Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of service area:	Dublin North
Name of provider:	Child and Family Agency Tusla
Type of inspection:	Risk based
Date of inspection:	22-25 February 2021
Lead inspector:	Erin Byrne
Support inspector(s):	Bronagh Gibson, Eva Boyle, Leanne Crowe, Pauline Clarke Orohoe, Sabine Buschmann

About monitoring of child protection and welfare services

The Health Information and Quality Authority (the Authority) 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 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, the Authority carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** 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 the Authority's findings.

The Authority inspects services to see if the National Standards are met. Inspections can be announced or unannounced. This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☒
Theme 4: Use of Resources	☐
Theme 5: Workforce	☐
Theme 6: Use of Information	☐

How we inspect

As part of this inspection, inspectors met with social work managers and staff. Inspectors observed practices and reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager and principal social workers
- focus groups with social work team leaders, social workers and social care staff
- speaking with parents and children
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a family welfare conference and referrals meeting for community services
- the review of 79 children's case files.

The inspection team issued a standard request for documentation and data to the service area in relation to each theme of the inspection. The inspection team endeavored to evaluate progress within the area in the management of identified risks and engaged with the social work teams and management with respect to progress in addressing risks ongoing within the service throughout 2020.

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

Profile of the service area

The Child and Family Agency

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

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

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

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

Service area:

Dublin North is one of the 17 areas within Tusla's Child and Family Agency and is part of the Dublin North East (DNE) Region. Dublin North local health area encompasses two geographical local authority catchment areas, namely Fingal County Council and Dublin City Council.

The aggregate population of the North Dublin is 358,009. North Dublin Service Area includes a portion of Dublin City Council, equating to a population of 87,117 and Fingal County Council, with the exception of Dublin Airport. Fingal has one of the highest birth rate in the country (19/1000 population). The 2016 Census shows that Fingal is one of the fastest growing counties in Ireland with a percentage population increase of 8.1% per year. There was a 12.4% increase of 0-17yrs from 89,580 to 100,654, representing 27.5% of the Area's total population. This is the third highest child populated Tusla Area in the country.

The 2016 Pobal HP Deprivation Index revealed 23.43% of the population of Balbriggan live in disadvantaged areas. The Census 2016 highlights that Fingal has

three of the fastest growing electoral divisions in the state, namely Balbriggan, Blanchardstown and The Ward.

The area is under the direction of the Service Director for the Tusla Dublin North East region and is managed by the Area Manager.

Child Protection and Welfare:

Dublin North service area is part of Tusla's Dublin North East Region which is oversee for the Service Director for Dublin North East. The child protection and welfare service in the area has three office sites, located in Swords (Airside), Coolock Primary Care Centre and Blanchardstown Primary Care Centre (Grove Court). There was a reconfiguration of the areas service provision in June 2020 to meet the changing demands and growth communities of the Area.

The 'Front Door' in Dublin North includes Screening, Preliminary Enquiry, Duty Intake/Initial Assessment and Assessment & Intervention teams up to requests for Child Protection Conferences (CPC). There are three screening and preliminary enquiry teams and nine Assessment and Intervention teams in the area. The screening and preliminary enquiry teams are overseen by two social work team leaders and they are line managed by the principal social worker for screening and preliminary enquiry. The nine assessment and intervention teams in the area include three pre-allocation teams. Three principal social worker have responsibility for direct line management of two social work team leaders and a senior social work practitioner, each of whom in turn manage teams of 4-6 social work and social care staff.

Referrals to the child protection and welfare service are received from mandated people such as schools, doctors, community workers, Gardaí etc. via the portal or the standard report forms by post or phone calls. Service users can also self-refer and members of the public may also make referrals. There were 5664 new referrals in 2020, an average 472/month. This amounts to an increase of 1822 referrals on 2019 figures (3842). There were 3415 referrals in 2018. The primary sources of mandated referrers are An Garda Síochána, schools and other professionals.

Compliance classifications

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

Compliant	Substantially compliant	Non-compliant Moderate	Non-compliant Major
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.	The service is not compliant with the standard. Where the non-compliance (moderate) does not pose a significant risk to the safety, health and welfare to children using the service, the provider must take action *within a reasonable time frame* to come into compliance.	The service is not compliant with the standard. Where the non-compliance poses a significant risk (major non-compliance) to the safety, health and welfare of children using the service the provider responds to these risks in a timely and comprehensive manner.

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

1. Capacity and capability of the service:

Leadership, Governance and Management

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

2. Quality and safety of the service:

Safe and Effective Services

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
22/02/2021	09:00 – 16:00	Erin Byrne Pauline Clarke Orohoe Sabine Buschmann Bronagh Gibson Leanne Crowe	Lead Inspector Inspector Inspector Regional Manager Inspector (Remote)
23/02/2021	10:00 – 16:00	Erin Byrne Pauline Clarke Orohoe Sabine Buschmann Bronagh Gibson Leanne Crowe	Lead Inspector Inspector Inspector Regional Manager Inspector (Remote)
24/02/2021	10:00 – 16:00	Erin Byrne Pauline Clarke Orohoe Sabine Buschmann Bronagh Gibson Eva Boyle Leanne Crowe	Lead Inspector Inspector Inspector Regional Manager Interim Head of Programme (Children's Services) Inspector (Remote)
25/02/2021	10:00 – 16:00	Erin Byrne Pauline Clarke Orohoe Sabine Buschmann Bronagh Gibson Eva Boyle Leanne Crowe	Lead Inspector Inspector Inspector Regional Manager Interim Head of Programme (Children's Services) Inspector (Remote)

Views of people who use the service

Inspectors spoke with members of eleven families, including ten parents and two children as part of this inspection, to seek their views on the service. When asked about their experience of having a social worker involved with their family, the response received from parents and children was mainly positive, particularly with respect to their experience of interactions with social workers. However, waiting periods and long delays were a feature of their experience for three of the parents spoken to and six of ten when asked, suggested improvements were required relating to timeliness of service provision.

Of ten parents who spoke with inspectors nine described positive, effective interventions and a supportive experience. Parents said that social workers were, "very reassuring and friendly", that they really "stepped up and took action" to protect their child. One parent said that the social worker had adapted her communication style effectively "so that the child could trust more easily" and another told inspectors that they had "clear communication and very positive interactions". Both children said that their social worker was "nice" and both were comfortable talking to their social workers about their situation and challenges within their family. For one family the experience had not been positive, their case had been placed on a waiting list following screening in December 2020 without any further contact or interaction.

