded, while in the fourth service area, Sligo/Leitrim/West Cavan, there was no record of Garda Síochána (police) vetting on file for one staff member.

The Kerry and Cavan/Monaghan service areas were non-compliant with this standard. In the Kerry service area, HIQA sought assurances from the Tusla Regional Service Director for the South that safe recruitment practices were in place and specifically that Garda vetting and professional registration were in place for all staff. Subsequently, HIQA was provided with satisfactory assurances describing how local management in the Kerry service area were satisfied that all staff on duty were registered and had up-to-date Garda vetting as appropriate. In addition, the regional director said a full review of staff files for Garda vetting and professional registration was underway with Tusla regional human resources to undertake a full review across the South region.

Similar shortcomings were found in the Cavan/Monaghan service area as there was no evidence of Garda vetting and police vetting from other jurisdictions on four staff files. Some staff files did not include records of qualifications, photo identification, employment history or verification of references. HIQA sought and received assurances from the Regional Service Director for the North East in relation to recruitment practices, specifically in relation to Garda vetting and professional registration. The service director also outlined that a regional review of recruitment practices was underway.

The service areas of Mid-West, Waterford/Wexford, Dublin North City, Louth/Meath and the Midlands self-reported that staff files contained all required information. Some regional service directors identified that, while there were gaps relating to updating of Garda vetting and certificates of professional registrations of some staff, this was being addressed at the time of the inspections. Hence, the inspections found these areas to be compliant with the standard.

Staff vacancies were a challenge across the majority of service areas inspected. Inspectors found that vacancies in staffing posts impacted service provision. Some service areas had a full or almost full complement of staff and this resulted in services without a waiting list. These services had a capacity to utilise resources effectively to fully implement their quality improvement plans.

There were permanent vacancies in eight out of 12 service areas inspected, and of those eight areas, six operated a waiting list for cases awaiting allocation to a social worker. Of these eight areas, there were between one (Mayo) and 18 (Louth/Meath) vacancies at the time of their inspection. A number of areas identified that they required additional resources. For example, three service areas (the Mid-West, Kerry and Donegal) had conducted resource analyses and concluded that current staffing levels were not sufficient and that additional staff were required. Issues associated with vacancies were managed through the use of agency staff, the temporary filling of posts and the assignment of additional duties, such as the completion of preliminary enquiries to social care professionals.

Some examples of the initiatives to manage vacancies included:

- in the Mid-West service area, where a bespoke recruitment campaign and action plan was put in place to improve staffing capacity
- six of the 12 service areas had re-structured teams to improve efficiency and maximise use of resources to meet strategic objectives
- staff were temporarily re-assigned to meet service needs in critically-affected teams in the Mid-West service area
- the Dublin South East/Wicklow and Dublin North City areas had employed agency staff to cover the vacancies in these areas
- in the Cavan/Monaghan service area, a team of social care workers was established to complete preliminary enquiries and the intake records for low priority cases.

Area managers appropriately escalated staff shortages to their regional directors and in turn to the national office. National initiatives to recruit staff included rolling programmes of recruitment and sponsoring social work students during their studies with an offer of employment post qualification. Additionally, other staff such as business support personnel were employed to support front-line staff.

**Standard 5.2**
**Staff have the required skills and experience to manage and deliver effective services to children**

| Judgment | No of areas | Service areas |
|---|---|---|
| **Compliant** | 7 | Mayo, Sligo/Leitrim/West Cavan, Cavan/Monaghan, Galway/Roscommon, Dublin South East/Wicklow, Mid-West, Midlands |
| **Substantially Compliant** | 3 | Kerry, Donegal, Louth/Meath |
| **Partially Compliant** | 2 | Dublin North City, Waterford/Wexford |
| **Non-compliant** | | |

Overall, the inspection programme found that staff had the required skills and range of experience to deliver effective services to children. During inspections, Tusla staff were knowledgeable and clear about the policies and procedures in relation to the management of referrals. Inspectors met with and observed motivated and engaged professional staff, who were committed to the delivery of services to children and their families.

As outlined previously, staff vacancies remained a challenge across the majority of service areas inspected. Inspectors found that eight service areas had vacancies in staffing posts, with adverse impacts in five of these eight areas. Two service areas were judged to be partially compliant in relation to this standard. The Dublin North City service area had significant staff vacancies (nine in total) at the time of the inspection, and Waterford/Wexford service area had a shortage of staff on the intake and assessment team which resulted in delays to the service provided to children and their families. The contingency plans did not adequately address deficits resulting from staff shortages. Three service areas were judged to be substantially compliant as some additional action was required to be fully compliant. The issues at the time of inspection related to:

- the Donegal service area, where there was one vacancy on the team and additional permanent staff were required to ensure that time frames for preliminary enquiries and initial assessments were met once the waiting lists had been eradicated
- the Louth/Meath service area, where there was a shortage of staff which resulted in delays to the service provided to children and their families. At the time of inspection, there were 10 vacant social work posts, six of

which were filled by agency workers and eight vacant senior social work practitioner posts

- the Kerry service area, where opportunities for managers to engage in further training would benefit both managers and service delivery.