Inspectors asked parents if there were areas that they would suggest could be improved by the service and the majority (7 of 10) were clear with respect to their interactions with member of staff from the social work department, their experience was positive. However, six of ten parents suggested improvements in communication from the social work department. One parent struggled without the availability of an interpreter during some interactions and suggested that this service be routinely available for all interactions where required. The remaining five suggestions for improvement concerned timeliness of response to concerns and delays or waiting times for a service. Parents said "I don't think Tusla take action quick enough", "Tusla can be slow to take action sometimes" and that they wished Tusla had taken "urgent" action sooner.

All parents and children were clear on the reasons for social work involvement and felt they were included in decisions. Where required, safety planning had taken place for all families and each was clear on the reasons for the discussion around safety as well as agreed plans.

Capacity and capability

In July of 2019 HIQA were informed by Tusla that Dublin North Service Area was subject of a service improvement plan put in place as part of the National Unallocated Cases Service Improvement Project, to address identified risks within the service. Throughout 2019 and 2020 HIQA sought regular updates on progress made to address these known risks. Due to persistent significant risks within the service, a decision was made by HIQA that a risk based inspection would be undertaken, focusing specifically on the progress with respect to the management of risks within the child protection and welfare service.

Dublin North social work child protection and welfare service is one which has been operating under considerable strain for a significant period of time. A shortfall between the demand for a child protection service, and the resources to meet that demand has existed for a number of years; this remained the case at the time of this inspection. Good governance structures, effective leadership and efficient use of data and information meant that despite this shortfall, children at highest level of risk were priortised and their needs met. At the time of inspection there was no longer a waiting list for children identified as needing a child protection conference and no high priority cases waited for a service. Staff's approach to working with families was child-centred and they were committed to ensuring the safety and protection of children. Safety planning was embedded in day to day practice and risk management was a key feature of the management priorities within each team. However, delays did exist throughout the service, and all children who required it did not receive a timely, safe service. Despite consistent reduction in the numbers of children and families impacted, at the time of inspection children identified as medium or low risk still waited unacceptable amounts of time for an assessment of their safety in many cases and long delays resulted in prolonged and increased risks for some of these children. At the time of inspection 711 cases were awaiting a child protection service at varying stages of the process.

The service had effective governance arrangement in place and clearly defined strategic objectives. Improvement plans which were aimed at meeting their obligations under Child Care Act, 1991, the Child and Family Agency Act 2013 and Children First Act 2015 were closely monitored and measures to address risks and adapted as required. The area had a service improvement plan which was being implemented since 2019 with particular focus on addressing long standing risks associated with waiting lists for a service at all stages of the child protection process. The area manager and principal social workers were clear on their service goals for

2021, to reduce waiting lists within the service and work towards achieving compliance with national standard business processes.

However, while the number of children waiting had consistently reduced, the service was not meeting requirements in line with national standard business processes. The sheer volume of children who waited for a service throughout 2020 meant that at the time of inspection the predominant focus for allocation of resources remained on addressing long standing risks and the backlog of cases. One of the main roles of all managers in the service was prioritising children who received a social work service against those who needed one but had to wait.

During the summer of 2020, there was a substantial re-structuring of the child protection and welfare service which allowed for a better flow of cases from the front door through to assessment and intervention teams. Throughout 2020 and up to the time of inspection in February 2021 addressing staffing deficits was a key priority of service planning as well as service provision. The restructuring of the child protection service led to an amalgamation of duty and child protection and welfare teams into the assessment and intervention pillar. This also involved the creation of dedicated screening and preliminary enquiry teams in each of the three offices. Nine assessment and intervention teams with responsibility for initial assessments and safety planning were also created, with three principal social workers overseeing three teams each. These changes helped to achieve consistent progress in the reduction of waiting lists throughout the service since August 2020.

The service management team had put effective initiatives in place to reduce the backlog of cases awaiting a service. Due to the high level of referrals, ongoing deficits in staffing resources and the practice of ensuring high priority cases were allocated, a significant amount of medium and low priority cases accumulated on a waiting list for allocation within the service. One of these initiatives was the use of commissioned services to complete initial assessments on lower priority cases. A recent initiative was the introduction of three pre-allocation teams, created within the assessment and intervention teams each led by a senior social work practitioner. These pre-allocation teams accepted cases identified as requiring an initial assessment following completion of a preliminary enquiry which could not be immediately allocated for assessment. At the time of inspection all high priority cases were allocated directly to the initial assessment teams with medium and low priority cases on waiting list for allocation sent to these pre-allocation teams. The focus of the pre-allocation teams included;

(1) ensuring that the immediate safety plans agreed at completion of preliminary enquiry were adequate,

(2) responding to all new re-referrals received on open cases awaiting allocation and to review the case in light of new information received and
(3) completing set tasks as identified by the principal social worker (PSW) & senior social workers as part of the review process for cases awaiting allocation, including, meetings with children and or development of safety networks with families.

These initiatives achieved good progress in the six months prior to inspection, in reducing waiting lists and improved the systems for safe management of cases while they awaited allocation to a social worker.

There were clear reporting procedures and lines of communication in place. The service management team were fully aware of the risks in their service and these risks were being effectively managed within each team. In late 2020, the service management team, through the established governance systems in place to monitored progress in the area, recognised that a bottle neck of low priority cases had developed at the front door. Where high and medium cases took priority for allocation, as well as action within the pre-allocation teams, efforts to manage low priority cases had limited success. In an effort to address this issue, a 'lows project' was created in the service in December 2020. Three specific workers were employed for this project. The initial focus was to address cases requiring minimal interventions from the pre-allocation teams, mainly legacy cases which had been awaiting a service over a significant period in 2020. The initial timeline for this project was four weeks however this had been extended and remained ongoing at the time of inspection.

The area manager provided regular supervision to all principal social workers during which service data and progress on meeting targets were reviewed. There were six weekly governance meetings attended by the child protection and welfare management team, the agenda for which included review of progress on the service areas quality improvement framework, service improvement plans as well as risk escalations and complaints. There were effective structures in place for reporting on progress and risks externally to the regional service director also. The area manager received monthly supervision from the regional service director and reported regularly on data relating to staffing, unallocated cases and progress on implementation of improvement plans.

The quality, timeliness and recording of supervision required improvement. Inspectors examined records of supervision for 16 staff including principal social workers, social work team leaders, social workers and social care workers. The quality of these was mixed in that only half (8 of 16) were found to be compliant or substantially compliant with requirements for the provision of supervision in line with Tusla Policy. In the other 8 records examined supervision was found to be sporadic or infrequent,

details recorded were not consistent and varied in quality. There was not a record of case management discussion or rationale for decision in all cases examined and not all functions of supervision including training and professional development were addressed.

There were good systems in place for monitoring and evaluating progress within the service on a regular basis. There was a clearly defined system for auditing which was implemented effectively and the findings of which were routinely shared. The area manager told the inspector that priorities for audit were based on present needs and the highest identified risks. Priorities were discussed as part of area management meetings and learning was routinely shared to inform practice in the service. However, the area manager also identified the need to more closely align the areas audit schedule with their service improvement priorities in order to ensure that focus was given to the areas of highest risk and needs, and that the actions to address findings of audits could be realistically achieved.

Inspectors examined a schedule of audits in place for 2021 and found that the priorities for auditing within the child protection and welfare service were appropriate and in line with service improvement priorities. The schedule included; an audit of intake records and adherence with timeframes as required by standard business processes, evidence of the voice of the child within records, review of unallocated cases; timeframes unallocated and last activity, an audit of all safety plans on unallocated cases at the assessment and intervention stage and an audit of staff supervision files for compliance with Tusla Policy. In addition, monthly reviews of unallocated cases and action plan progress updates were scheduled, the findings of each to be reported directly to the area manager. Social workers told inspectors that they received regular feedback from audits and managers spoke about the effectiveness of audits at evaluating progress within the service.

Inspectors found the implementation of actions to address findings from audits and ensure improved practice was slow and required improvement. Inspectors sampled an audit of supervision records completed in June 2020, which identified deficits in the provision of supervision, the same as those found during this inspection. Effective and timely action had not been taken to address the findings of this service audit.

Qualified and experienced managers provide strong leadership to staff. Managers told inspectors that their improvement plans in place were designed to achieve compliance with national standards and anything less was not acceptable to them. They told inspectors that their current situation meant that the key focus was on managing risks within the resources available. Each manager was confident that risks were effectively managed within their service.

Inspectors found that improvements were required with regard to evidencing managerial oversight. Social work team leaders said that they provided regular support to staff and maintained a close level of oversight of decisions on cases. However, inspectors found that mechanisms for recording this oversight were not adequate. Individual case supervision records were not routinely placed on children's files. Therefore clear records of management input into practice or decisions on a case, were not always available on children's files.

Inspectors found through discussion with team leaders that they had a high level of knowledge about cases and when clarification was sought on actions or decisions this was provided. A review of files identified that social work team leaders also completed tasks and required actions on many cases, particularly those which could not wait. While this supported the management of urgent or immediate risk, it did not support effective and sustainable management systems. The necessity for managers to complete tasks typically assigned to social workers had a knock on effect in creating further delays within the service. Inspectors found delays in sign off on records by managers, such as intake records documenting preliminary enquiries or initial assessment reports, which further impacted on children moving between teams to the next stage of the child protection process.

In addition, it had become routine practice in the area that managers provided direct input and oversight on interventions assigned for completion by student social workers or social care staff. However, not all of these staff had access to children's records. There was no clear procedure in place for ensuring that records of action taken or interventions with families by staff members without access to the national child care information system (NCCIS), were documented efficiently and effectively as part of children's case files.

The service had a risk register which was reviewed and updated regularly as required and appropriately identified risks, such as risks associated with children awaiting a child protection service. Mechanisms put in place to manage these risks, as well as improved management structures, had achieved progress in reducing the impact of risks on children and families, particularly since August 2020. Where ongoing risks could not be resolved locally these were escalated up through regional and national channels within Tusla as required. While the risk register was reviewed routinely, it rarely changed as the risks within the service were persistent for a number of years. Risks relating to unallocated cases as well as non-compliance with standard business processes were listed on the areas risk register since 2018, and these remained the prominent risks within the child protection and welfare service at the time of inspection.

The service effectively managed risks which presented as a result of Covid 19 and continued to provide child protection and welfare services throughout the pandemic. Creative solutions were identified for ensuring families were supported and where necessary home visits and face to face contact with children continued. Staff members were supported to adapt their work to include remote working arrangements as required. The management team ensured that new staff members were inducted into their roles effectively through resourceful management of office space and collaborative team working throughout the service.

There were arrangements in place for the monitoring and management of risks associated with unallocated cases but these required improvement. The effectiveness of oversight arrangements for cases on waiting lists was dependent on the demand for the service. Decisions were guided by a priority in all instances to address the highest risks and while this was appropriate in the circumstances, it meant there was a lack of capacity to address lesser risks for prolonged periods. Cases that awaited allocation were reviewed by managers but there was no clear system in place to ensure that these reviews were effective at identifying and managing risks. There was no clear timeframe between reviews, they were not clearly or consistently recorded and where reviews occurred and identified actions for completion, these were not completed as required in all cases. There was no clear system in place which ensured consistent, timely and effective review of cases awaiting allocation.

In examining the management of risks inspectors found that there were monitoring systems in place which ensured that managers had regular review of their teams practice and quality of the service. Principal social workers demonstrated to inspectors a working knowledge of cases in their respective teams particularly those awaiting allocation. Principal social workers told inspectors that they provided hands on support and direct line management on a daily basis due to demands of the service.

Inspectors found that when children were receiving a service, they received good quality care and protection and in most cases, were safer as a result of engaging with the service. Children experienced a consistent approach from staff providing the service and benefitted from learning which had been identified as a result of previous successes and challenges. Children's views were clearly represented within records and their needs as well as their best interest was the key message delivered throughout records examined by inspectors. Parent's views were clearly documented where these were available and social workers documented analysis of risks and strengths within families illustrated a respectful and collaborative approach to their work with children and families.

Social workers and managers who met with inspectors presented a culture of commitment to serving the best interest of children at every level, ensuring their safety and protection and promoting the welfare of children being at the forefront of all decisions within the service. The culture of the service was found to resonate within the experience of families who spoke with inspectors in that they all spoke positively about their interactions with staff. Parents felt they were treated fairly, they were supported and respected and their opinions as well as those of their children were valued.

There was a culture of continuous learning and development promoted amongst the managers within the service and social work and social care staff told inspectors that they were supported and encouraged by all managers throughout the service. There were clear mechanisms in place for notification and review of serious incidents and learning from such events were shared with all staff within their established communication structures. Staff told inspectors that they were supported to develop their practice. They talked about a culture of open communication where no question was unwelcome and where support was available at all times. Managers told inspectors that staff support was a key priority for them particularly in light of the number of new staff in the service. They also said that ensuring staff were supported to develop skills would benefit children and families and would encourage them to remain in the service. This was a key priority which informed decisions of managers.

Allocation of children to social worker was considered and decisions to allocate a child was based on a number of factors including caseload, level of risk / need of the child and experience of the social worker. There were buddy or shadow systems in place which enabled less experienced staff to learn from more experienced colleagues while being supported to do so. Staff were given opportunities to learn basic practices and systems by being allocated to lower priority cases with direct oversight of a manager and this worked well to build social work skills and practice.