**Standard 5.3: All staff are supported and receive supervision in their work to protect children and promote their welfare.**

| Judgment | No of areas | Service areas |
|---|---|---|
| **Compliant** | 2 | Donegal, Midlands |
| **Substantially Compliant** | 6 | Mayo, Sligo/Leitrim/West Cavan, Galway/Roscommon, Dublin South East/Wicklow, Mid-West, Waterford/Wexford |
| **Partially Compliant** | 4 | Cavan/Monaghan, Kerry, Dublin North City, Louth/Meath |
| **Non-compliant** | 0 | |

The provision of regular supervision and access to support enables staff to perform their role to the required level. Regular supervision and good quality supports are also fundamental to the retention of experienced staff. For supervision to be of good quality, it should be regular, be accurately recorded and should include discussions on the worker's wellbeing, as well as on individual cases.

The inspection programme found that two service areas were compliant with this standard, six service areas were substantially compliant and four service areas were partially compliant.

Overall, this thematic inspection programme found that the quality of staff supervision was mixed and required improvement. Tusla's supervision policy outlines the purpose, content and regularity of supervision. Inspectors found that the frequency and quality of supervision was not consistent with Tusla's policy across ten of the 12 service areas inspected.

Formal and informal supervision was available to staff. In some service areas inspectors found that group supervision was used to facilitate discussions and inform decisions on cases using the national approach to practice. These sessions were used to map out and problem solve cases. This helped to build the confidence, knowledge and expertise of team members.

In the Donegal and Midlands service areas, both of which were compliant with the standard, supervision occurred in line with Tusla's supervision policy and was well recorded. In the Donegal service area, supervision sessions provided guidance and direction in relation to casework and also included training, professional development and the wellbeing of staff. In the Midlands service area, supervision was undertaken as a collaborative approach, with expectations and standards clearly

set out in supervision contracts. Supervision records reflected a focus on the quality of child protection practice and decisions were clearly recorded. Supervision records also included recognition of positive practice and individual achievements.

In the service areas that were found to be substantially compliant, some additional action was required to reach compliance. These included:

- consistency in the recording of supervision record including recording decisions and actions
- the frequency of supervision
- attention to staff wellbeing and or support
- systems for appraisal of staff through personal development plans.

In the four service areas judged to be partially compliant in relation to this standard, some of the requirements were met while others were not. For example, in the Kerry service area, records of supervision were not consistently available. In the Louth/Meath service area, the frequency of supervision sessions was not in line with the policy, particularly for newly-qualified social workers, while in the Dublin North City service area there were significant gaps in the provision of supervision for some social workers. In the Cavan/Monaghan service area, the tracking of decisions was poor and decision making was not clearly recorded.

At a national level, Tusla established a national programme, Empowering Practitioners in Practice Initiative (EPPI), the aim of which is to develop the confidence and expertise of social workers, so that they achieve better outcomes by applying evidence and knowledge into their day-to-day practice. This initiative was found to be in place during the inspection programme.

A range of local initiatives were also in place that facilitated staff development with of child centred practice. For example, complex case meetings were chaired by managers and afforded staff an opportunity to present a complex case, to explore options for interventions and to progress the case in the best interests of the child and their family (Mayo, Sligo/Leitrim/West Cavan, Cavan/Monaghan, Galway/Roscommon, Dublin South East/Wicklow and Dublin North City service areas).

Staff training, based on analysis of training needs, provided an opportunity for staff to enhance skills and knowledge in specific areas of practice. There was a range of training available for staff which included the national approach to practice, youth participation, court skills, domestic violence and sexually harmful behaviours. In the Kerry service area, plans were put in place to rotate social work positions to diversify roles and enhance learning opportunities within the workplace. In the Galway/Roscommon and Dublin South East/Wicklow service areas, training initiatives with local universities were in place. In the Dublin South East/Wicklow service area

there was also a joint learning forum between the service and a school of social work in Dublin.

There was good awareness among area managers of the requirement to support staff members' wellbeing to sustain and assist in staff retention. In the majority of service areas, additional supports were provided to staff to support their wellbeing. As a national organisation, all staff had access to services such as occupational health service and an employee assistance programme. Some areas had undertaken staff surveys that focused on wellbeing (Mid-West) and staff satisfaction (Waterford/Wexford). These surveys were informing their programme of supporting staff. Team development days were held in several service areas (Mayo, Sligo/Leitrim/West Cavan, Galway/Roscommon, Dublin South East/Wicklow, Donegal, Mid-West, Cavan/Monaghan and Dublin North City). Some service areas identified their roles or as a response to particular situations or incidents. Inspectors found that a range of bespoke and innovative arrangements were in place. These included social events along with:

- individual counselling for staff (Cavan/Monaghan) and external professional support (Dublin North City)
- a programme facilitated by a psychotherapist (Dublin South East/Wicklow)
- events to build resilience facilitated by a psychologist (Donegal)
- a course on self-care (Cavan/Monaghan)
- specific resources to support individual staff (Mayo)
- bespoke counselling and support was put in place for staff in response to specific issues arising from the management of a serious case (Cavan/Monaghan and in the Mid-West).