There was good use of data within the service and this informed planning as well as service delivery. Nonetheless, improvements were required with respect to the management of children's records, particularly clear procedures for reporting, recording and retaining information relating to actions or interventions completed by staff members who do not have routine access to the national child care information system. In certain circumstances, student social workers completed interventions and or required actions in relation to a case on the direction of their manager. While these activities were appropriately supervised and overseen by managers within the service, they were not always appropriately recorded.

In addition, inspectors identified a number of cases where records of action taken to address risks to children were not available on their files and sought assurances from social workers only to be informed that all pertinent information was available on

their siblings file. In other circumstances where assurances were sought due to the absence of evidence of action taken to address risks to a child, written records were not available as these had not been uploaded to the child's file. Improvements were required to ensure that all children's files contained an up to date accurate record of supports and interventions provided. As referenced above, where student social workers or other staff members who did not have access to the National Child Care Information System were engaged to provide supports to children and families there was no clear mechanisms in place for ensuring these interventions were recorded and stored as required.

Records of management meetings and decision-making forums are well recorded. Actions were clearly identified and there was good follow through on decisions.

Child Protection and Welfare **Standard 3.1** The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	**Judgment** Non-Compliant Moderate
There was a shortfall in capacity to meet the service demands and the service was not meeting requirements in line with national standard business processes. Governance and oversight of cases awaiting allocation required improvement. There was no clear system in place which ensured consistent, timely and effective review of cases while they awaited allocation. Improvements were also required with regard to evidencing managerial oversight in many cases and the quality, timeliness and recording of supervision of staff was not in line with Tusla policy. It is for these reason that the service has been judged non-compliant moderate with this standard.	
Child Protection and Welfare **Standard 3.3** The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.	**Judgment** Non-Compliant Moderate
Systems for monitoring and evaluation of service provision required improvement to ensure sustained progress and consistent review of risks. Risks relating to unallocated cases as well as non-compliance with standard business process remained on the service risk register since 2018. This was despite being escalated to regional and national level. More substantial action was required to effectively address these risks. Inspectors also found that actions to address findings from service audits were slow to be implemented. It is for these reasons that the service has been judged to be in moderate non-compliance with this standard.	

Quality and Safety
Safe and Effective Services

Improvements were required to ensure that all child protection and welfare referrals were managed in a timely manner in line with Children First 2017. Immediate risk to children were effectively managed. Where preliminary enquiries and initial assessments were undertaken by social workers, interventions were good quality, child-centred and effectively ensured that children were safe. However, preliminary enquiries were not completed within the required 5 day period and delays in many cases meant that children waited in situations where risks existed for unacceptable periods of time before social workers took this initial action to fully understand the severity, nature and impact of these risks. There were also delays in completing initial assessments. Delays in commencements and completion of assessments impacted on the quality and safety of service delivery.

There was a clear procedure for screening referrals received into the service which was consistently implemented throughout the areas screening teams and this was found to be effective. The service ensured that all referrals were screened promptly with evidence of screening within 24 hours of receipt was found on the majority of files examined. Referral received into the service from An Garda Síochána were all received and reviewed by the PSW, who then closed or directed them to the relevant teams as appropriate.

The screening process was prompt and effective at establishing the appropriateness of each referral to the service and referrals which indicated a high level of risk to a child were effectively identified and prioritised for allocation for completion of the next stage of the process, preliminary enquiry.

Instances where referrals indicated high level of risk or immediate risks to children were responded to appropriately. These cases were priortised for allocation to a social worker for intervention. Where necessary immediate action was taken by the screening team social worker in collaboration with an identified social worker from the assessment and intervention team to ensure the safety and protection of a child. Inspectors examined nine referrals which indicated immediate risk to children, each of which was responded to effectively and were promptly allocated to a social worker.

Each screening team who had responsibility for reviewing all referrals within 24 hours of receipt also had responsibility for completing preliminary enquiries. Preliminary enquiries were not completed in line with standard business processes and delays at this initial stage of the child protection and welfare process posed a risk to the children who waiting a service. Where preliminary enquiries were completed inspectors found that the social work practice was good quality, child-centred and

effectively ensured that children were safe. Records of preliminary enquiries which had been completed were good quality, contained all relevant information and detailed analysis of information which informed decisions relating to a case.

Inspectors examined 57 referrals for the purpose of assessing the quality and timeliness of screening and preliminary enquiries and found despite referrals being screened promptly, there were delays in completing preliminary enquiries in 88% (50 of 57) of cases examined. For some children, this meant that risks to their safety were prolonged and interventions to support them were delayed as a result of being placed on a waiting list for preliminary enquiry. In 37 out of the 57 referrals, inspectors found that social workers had taken action to ensure children's safety while they awaited completion of preliminary enquiries. Of the remaining 20, long delays in completing the preliminary enquiry's meant potential risks went unassessed for significant periods. Despite this, inspectors did not find any that children were harmed or placed at risk of harm owing to delays in these assessments.

Amongst the cases examined for timeliness as part of this inspection periods of delay varied for example, five were completed in under a month but two remained ongoing for almost a year since March 2020. Four took more than six months to complete, while another two referrals received six months prior to the inspection, remained ongoing and open to the service, at the time of inspection.

Where there was a suspected case of physical or sexual abuse and or wilful neglect, this information was shared with An Garda Síochána as required in all cases examined. It is of note however, that there were delayed in reporting allegations of abuse to An Garda Síochána in five of 18 cases examined.

Overall safety planning in the area was of mixed quality. Where children were allocated a social worker, the quality of safety planning was good. However, where children awaited allocation to a social worker, safety plans were not monitored or reviewed as required. Safety planning was a key part of procedures in place for ensuring children were protected and agreeing safety plans with children and families was common practice within the service. Inspectors reviewed 25 files for the purpose of examining the quality and timeliness of safety plans in place and found the majority 80% (20 of 25) were good quality. Poor quality safety plans were identified in 20% (5 of 25), for the most part due to delays and long gaps between monitoring and or reviews of safety plans, for children on waiting lists for allocation.

Safety planning judged to be good quality had evidence of regular review and monitoring. Case records evidenced detailed discussions with children and families agreeing safety measures, which included the identification and involvement of a

support networks. Safety planning arrangements reviewed by inspectors included details of action taken to ensure children were fully aware of agreed plans for their safety and protection. However, children who awaited allocation to a social worker received less than ideal level of intervention or support. Social workers monitoring of safety plans through check in's with families and network supports was less frequent. Where changes in circumstances occurred these were not responded to promptly in all situations. For example, the impact of schools remaining closed following Christmas break did not increase the priority level of cases for review of safety planning, despite schools forming part of network supports for children concerned.