Appropriate supports were provided to new staff and less experienced staff in order to support and develop their skills. Induction programmes were in place for new staff and these were supported by a range of e-learning modules on a range of topics related to staff roles. Formal mentoring or a 'buddy' system for inexperienced social workers were common across all service areas. Newer staff had protected caseloads which were incrementally increased as their experience grew.

Overall, staff outlined how a culture of support was promoted within service areas. Area managers across all service areas were focused on retaining staff and were proactive in putting appropriate supports in place. Continuity of staffing is important as it promotes better outcomes for children who are in receipt of child protection. and welfare services.

# 7. Quality and safety

This section focuses on the measures that were taken by Tusla staff in providing services to children, where there were concerns in relation to their safety and welfare. Two standards were assessed as part of this inspection programme. The first, Standard 1.3, relates to provision of accessible information to and effective communication with children. In the 12 areas inspected, inspectors largely agreed with the senior managers' self-assessment of their performance relating to this standard and found that the inspections supported these ratings. That is, the evidence found on inspection fieldwork supported the area's self-assessment of their compliance with standards relating to provision of accessible information to and effective communication with children. All 12 service areas inspected were found to be compliant or substantially compliant with this standard.

The second, Standard 2.1, relates to the provision of a safe and effective service. No areas were fully compliant, with three assessed as substantially compliant and nine as partially compliant. In their self-assessment questionnaires, management teams in 10 service areas rated themselves as a three on a scale of one to four, where four was a good service. Two service areas rated themselves at two, which meant that they recognised they had some way to go to achieve compliance with the standard and there were many areas in which improvement was required. These inspections found that three service areas were substantially compliant with this standard and nine areas were partially compliant. Inspectors did not agree with the area's self-assessment in seven service areas. In five areas, judgments of partially compliant primarily related to the operation of waitlists with the remaining four judgments relating to timelines in commencing and completing initial assessments.

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

| Judgment | No of areas | Service areas |
|---|---|---|
| **Compliant** | 8 | Mayo, Sligo/Leitrim/West Cavan, Dublin South East/Wicklow, Donegal, Mid-West, Waterford/ Wexford, Louth/Meath, Midlands |
| **Substantially Compliant** | 4 | Cavan/Monaghan, Kerry, Galway/ Roscommon, Dublin North City |
| **Partially Compliant** | 0 | |
| **Non-compliant** | 0 | |

## Communication with children and families

A good child protection and welfare service promotes the delivery of a child-centred approach within a culture of protecting children and promoting their welfare. This child-centred approach includes providing information to children and their families in a meaningful way and consulting with them about decisions and interventions that will affect their lives.

The thematic programme found that Tusla service areas promoted child-centred communication and had innovative means of communicating with children and their families. Of the standards inspected, this standard had the highest level of compliance, with eight areas in compliance and four substantially compliant. Many children and families who participated in these inspections were positive about their interactions with social work services.

Quality improvement plans were used by areas to identify the key aspects of service delivery for improvement. For example, both the Midlands and Waterford/Wexford service areas identified the need for improved communication with children in their quality improvement plans and deemed themselves to be substantially compliant with Standard 1.3. Both service areas had achieved compliance with the standard by the time of their inspections.

In all service areas, information was available for children and their families about the child protection and welfare service and the role of the social worker. For the most part, children were provided with this information by the use of information packs, child-friendly leaflets and booklets, some in different languages, including Irish.

Social workers used a variety of ways to communicate appropriately with children and their families such as direct conversations with children, the use of interpreters and signers when required, and direct work or play with children. Staff in the Dublin South East/Wicklow and Sligo/Leitrim/West Cavan service areas had completed participation training to enhance their skills in communicating with children.

From a review of children's files, inspectors found that staff used simple child-friendly language in conversations with children and artwork was used to help them express their views or worries. Social workers took account of children's ages and stages of development and used appropriate tools such as drawing, storytelling and pictures to enhance their communication with children.

Transparent and clear communication was used with families so they were clear on the reasons for social work involvement with their families. In the majority of service areas, families were kept informed about the progress of the social work interventions and the decisions made about their child's case throughout their involvement with services. One exception to this was the Cavan/Monaghan service area, where inspectors found that families were not consistently informed of the outcome of assessments and the closure of cases.

Service areas sought feedback from children and families and used this to inform and improve their service. For example, when cases were being closed in the Donegal service area, families highlighted the value they gave to the supports that had been put in place. The Midlands service area actively sought to use compliments and complaints to support organisational learning and quality improvement, using positive feedback from children and their families to reflect on what worked well.