Inspectors found that despite gaps in review and monitoring of safety plans in some cases, there was good awareness of these cases amongst the management team. Additionally, alternative support services were engaged to aid in supporting children and families where the child protection and welfare service could not meet requirements. At the time of inspection all safety plans had been reviewed as required in the weeks and months prior to inspection despite long gaps since their previous contact with the social work department. Improvements in timeliness and frequency of monitoring of safety plans were evident and this was set to continue. However, further improvements were required to ensure continued relevance and effectiveness of agreed safety plans, particularly where there were changes in circumstances for children and families.

The quality of completed initial assessment reports was good but there were delays in commencements and completion of assessments. There was a significant waiting list for children who required an initial assessment mostly made up of those who had already experienced delays while awaiting preliminary enquiries. High priority cases were allocated promptly and those cases which indicated high levels of risk were rarely placed on a waiting list and never for long periods of time.

The quality of completed initial assessment was good, social work practice was child centred and assessments were comprehensive. Inspectors reviewed 18 completed initial assessments for the purpose of examining timeliness and quality. Sixteen of 18 completed assessments examined were found to be of good quality. Children were seen and consulted where appropriate in all cases and there was evidence of clear communication with parents. Where required professionals from other disciplines were contacted for their input into the assessment and there was evidence of managerial oversight. Social workers clearly documented all identified risks to children as well as their analysis of these risks as to how they impacted on the child's safety. Decisions resulting from initial assessments were appropriate and based on information gleaned through the course of assessment, decisions considered the views of parents and children and outcomes of each assessment was clearly recorded

and communicated with all relevant people. Two of 18 completed initial assessments were judged to be of poor quality as there was no evidence of communication with anyone outside of the immediate family and there was information within one assessment which was not relevant to the concerns being assessed.

Initial assessments were not completed within timeframes outlined in standard business processes and periods of delay varied greatly. Owing to these delays, there was a negative impact on children and families as supports and services which were identified as being required during assessment were not provided sooner. Of 18 completed initial assessments examined only five were completed promptly as required and there were delays in the remaining 13. Timeframes for delays varied and most of those examined were significantly outside of the 40 day timeframe for their completion. For example, four initial assessment reviewed by inspectors were completed in the weeks prior to this inspection. These related to referrals received in March, August, September and November of 2020. Social work staff told inspectors that delays in completing assessments once commenced, predominantly resulted from a need to prioritize high priority referrals as they were received into the service. In 18 completed assessments reviewed by inspectors, an outcome of ongoing risk of significant harm to the child was identified in 8. Only four of these assessments were completed without delays. In one of the four cases examined the child had waited from October to February for the commencement of the initial assessment which identified ongoing risk of significant harm and required child protection intervention, illustrating the potential impact of delays early in the child protection process on children at risk of harm.

Inspectors examined four cases where further assessment was required and found that once an initial assessment had identified the need for further assessment these occurred promptly. Evidence showed that once risks to a child were identified, interventions to ensure the child's safety were promptly implemented and were effective.

Waiting lists were a predominant features of all stages of the child protection and welfare process. Procedures in place were not fully effective at ensuring consistent and safe monitoring of cases, while they awaited a service.

Data provided by the area prior to inspection indicated that there were in total 711 cases on waiting lists within the service. Of these 711, 64 awaiting preliminary enquiry, 408 awaiting initial assessment and 239 cases awaited allocation for completion of other actions or interventions such as safety planning. Importantly no cases identified as high priority remained on the waiting list at the time of inspection and no children at risk were identified by inspectors. Concerning delays reported in

September 2020, for children and families requiring a child protection conference, had been effectively addressed and in all cases where a high level of risk was indicated or immediate risk was identified these were responded to promptly and effective action was taken to ensure children were safe.

The service had achieved a reduction in numbers of cases on waiting lists for allocation in the six months prior to inspection. Published data relating to numbers of unallocated cases, reported 1065 cases unallocated in Dublin North in the third quarter of 2020. The restructuring or the service and reorganisation of resources had achieved progress in reducing the volume of children and families impacted by delays. While the progress in reducing the waiting list was positive, the management of cases awaiting allocation was inconsistent and did not ensure that risks to children were adequately assessed in all cases. Inspectors identified cases awaiting allocation for significant periods without review as well as cases which were reviewed by a manager and clear actions to be implemented had been identified but the mechanisms in place for ensuring these actions were implemented were flawed, as children often waited again before identified actions were completed.

Interval between reviews of cases awaiting allocation varied greatly and there was no consistently agreed criteria determining the timeframe for review of cases. Inspectors examined cases on a waiting list for shorter periods which were subject to multiple reviews and others where reviews were undertaken up to five months apart without any contact or action taken to ensure relevance or accuracy of information in identifying actions or recommendations of the review.

Children's records were not up to date in all cases and there was a backlog of case notes and records absent from children's case files, which had the potential to impact on the quality of decision making in reviews of cases awaiting allocation. Records evidencing interventions which supported accurate review of cases were not available on children's care files in all cases. In the majority of circumstances, where this was identified as an issue by inspectors, social workers or their managers were able to provide clarity and further information supporting actions or recommendations on a case. Inspectors were told that this issue related to uploading of records rather than sharing of information. Social workers told inspectors that they had received a verbal handover of relevant information upon allocation of the case therefore were confident that actions agreed on these cases had considered all relevant available information, despite the absence of up to date records on a child file.

Inspectors also found some instances where records were retained on one child's file with no evidence of intervention or action on case files of their siblings. This led to confusion and concern for inspectors in review of some cases which was later allayed

by provision of information from a siblings file. Inspectors observed, during a meeting in relation to review of cases awaiting allocation on the screening team, a child named on the waiting list was known by a member of the team to be a sibling of another child who was allocated and their assessment ongoing. Delays at initial stage of the process with respect to conducting basic initial checks meant that connections between referrals for example multiple referrals relating to one family, were not always promptly identified.

There was a clear and effective procedure in place for dealing with new referrals on cases already open to the service. The processes in place ensured that new information was considered in reviews of children's cases. However, where addition or new referrals on open cases which were awaiting allocation were received there was a procedure in place to close new referrals and cross reference the original referral which was ongoing. This practice meant that due to delays and waiting lists referrals received in 2020 were being addressed in assessments, potentially ongoing since 2019. The service required clear procedures for ensuring that all new referrals containing additional or updated information, were considered as part of ongoing review of a case awaiting allocation and assessments, as well as, clear mechanisms for recording this information.

Cases were closed appropriately but, there was drift due to delays in completing tasks required prior to closure in more than half of all cases examined. Inspectors reviewed 17 closed cases for the purpose of examining quality as well as appropriateness of closure and found all cases were closed appropriately. In the majority of those examined a summary of action taken and rationale for closures were recorded within intake records or initial assessments, and families were notified of closure as required. There were delays in closing in 10 of 17 cases reviewed by inspectors. Delays included drift in sign off on documents by managers or delays in completing tasks such as sending letters notifying families of closure, all of which needed to be completed prior to closure. Inspectors found that delays did not impede families transferring to other services however as referrals were promptly made as required.

Child Protection and Welfare **Standard 2.2** All concerns in relation to children are screened and directed to the appropriate service.	**Judgment** Non-compliant Moderate
There were delays in completion of preliminary enquiries, some significant, resulting in prolonged risks to children and families who awaited supportive or protective interventions by social workers. There were delays in reporting of allegations of abuse to An Garda Síochána in some cases. While progress had been made, there remained a need for significant improvement to achieve compliance with national standards and to ensure safe and effective service.	
Child Protection and Welfare **Standard 2.3** Timely and effective action is taken to protect children.	**Judgment** Non-compliant Moderate
Social work practice and oversight in respect of safety planning was good, albeit impeded by the lack of the capacity of the service to fully meet demands. Immediate action was taken where required. While all safety plans had been reviewed as required in the weeks and months prior to inspection there were significant periods of time during which children and families subject to safety plans had no contact with a social worker. Improvements were required with respect to timeliness and frequency of monitoring of safety plans for some children and the potential impact of changes in circumstances required greater consideration in assessing the ongoing effectiveness of safety plans. It is for these reasons that the service has been judged substantially compliant with this standard.	
Child Protection and Welfare **Standard 2.4** Children and families have timely access to child protection and welfare services that support the family and protect the child.	**Judgment** Non-compliant Moderate
The management of cases awaiting allocation was inconsistent and did not ensure that risks to children were adequately assessed in all cases. Interval between reviews of cases awaiting allocation varied greatly and there was no consistently agreed criteria determining the timeframe for review of cases. Procedures for monitoring and recording information considered as part of reviews varied also in that documentation evidencing interventions which supported accurate review of cases were not available on children's care files in all cases. It is for these reasons that the service has been judged in moderate non-compliance with this standard.	

Child Protection and Welfare **Standard 2.5** All reports of child protection concerns are assessed in line with Children First and best available evidence.	**Judgment** Non-compliant Moderate
The quality of completed initial assessment reports was good. However, delays in commencements and completion of assessments impacted on the quality and safety of service delivery to children and families. Initial assessments were not completed within timeframes outlined in standard business processes. There was a significant waiting list for children who required an initial assessment, mostly made up of those who had already experienced delays while awaiting preliminary enquiries. Children's records were not up to date in all cases and the practice for linking cases involving siblings required improvement to ensure information was available on all children's files. Due to the delays in commencements and completion of assessments, the service was identified as being in moderate non-compliance with this standard.	

Compliance Plan

This Compliance Plan has been completed by the Provider and HIQA has not made any amendments to the returned Compliance Plan.

Provider's response to Inspection Report No:	MON-0031589
Name of Service Area:	The Child and Family Agency, Dublin North
Date of inspection:	22nd – 25th February 2021
Date of response:	Initial submission date 14th May 2021 Response delayed due to inability to access report as a result of cyber-attack. New submission date is 11th June 2021. Second submission date is 30th June 2021

These requirements set out the actions that should be taken to meet the *National Standards for the Protection and Welfare of Children* (2012).

2: Safe and Effective Services

Theme Standard 2.2
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

1. Preliminary enquiries were not timely in line with Tusla standard business processes and this resulted in prolonged risks to children and families who awaited supportive or protective interventions by social workers.
2. There were delays in reporting of allegations of abuse to An Garda Síochána.

Action required:

Under **Standard 2.2** you are required to ensure that:

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

Please state the actions you have taken or are planning to take:

Actions Tusla North Dublin plan to take:

Action 1:

1.1 Practice intensive workshops will be scheduled quarterly to compliment the Lows and Mediums project to reduce wait times at the front door and close cases. This will be commenced in Q3 2021 and reviewed in Q1 2022. This interim action will continue until requisite staff are in place to meet this standard.
Actioned by: Area Manager's Office and PSW's
Timeframe: This action will commence in Q3 and is ongoing

1.2 Tusla Dublin North will consider reconfiguration of staff teams for maximum efficiency of resources. The Area will undertake a comprehensive review of staffing levels required to support preliminary enquiries and initial assessments being completed in line with Tusla Standard Business Processes. This review report will be submitted to the Service Director, together with a business case, outlining the additional resources required.
Actioned by: Area Manager's Office and PSW's
Timeframe: Q3 2021

Action 2:

2.1 All incoming Child Abuse Notifications will be screened within 24 hrs, prioritised and categorised in line with Standard Business Processes. All outgoing Child Abuse Notifications will be completed without delay in line with Intake Record/ Standard Business Process. This will ensure unnecessary delays in reporting of allegations of abuse to An Garda Síochána.
Actioned by: PSW's
Timeframe: This action has commenced and is ongoing

2.2 All incoming and outgoing Child Abuse Notifications will be recorded on a local central register by a dedicated staff member with oversight by the Principal Social Worker. The central register will have access to the date of referral and date of completion of Child Abuse Notifications. This will ensure all notifications are captured and tracked to avoid delays in reporting of allegations of abuse to An Garda Síochána.
Actioned by: SW's, SWTL's and PSW's
Timeframe: This action has commenced and is ongoing

2.3 Child Abuse Notifications will be a standing item at staff supervision and Area Governance meetings to avoid delays in reporting of allegations of abuse to An Garda Síochána.
Actioned by: PSW's and Area Manager's Office
Timeframe: This action has commenced and is ongoing

2.4 Training/Information session will be provided to frontline workers on the process to be followed where Child Abuse Notifications are received and/or required on open cases.
Actioned by: PSW's and SWTL's
Timeframe: Q4 2021

Proposed timescale: **1.1 Q3 2021 and ongoing** **1.2 Q3 2021** **2.1 Commenced and ongoing** **2.2 Commenced and ongoing** **2.3 Commenced and ongoing** **2.4 Q4 2021** **All actions are planned to be completed by Q4 2021 and reviewed thereafter through monthly CPW Governance forum to ensure compliance with standard**	**Person responsible:** **PSW's and SWTL's** **Area Manager's Office, PSW's** **PSW's** **SW's, PSW's and SWTL's** **PSW's and Area Manager's Office** **PSW's and SWTL's**

Standard 2.3
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

1. There were significant periods of time during which children and families subject to safety plans, who were on waiting lists for allocation had no contact with a social worker.
2. Timeliness and frequency of monitoring of safety plans for some children was not adequate and the potential impact of changes in circumstances required greater consideration in assessing the ongoing effectiveness of safety plans.