Inspectors found that some areas had created participation groups for children which were used to inform service development. Some service areas, such as Dublin South East/Wicklow, Midlands, Donegal and the Mid-West, had participation groups or projects where children were consulted and involved in developing and enhancing communication by the service with children and families. The quality improvement plan in the Donegal service area included an action for children to participate in a review of the intake system and had already consulted a children's group about their new premises to ensure it was child and family friendly.

Some service areas were innovative and creative in developing their communication with children and their families. Such innovations included:

- the Mid-West service area, where a series of child-friendly animations were developed to be shared with children when a social worker was allocated to them and their family
- the Dublin South East/Wicklow service, area where a child-friendly website was developed which grew into a national project. Their website, 'Changing

Futures', was designed to help young people to better understand the work that Tusla does
- the Louth/Meath service area, where materials in multiple languages were developed, including Irish, and an interactive translation function on their website
- the Midlands service area, where a youth participation group had been involved in the development of a short animation to help explain the role of the social worker to children. The film used feedback from children to raise awareness of what worked best in engaging and listening to them
- the Cavan/Monaghan service area, where the development of a cultural champion initiative provided support such as translating language and culture at meetings for families. This process enabled more effective communication between staff and children and their families
- the Waterford/Wexford service area, where information packs were available in various languages, including braille, and were a valuable resource at ensuring families had access to necessary information about the child protection and welfare service, processes and supports.

While the inspection programme found good examples of creative communication with children, some areas were judged as substantially compliant and improvements were needed in order for areas to achieve full compliance with the standard. These improvements included:

- communicating regularly with families on waiting lists
- ensuring that families were informed in a timely way when a concern about them was reported to the child protection and welfare service
- ensuring that children and families were informed of the outcome of initial assessments
- ensuring that families were informed when their case file was being closed to the social work department
- evidencing that leaflets had been consistently provided to children and their families (Kerry, Cavan/Monaghan, Dublin North City) and of attempts made to elicit the views of children (Kerry).

**Standard 2.1: Children are protected and their welfare is promoted through the consistent implementation of *Children First***

| Judgment | No of areas | Service areas |
|---|---|---|
| **Compliant** | 0 | |
| **Substantially Compliant** | 3 | Mayo, Sligo/Leitrim/West Cavan, Dublin South East/Wicklow |
| **Partially Compliant** | 9 | Cavan/Monaghan, Kerry, Galway/ Roscommon, Donegal, Mid-West, Waterford/ Wexford, Dublin North City, Louth/Meath, Midlands |
| **Non-compliant** | 0 | |

Tusla had a national model of practice in place in order to achieve standardised practice in child protection and welfare services. This was a strengths-based approach to child protection casework whereby child protection professionals build working relationships with parents where there are concerns about child abuse and neglect in order to keep children safe at home. The Tusla standard business process set out the procedures to be followed and the timelines for the completion of tasks associated with the processing of referrals through the system from receipt of the report through to completion of an initial assessment and beyond.

### Screening and preliminary enquiries

When a report of a concern for the safety and wellbeing of a child (referral) is received by Tusla, it must first be screened to identify whether it is an appropriate referral to the child protection and welfare service. Referrals that do not meet the child protection and welfare eligibility criteria include:

- requests for diversion to another agency
- a report where there are no reasonable grounds for concern or no harm to a child indicated or
- a report that does not require a Tusla-led intervention.

These referrals are recorded on the system but do not require a preliminary enquiry process to be completed. Once accepted as an appropriate referral, preliminary enquiries are completed to establish whether the family was previously known to the service, and whether they are known to other agencies and professionals. The preliminary enquiry is recorded on an Intake Record (IR). Tusla has a time frame of five working days during which a referral should be screened and a preliminary

enquiry completed. HIQA used Tusla's standard business process to identify five key quality indicators which were then used by inspectors to assess the overall quality of screening and preliminary enquiries.

These quality indicators were as follows:

- completed within five working days
- classification appropriate
- internal checks carried out
- details clarified with the referrer
- priority level appropriate.

## Screening

According to Tusla's standard business process, screening should be completed within a 24-hour time frame. The inspection programme found that all service areas screened new referrals and took immediate action in emergency situations to protect and promote the safety of children. In response to lower priority referrals, the majority of service areas ensured screening was completed within 24 hours of receipt of a referral. However, the recording of the process was inconsistent.

Tusla did not have a nationally agreed recording method for screening. While the national recording template for recording screening and preliminary enquiries did not allow for evidencing of screening, screening was evidenced in various ways, such as:

- opening a preliminary record on the same day as the referral was received, or
- including a note within the preliminary record stating that the referral had been accepted
- some service areas had developed specific screening forms which were uploaded into NCCIS. For example, in the Dublin South East/Wicklow service area, a standard screening tool was introduced in December 2019 as an interim measure. Prior to this, the screening process had been recorded in a number of ways such as in the intake record or in case notes. In addition, the Cavan/Monaghan, Kerry, Donegal, Dublin North City and Louth/Meath service areas had developed their own screening form.

These inspections found that, in the sample of files reviewed for screening, between 35% (Mayo) and 93.6% (Dublin North City) of referrals sampled had evidence of screening within the 24-hour time frame. In some areas, it was evident that there was a delay in the recording of completed work. Inspectors found that in some of the areas inspected, the recording of the screening process differed between social work offices within the same service area. For example, in the Waterford/Wexford service area, screening was recorded in a number of different ways across the two

counties. The area had recently introduced a screening document in an effort to standardise practice. In addition, it was difficult for some areas to evidence whether or not the screening process had taken place: in the Mid-West service area, the screening process was recorded in a number of ways and it was difficult to determine how long the process had taken. In the Kerry service area, while evidence of screening was not routinely available, new screening forms had recently been introduced with improved management oversight of the process.

### Preliminary enquiries

Overall, the inspection programme found that the quality of completed preliminary enquiries was generally good. Records of preliminary enquiries provided an analysis of the risks based on available information and appropriate recommendations for next steps. Good quality preliminary enquiries included the following quality indicators:

- appropriate categorisation of referrals as neglect or physical, sexual or emotional abuse
- network checks with professionals completed as appropriate
- details of the referral were checked with the referrer
- previous referrals were considered when a new referral was received
- referrals were appropriately prioritised as low, medium or high priority.

In addition, other elements of good quality preliminary enquiries were found and these included:

- home visits to children and families where necessary
- safety planning where required
- good analysis of information to inform decision-making about the next steps
- referrers and parents informed in writing of the outcome of the screening and preliminary enquiry.

None of the service areas inspected as part of the thematic programme consistently met Tusla's five-day time frame for the completion of preliminary enquiries. In all 12 service areas there were delays in either commencing, completing and or recording preliminary enquiries. Inspectors reviewed a sample of files, from receipt of the referral to completion of the preliminary enquiry and found there were delays that ranged from a few days (Mayo) to within three weeks (Dublin South East/Wicklow), and up to 12 months (Louth/Meath) in a small minority of cases reviewed. In some files, the reasons for shorter delays were reasonable and were recorded in the preliminary enquiry record. Inspectors found that longer delays were not acceptable. The reasons for delays included high volumes of work and the non-engagement of families with the service. In other files reviewed, the rationale for the delays was not

always recorded or evident from case files. Inspectors found that delays were sometimes due to records not being uploaded onto the NCCIS electronic case recording system until all work was completed, the records did not always reflect the work that had been done or there was a delay in managers signing-off that the work was completed.

In addition to the lack of timely completion of preliminary enquiries, other areas of practice that required improvement included evidencing parental consent for network checks (Sligo/Leitrim/West Cavan, Galway/Roscommon, Dublin South East/Wicklow) and the recording of these completed checks or inadequate network checks (Cavan/Monaghan).

### Immediate Action

All service areas were effective at identifying and responding to children at serious and immediate risk of harm. In many situations, Tusla staff worked in co-operation with their colleagues in An Garda Síochána and or community and medical services in order to ensure the immediate safety of children.

### Initial assessments

Following the completion of preliminary enquiries, a decision is made whether an initial assessment of the child and families' needs is required. The thematic inspections found good quality, comprehensive initial assessments in all service areas inspected, but improvements were required in the timely commencement and completion of initial assessments.

A good quality initial assessment should be timely and be conducted in line with Children First (2017), Tusla's own initial assessment framework and best practice. Good quality initial assessments incorporate the following elements:

- the child is seen, spoken with and or observed in their own home
- both parents and or guardians are consulted during the assessment
- the child's support network is identified and consulted as appropriate
- multidisciplinary and interagency consultation and sharing of information is evident
- all concerns and risks are clearly recorded
- strengths and existing safety factors are considered
- the child's needs are identified, described and analysed.

The resulting record of the initial assessment should:

- clearly state the risk status of the child
- be clear about the outcome of the assessment
- detail the next steps to be taken
- and should be shared with the child and family in an appropriate manner.

There should also be very good managerial oversight of the initial assessment process which should be completed within 40 days from receipt of the referral.

Initial assessments followed Tusla's national approach to practice and included many of the elements outlined above. Assessments demonstrated child-centred practice and reflected good analysis of all information gathered. In all areas inspected, inspectors found that children and their families were appropriately consulted about their views and the child's needs, risks and safety factors were outlined and assessed. Children were seen on their own by social workers and observation of children, particularly infants in their home environment informed their assessment. Other professionals or agencies such as general practitioners (GPs), teachers, and public health nurses were routinely consulted, which was in line with good practice. Assessments included clear conclusions and recommendations on the next steps. Where children were assessed as being at significant risk of harm, appropriate next steps included scheduling a child protection conference or seeking legal advice.

Improvements were required across all areas in adhering to Tusla's requirement that initial assessments are completed within 40 days. The inspection programme found mixed findings across all 12 service areas as, while a proportion of initial assessments were completed within 40 days, all service areas had delays in commencing and or completing of initial assessments to varying degrees.