Action required:

Under **Standard 2.3** you are required to ensure that:

Timely and effective action taken to protect children.

Please state the actions you have taken or are planning to take:

Actions Tusla North Dublin plan to take:

Actions 1:

1.1 A Dedicated Social Worker will be assigned within the pre-allocation teams to review safety plans for children and families on waiting lists for allocation and liaise with their identified safety networks. This will ensure children who are unallocated will have contact with a social worker on a monthly basis in line with the Protocol for Cases awaiting allocation. This action has commenced in the three pre allocation teams. Two teams have a dedicated social worker undertaking this action and the third team has a SWTL pending filling a SW post by Q3 2021.
Actioned by: PSW's and SWTL
Timeframe: Commenced and ongoing

Actions 2:

2.1 Dedicated Social Workers will engage with their line manager on a monthly basis to review the existing prioritisation of cases awaiting allocation. This will ensure the ongoing governance of safety plans.
Actioned by: SWTL's and PSW's
Timeframe: This action has commenced and is ongoing

2.2 Dedicated Social Workers will ensure timely and frequent monitoring of safety plans for children taking into consideration the potential impact of changes in circumstances as identified through Covid-19 Pandemic. This will involve contacting the child's family and the identified safety network. This will ensure the ongoing effectiveness of safety plans.
Actioned by: PSW's and SWTL'S
Timeframe: This action has commenced and is ongoing

Proposed timescale:	**Person responsible:**
1.1 Commenced and ongoing	**SWTL's and PSW's**
2.1 Commenced and ongoing	**SWTL's and PSW's**
2.2 Commenced and ongoing	**SWTL's and PSW's**
All actions are planned to be completed by Q4 2021 and reviewed thereafter through monthly CPW Governance forum to ensure compliance with standard	

Standard 2.4
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

1. The management of cases awaiting allocation was inconsistent and did not ensure that risks to children were adequately assessed in all cases.
2. Record of reviews of cases while they awaited allocation did not demonstrate that all relevant information was considered.

Action required:
Under **Standard 2.4** you are required to ensure that:
Children and families have timely access to child protection and welfare services that support the family and protect the child.
Please state the actions you have taken or are planning to take:

Actions Tusla North Dublin plan to take:

Action 1:

1.1 A dedicated Social Worker will contact all children and/or their families awaiting allocation on a monthly basis to review the identified steps that were agreed to ensure the immediate safety of the child while they await allocation. This action has commenced and will remain a priority task on all pre-allocation teams.
Actioned by: SWTL's and PSW's
Timeframe: This action has commenced and is ongoing

1.2 The management of unallocated case will be a standing item at supervision and at Area Governance Meetings. This will ensure unallocated cases remain a priority within the service improvement plan.
Actioned by: Area Manager's Office and PSW's, SWTL's
Timeframe: This action has commenced and is ongoing

1.3 The protocol for the management of cases awaiting allocation will be reviewed by Principal Social Workers to ensure consistency across the Screening and Assessment & Intervention teams and mitigate risk to children.
Actioned by: PSW's
Timeframe: Completed by Q4 2021

1.4 Any new information received that will escalate risk to a child who is awaiting allocation, will be reviewed within 24 hours, prioritised and categorised in line with Standard Business Process.
Actioned by: SWTL's and PSW's
Timeframe: This action has commenced and is ongoing

Action 2:

1.5 Any new information received in respect of an active referral, will be evident or placed on the active referral, even in circumstances where the subsequent referral does not require an Intake form. This will ensure that all information relevant to assessing the risk, is available on the active referral.
Actioned by: SWTL's and PSW's
Timeframe: This action has commenced and is ongoing

1.6 All information received in respect of a child awaiting allocation will be reviewed, prioritised and categorised and the agreed steps identified to ensure the immediate safety of the child, while the safety planning process is ongoing, will be amended accordingly.
Actioned by; SWTL's and PSW's
Timeframe: This action has commenced and is ongoing

1.7 An audit of case records will be undertaken to ensure all information is available to inform the Safety Plan.
Actioned by: PSW's
Timeframe: Completed by Q4 2021

Proposed timescale:	Person responsible:
1.1 Commenced and ongoing **1.2 Commenced and ongoing** **1.3 Q4 2021** **1.4 Commenced and ongoing** **2.1 Commenced and ongoing** **2.2 Commenced and ongoing** **2.3 Q4 2021** **All actions are planned to be completed by Q1 2022 and reviewed thereafter through monthly CPW Governance forum to ensure compliance with standard**	**SWTL's and PSW's** **Area Manager's Office and PSW's** **PSW's** **SWTL's and PSW's** **SWTL's and PSW's** **SWTL's and PSW's** **PSW's**

Standard 2.5
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

1. Initial assessments were not completed in a timely manner in line with Tusla's standard business processes.
2. There was a significant waiting list for children who required an initial assessment, mostly made up of those who had already experienced delays while awaiting preliminary enquiries.
3. Children's records were not up to date in all cases.
4. The practice for linking cases involving siblings did not ensure information was available on all children's files.

Action required:
Under **Standard 2.5** you are required to ensure that:
All reports of child protection concerns are assessed in line with Children First and best available evidence.
Please state the actions you have taken or are planning to take:

Actions Tusla North Dublin plan to take:

Action 1:
1.1 Training will be provided to all staff on completion of initial assessments within Tusla's standard business processes timeline.
Actioned by: SWTL's and PSW's
Timeframe: Completed by Q4 2021
1.2 Initial Assessments will be completed as the primary action, (once safety has been established) with the family post screening (Intake) to determine appropriate intervention thereafter. This is a change to current practice and will ensure compliance with Tusla's standard business processes and establish future plans for intervention with the family.
Actioned by: SWTL's and PSW's
Timeframe: This action has commenced and is ongoing
1.3 Quarterly audits of Initial Assessments will be completed to ensure compliance with Tusla's Standard Business Processes and this will form part of the Area Governance Forum and feed into the service improvement plan. This action will be ongoing but reviewed through the Area Governance Forum to establish service improvement.
Actioned by: PSW's
Timeframe: Completed by Q4 2021

Action 2:
2.1 Practice intensive days will be scheduled to complete outstanding initial assessments on children awaiting allocation that have exceeded the timeline as set by Standard Business Process.
Actioned by: SWTL's and PSW's
Timeframe: This action has commenced and is ongoing
2.2 The Area will undertake a comprehensive review of staffing levels required to support all initial assessments being completed in line with Tusla Standard Business Processes. This review will be submitted to the Service Director, together with a business case, outlining additional resources required.
Actioned by: Area Manager's Office and PSW's
Timeframe: Q3 2021