Three areas judged substantially compliant, included the Mayo and Sligo/Leitrim/West Cavan service areas, where there were delays of between three to four weeks delays in commencing or completing some initial assessments. The Sligo/Leitrim/West Cavan service area reduced the impact of delays in commencing initial assessments by ensuring that children and their families were receiving support services while the assessment was ongoing. In the third service area, Dublin South East/Wicklow, the majority of initial assessments were completed in a timely manner and where there were delays of two to five months in a small number of cases, practitioners were undertaking work with children and families.

In the nine service areas judged to be partially compliant, there were delays in the commencing and or completing of initial assessments of up to six months in the Cavan/Monaghan, Kerry, Galway/Roscommon, Mid-West, Dublin North City, Louth/Meath service areas. There were further delays of between eight and 15 months found in a small number of cases in the Waterford/Wexford, Donegal and Midlands service areas. Overall, these delays meant that some children's needs were not assessed in a timely manner so that appropriate interventions could be put in place.

In some service areas (Mayo and Kerry), the reasons for the delays in commencing or completing some initial assessments were documented. In other areas, such as

the Dublin South East/Wicklow and Mid-West service areas, the reasons for delays were not clearly or consistently documented.

## Waiting lists

The use of waiting lists in child protection and welfare service indicates that children and families will not receive a timely service. Examples of waiting lists included the completion of a preliminary enquiry or initial assessment for those waiting a child protection service. If not managed appropriately, waiting lists become a significant risk to children and families who may not be assessed or receive the right service at the right time. Poorly managed waiting lists can also become a significant risk to the service itself, as they become a barrier for the organisation in meeting statutory obligations.

Throughout this programme, inspectors found that the operation of waiting lists required a greater consistency in oversight, to ensure risks associated with waiting lists did not escalate into a more significant issue.

In nine service areas there were waiting lists for preliminary enquiries and or initial assessments at the time of the inspections. The service areas with no waiting lists at the time of inspection included the Mayo, Sligo/Leitrim/West Cavan and Galway/Roscommon service areas. The numbers of preliminary enquiries awaiting allocation ranged from 14 in Louth/Meath to 76 in Dublin North City. In nine service areas there were waiting lists for initial assessments. The numbers on the waiting list for an initial assessment ranged from 15 in each of the Cavan/Monaghan and Dublin South East/Wicklow service areas to 112 in the Louth/Meath service area. The inspections did find that children of the highest priority were allocated to a social worker and waitlists generally consisted of medium and low priority cases.

A Tusla 'Practice Matters' document, which outlined clearly-defined procedures to guide the management of the risk associated with cases awaiting allocation, was issued by the Tusla national office. Some areas also had local standard operating procedures that provided further guidance. As stated there were waiting lists in nine service areas, of which four were well managed: these were the Dublin South East/Wicklow, Donegal, the Mid-West and Midlands service areas. The components of well-managed waiting lists included:

- regular review of cases on waiting lists
- re-prioritisation of cases where appropriate following review
- strategies in place to reduce the waiting lists. For example, one service area had protocols in place to manage and monitor the current waiting lists to eliminate the waiting list in a specified time frame
- duty systems to ensure that safety plans were reviewed and to address any issues that arose while cases were waiting allocation

- steady progress in reducing the numbers and waiting times for children for a service
- a dedicated resource to regularly check-in with children and families while they awaited initial assessment.

In the Louth/Meath service area, an initial assessment project was established to address waiting lists for initial assessments. This led to the design of an Initial Assessment Practice Manual which was used to guide practitioners in completing initial assessments.

In five service areas (Cavan Monaghan, Kerry, Waterford Wexford, Dublin North City and Louth Meath), the management of waiting lists required improvement. In these areas, monitoring and oversight of cases on waiting lists was ineffective as there:

- were cases awaiting allocation that were not subject to consistent monitoring, in line with local procedures, in the Cavan/Monaghan, Waterford/Wexford and Dublin North City service areas
- was improvement required in the recording of the review of cases awaiting allocation in the Kerry service area
- ineffective prioritisation systems for cases on waiting lists (in the Louth/Meath service area.

In the Kerry service area, despite inspectors being told that reviews of unallocated cases took place, there were no records of reviews in the majority of unallocated children's records sampled by inspectors. In the Waterford/Wexford service area, monitoring and oversight of waiting lists was managed through the use of trackers. Senior managers told inspectors that while they reviewed waiting lists, a record of that individual review was not maintained. This type of oversight was not effective, as they did not ensure that basic checks with network supports or regular check-ins with families occurred. Despite cases being subject to a review prior to the inspection, assurances were sought following this inspection in relation to the effective monitoring of cases awaiting allocation. In response, the area manager detailed a plan being implemented to strengthen oversight of unallocated cases.

In the Dublin North City service area, inspectors escalated five cases to the area manager as there were no records of review or case management activity recorded on NCCIS. The area manager subsequently provided assurances that while the cases had been reviewed and managed; the information had not been uploaded onto NCCIS for inspectors to review. In addition, the area manger provided assurance that all cases awaiting a service were effectively monitored, routinely reviewed and managed.

These inspections found that, in the main, area managers escalated risks associated with waiting lists to service directors, except in the Kerry service area where all risks

at the time of inspection were not routinely escalated. In addition, waiting lists were included in risk registers maintained by service areas as an impact of insufficient workforce capacity to address the volume of referrals in a timely manner.

## Safety planning

Safety planning was identified as a risk during the statutory investigation by HIQA in 2018, when it was recommended that improvements were required to ensure a consistent approach to safety planning. At that time, Tusla was in the early stages of implementing a new process for safety planning as part of its national approach to practice across the agency to support the management of risk for children and families. Safety plans can and should occur at any stage of management of a referral where there are identified concerns about a child's safety. Safety plans can be verbal, written, immediate, interim, short term and long term. In July 2020, Tusla introduced an updated standard operating procedure which outlined that formal safety planning commenced following completion of the initial assessment.

This inspection programme found that service areas were at different stages of implementing the national approach at the time of the inspections. The quality of safety planning varied throughout inspections and across service areas. Where safety planning was of good quality, they were effective at ensuring the safety of children. Inspectors found elements of good quality safety planning in all service areas.

Nonetheless, improvements to safety planning, particularly in the monitoring of safety planning, was a feature in eight out of 12 service areas inspected.

The components of good safety planning include:

- parental capacity to safeguard is appropriately assessed
- children and parents are involved in the development of the safety plan where appropriate
- children's support network is clearly identified and involved in the development of the safety plan
- children's support network is actively involved in keeping the child safe
- there is evidence of appropriate interagency co-operation.

Safety plans should also:

- adequately address all the identified risks or concerns about a child
- be regularly monitored for implementation and effectiveness
- be appropriately updated following review.

The safety planning process can be recorded in a number of ways. These inspections found that although safety planning was recorded in various places in the child's record, there was evidence of some good practice in regard to safety planning:

- children and their families were appropriately consulted in the development of safety plans
- many safety plans were written formalised documents that addressed all identified risks to the child
- due consideration was given to parental capacity to safeguard the child
- safety plans were comprehensive and of good quality, incorporating all the elements required to best ensure children's safety
- there was a focus on safety from the point of referral and throughout the management of the referral through the service
- safety plans were well-monitored, reviewed and amended to ensure they adequately safeguarded the child
- some safety plans translated into the native language of the child and their family
- in the Galway/Roscommon service area, a picture version of their safety plan was created for children
- safety planning was embedded within family support plans for those children and families that required ongoing support.

Eight out of the nine service areas (Cavan/Monaghan, Kerry, Galway/Roscommon, Donegal, Mid-West, Waterford/Wexford, Dublin North City, Louth/Meath) judged as partially compliant were found to require continued improvement in the safety planning process.

Practice which required improvement included:

- improved consultation with children in developing their plan
- including protective adults or network supports in safety plans to ensure that agreed safety measures were adequate
- ensuring that safety plans included meaningful and ongoing collaboration with the identified safety network
- better use of the families' wider support network in the development and monitoring of the safety plan
- consistent recording, monitoring, review and updating of safety plans
- ensuring the quality of safety plans was consistent.

In the Mid-West service area, one child on a waiting list for an initial assessment did not have a safety plan in place and assurances were provided by the area manager that the case would be allocated. In the Louth/Meath and Kerry service areas, where children did not have safety plans in place as required, assurances regarding safeguarding measures were sought. In these three areas, the response received outlined that satisfactory safety planning was subsequently put in place to ensure the safety of children.

## Notification of suspected abuse to An Garda Síochána

Tusla and An Garda Síochána are the key agencies who have statutory responsibilities to carry out assessments and criminal investigations, respectively, of suspected child abuse and wilful neglect. Under Children First (2017), if Tusla suspects that a crime has been committed and a child has been wilfully neglected or physically or sexually abused, it will formally notify An Garda Síochána without delay.

Overall, the inspection programme found that improvements were required in the completion and timeliness of notifications of suspected abuse to An Garda Síochána. Four service areas (Mayo, Dublin South East/Wicklow, Louth/Meath and the Midlands) ensured appropriate and timely notification to An Garda Síochána. Inspectors found delays in notifications to An Garda Síochána in eight of the 12 service areas inspected. Some service areas were mostly compliant in completing timely notifications (Mid-West, Galway/Roscommon), others had delays of up four weeks (Sligo/Leitrim/West Cavan, Donegal and Dublin North City), one had delays of up to two months (Cavan/Monaghan), while two other service areas had significant delays of up to 10 months (Kerry and Waterford/Wexford). Often the reasons for the delays were not recorded or clear from the child's file. In some areas, the monitoring and oversight of notifications to the Gardaí had improved but there was room for further improvement.