Action 3:
3.1 An audit of Case records will be completed in Q4 2021 and case records will continue to be reviewed through supervision and random sampling, to ensure records are up to date in all cases.
Actioned by: PSW's
Timeframe: Q4 2021

Action 4:
4.1 Training on the practice for linking referrals involving siblings on NCCIS will be provided to all staff.
Actioned by: SWTL's
Timeframe: Q4 2021

Proposed timescale:	**Person responsible:**
1.1 Q4 2021	**SWTL'S and PSW's**
1.2 Commenced and ongoing	**SWTL'S and PSW's**
1.3 Q4 2021	**PSW's**
2.1 Commenced and ongoing	**SWTL's and PSW's**
2.2 Q3 2021	**Area Manager's Office and PSW's**
3.1 Q4 2021	**PSW's**
4.1 Q4 2021	**SWTL's**
All actions are planned to be completed by Q1 2022 and reviewed thereafter through monthly CPW Governance forum to ensure compliance with standard	

Theme 3: Leadership, Governance and Management

Standard 3.1
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

1. There was a shortfall in capacity to meet the service demands and the service was not meeting requirements in line with national standard business processes.
2. There was no clear procedure in place for ensuring consistent, timely and effective review of cases while they awaited allocation.
3. Improvements were also required with regard to evidencing managerial oversight.
4. The quality, timeliness and recording of supervision of staff was not in line with Tusla policy.

Action required:
Under **Standard 3.1** you are required to ensure that:
The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
Please state the actions you have taken or are planning to take:

Actions Tusla North Dublin plan to take:

Action 1:
1.1 The Area has recently received an additional allocation of 13 posts. The Area anticipates the following:
- Temporary staff to be converted to permanent posts.
- Graduates to be sent out Expressions of Interest by July 2021. Graduate Social Workers to be in post by end of Q3 2021.
- Transfer of staff from other Areas to Dublin North.

Actioned by: Area Manager's Office, Tusla Recruit
Timeframe: Q3 2021

1.2 Tusla Dublin North will consider reconfiguration of staff teams for maximum efficiency of resources. The Area will undertake a comprehensive review of staffing levels required to support preliminary enquiries and initial assessments being completed in line with Tusla Standard Business Processes. This review report will be submitted to the Service Director, together with a business case, outlining the additional resources required.
Actioned by: Area Manager's Office and PSW's
Timeframe: Q3 2021

Action 2:
2.1 The management of cases awaiting allocation protocols will be reviewed across the Screening and Assessment & Intervention teams to ensure a realistic but consistent, timely and effective response to mitigate risk.
Actioned by: SWTL's and PSW's
Timeframe: Q4 2021

2.2 Cases awaiting allocation will be reviewed monthly in supervision, to ensure that the identified steps, agreed to ensure immediate safety of the child, are adequately assessed and responded to appropriately.
Actioned by: SWTL's
Timeframe: This action has commenced and is ongoing

Action 3:
3.1 A Supervision working group is being developed to further evidence formal (structured supervision) and informal (manager consults) managerial oversight on case records on NCCIS.
Actioned by: PSW's
Timeframe: This action is due to commence with completion date of Q4 2021

3.2 All case supervision records will be available on the child's record.
Actioned by: SW's
Timeframe: This action has commenced and is ongoing

3.3 All managerial decisions in respect of children will be identified as 'case management' case notes on the child's record.

Actioned by: SWTL and PSWs

Timeframe: This action has commenced and is ongoing

Action 4:

4.1 A supervision working group will be established to identify a consistent supervision template to achieve uniformity across the Pillars in line with Tusla Supervision Policy. This will ensure standardised and consistency to the quality of content.

Actioned by: PSW's and Area Manager's Office

Timeframe: This action will commence with expected completion in Q4 2021

4.2 All Principal Social Workers will hold schedules of supervision for their teams and these will be audited quarterly by the Area Manager's Office.

Actioned by: PSW's and Area Manager's Office

Timeframe: Q4 2021

4.3 All supervision records will be identified by 'case management' case note on the child's record on NCCIS.

Actioned by: SWTL's

Timeframe: This action has commenced and is ongoing

Proposed timescale:	**Person responsible:**
1.1 Q3 2021	**Area Manager's Office and Tusla Recruit**
1.2 Q3 2021	**Area Manager's Office**
2.1 Q4 2021	**SWTL's and PSW's**
2.2 Commenced and ongoing	**SWTL's**
3.1 Q4 2021	**PSW's**
3.2 Commenced and ongoing	**SW's**
3.3 Commenced and ongoing	**SWTL's and PSW's**
4.1 Q4 2021	**PSW's and Area Manager's Office**
4.2 Q4 2021	**PSW's and Area Manager's Office**
4.3 Commenced and ongoing	**SWTL's**
All actions are planned to be completed by Q1 2022 and reviewed thereafter through monthly CPW Governance forum to ensure compliance with standard	

Standard 3.3
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

2 Risks relating to unallocated cases as well as non-compliance with standard business process remained on the service risk register since 2018 despite being escalated to regional and national level.
3 Actions to address findings from service audits were slow to be implemented.

Action required:
Under **Standard 3.3** you are required to ensure that:
The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
Please state the actions you have taken or are planning to take:

Actions Tusla North Dublin plan to take:

Action 1
1.1 Tusla Dublin North will consider reconfiguration of staff teams for maximum efficiency of resources. The Area will undertake a comprehensive review of staffing levels required to support preliminary enquiries and initial assessments being completed in line with Tusla Standard Business Processes. This review report will be submitted to the Service Director, together with a business case, outlining the additional resources required.
Actioned by: Area Manager's Office and PSW's
Timeframe: Q3 2021
1.2 Any further risks relating to unallocated cases as well as non-compliance with standard business will be reviewed and updated accordingly on the regional and national risk registers.
Actioned by: PSW's and Area Manager
Timeframe: Commenced and ongoing.

Action 2
2.1 Actions to address findings from service audits will form part of the agenda at the Area Governance Forum. This will ensure that the implementation of same can be tracked in a consistent and timely fashion.
Actioned by: PSW's and Area Manager's Office
Timeframe: This action has commenced and is ongoing

Proposed timescale:	**Person responsible:**
1.1 Q3 2021 **1.2 Commenced and ongoing** **2.1 Commenced and ongoing** **All actions are planned to be completed by Q4 2021 and reviewed thereafter through monthly CPW Governance forum to ensure compliance with standard**	**Area Manager's Office and PSW's** **PSW's and Area Manager** **PSW's and Area Manager's Office**