In addition, inspectors found a small number of referrals that had not been appropriately notified to An Garda Síochána in the Sligo/Leitrim/West Cavan, Donegal, the Mid-West and Dublin South East/Wicklow service areas. These were escalated to area managers who subsequently provided satisfactory assurances that notifications had been completed.

As the inspection programme progressed, Tusla implemented changes to improve this process. For example, in the latter part of 2020, a prompt was included in the revised intake and initial assessment templates on the integrated information system to remind staff to notify the Gardaí where required.

The inspection programme found that once notifications of suspected abuse were made, there was evidence of good joint working between Tusla and An Garda Síochána. A joint working protocol for An Garda Síochána and Tusla liaison is in place between these two agencies and it details how they cooperate and interact in dealing with child protection and welfare concerns. This protocol outlines the formal communication required between the two agencies about notifications and recording of joint working and decision-making. Good co-operation, liaison and decision-making between social work teams and members of the Gardaí occurred through individual contact and strategy meetings in relation to individual cases. An Garda Síochána liaison meetings and senior local An Garda Síochána and Tusla

management liaison forum meetings[4] routinely occurred in all areas and these provided an opportunity to examine trends in notifications, operational risks and implement improvements.

## Closed cases

A good child protection and welfare service ensures that children and their families benefit from services and interventions or as long as they need them. Cases are not closed until there are appropriate and sustainable arrangements in place to keep children safe. The rationale for the case being closed should be clearly recorded in the child's case record and be overseen by a manager. Families should be informed when their case is being closed by the service.

Inspectors found that, in all service areas, referrals were appropriately closed when children and their families no longer required a social work service. Case closures were managed effectively and there were good processes in place to ensure this. In most service areas, families were informed when their file was being closed and they were referred to support services where required. Many areas made use of closure summaries and the reason the case was being closed was clearly recorded. Some used written chronologies of important events in the child's life and also included checks of ongoing support needs and other agencies' continued involvement prior to closure.

The Dublin South East/Wicklow service area used child-friendly closure letters to inform children of the closure of their case, including an acknowledgement of the child's original worries and reminding the child of the importance of continuing to talk to the supportive adults in their lives. Parents in the Dublin South East/Wicklow service areas were also sent similar letters which reflected an acknowledgement of the parents' involvement and thanked them for their participation in the relevant processes. In the Galway/Roscommon service area, the development of a child-friendly closure letter was included as an action in their service improvement plan.

Areas of practice requiring improvement in relation to case closure included:

- having a consistent and standardised method of informing children, parents and professionals that cases were being closed
- not allowing cases to drift which resulted in delays in closing the case.

[4] A protocol (*Tusla and An Garda Síochána Children First – Joint Working Protocol for Liaison between both Agencies*) is in place between the two agencies that details how they cooperate and interact in dealing with child welfare and protections concerns.

## Conclusion

HIQA as part of its ongoing monitoring of services will continue to monitor each Tusla service area and when required will carry out risk based inspections. As outlined throughout this report, the service areas involved in this programme were committed to continuously improving their service. It is the responsibility of each service area to implement ongoing quality improvements in their service under the governance of Tusla's national office.

This programme of inspection focused on the receipt and management of referrals up to and including an initial assessment. At the conclusion of an initial assessment if a child is assessed as being at ongoing risk of significant harm, a child protection conference is held to develop a multidisciplinary safety plan and are placed on the child protection notification system.

In August 2021, HIQA commenced a focused programme of inspection of the management of children who are at ongoing significant risk of harm and who are placed on Tusla's child protection notification system. All 17 of Tusla's service areas will be inspected as part of this programme of inspection.

# Appendix 1 – Members of the External Advisory Group (EAG)

This group comprised representatives from:

- The Child and Family Agency (Tusla)
- The Department of Children, Equality, Disability, Integration and Youth
- Barnardos
- EPIC Empowering People in Care (an advocacy organisation for children in care and care leavers)
- Trinity College Dublin
- The Director of People (Children and Adults) from Medway Council in the United Kingdom.

# Appendix 2 — Thematic inspections by service area

| Service area | Inspection dates |
|---|---|
| Mayo | 1-4 October 2019 |
| Sligo/Leitrim/West Cavan | 22-25 October 2019 |
| Cavan/Monaghan | 11-14 November 2019 |
| Kerry | 25-28 November 2019 |
| Galway/Roscommon | 28-31 January 2020 |
| Dublin South East/Wicklow | 10-13 February 2020 |
| Donegal | 10-12 March 2020 |
| Mid-West | 5, 6, 10, 11 August 2020 |
| Waterford/Wexford | 31 August, 1-3, 7 September 2020 |
| Dublin North City | 16, 17, 21, 22 September 2020 |
| Louth/Meath | 30 November, 1-3 December 2020 |
| Midlands | 22-26 March 2021 |

**Published by the Health Information and Quality Authority (HIQA).**

For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7
D07 E98Y

Phone: +353 (0) 1 814 7400
Email: info@hiqa.ie
URL: www.hiqa.ie



Safer Better Care