Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Inspection of the HSE Child Protection and Welfare Service in Carlow/Kilkenny Local Health Area in the HSE South Region

**Inspection Report ID Number: 631**
**Inspection Fieldwork: 12 – 23 November 2012**
**Publication Date: 10 May 2013**

| **Service information**[‡] | |
|---|---|
| **Name of HSE local health area:** | Carlow/Kilkenny |
| **Name of Integrated Service Area:** | Carlow/Kilkenny/South Tipperary |
| **Type of HSE service:** | Child protection and welfare service |
| **Report ID number:** | 631 |
| **Type of inspection:** | ☒ Announced<br>☐ Unannounced<br>☐ Triggered<br>☐ Targeted<br>☐ Follow-up |
| **Legal authority to inspect:** | Health Act 2007 Section 8(1) (c) |
| **Relevant Standards:** | *National Standards for the Protection and Welfare of Children* (2012) |
| **Other key National Guidance:** | *Children First: National Guidance for the Protection and Welfare of Children* (2011) |
| **Lead HIQA inspector:** | Ann Delany |
| **HIQA support inspector(s):** | Patrick Bergin, Eimear Short |
| **Date of last inspection:** | First inspection of service |
| **Type of last inspection:** | ☒ Not applicable - first inspection of service<br>☐ Announced<br>☐ Unannounced<br>☐ Triggered<br>☐ Targeted<br>☐ Follow-up |
| **ID number of last HIQA inspection report for this service:** | ☒ Not applicable - first inspection of service |

[‡] Data source: HSE Child and Family Services Template completed by HSE Carlow/Kilkenny at the request of inspectors as part of this inspection with amendments following verification by inspectors on site.

# About the Authority's monitoring approach

The Health Information and Quality Authority is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public. The Authority, through its monitoring programmes, aims to provide assurances to the public that service providers are implementing and meeting national standards and regulations.

In July 2012, the *National Standards for the Protection and Welfare of Children* were approved by the Minister for Children and Youth Affairs and publicly launched. These National Standards set out the key attributes of an effective child protection and welfare service. The Standards are child-centred and promote the delivery of safe and effective services to children and their families.

Under section 8(1)c of the Health Act 2007, the Authority monitors the compliance of the Health Service Executive (HSE) Children and Family Services with the National Standards and advises the Minister for Children and Youth Affairs and the HSE as to the level of compliance.

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

- **assess** if the HSE Children and Family Services (the service provider) has all the elements in place to safeguard children and young people
- **establish** if failure to have these elements in place poses a serious risk to the children receiving these services
- **seek assurances** from service providers that they are **safeguarding children** through the mitigation of serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

The Authority's inspection process focuses on the effectiveness of the service in identifying children suffering, or likely to suffer, harm from abuse or neglect; and the provision of early help where it is needed. It also considers how the service provider protects these children if the risk remains or intensifies and how the service works in partnership with the community to safeguard and promote the welfare of children and young people.

The Authority's approach considers the key aspects of a child's journey through the child protection and welfare system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection they are offered.

# Contents

# 1. Introduction

The purpose of the inspection report is to provide assurances to the public that service providers have implemented and are meeting the National Standards and are making the quality and safety improvements that safeguard children and young people.

The delivery of children and family services is undergoing a period of change in Ireland. Statutory responsibilities in relation to child protection and welfare will be transferred to a new agency, the Child and Family Agency (CFA) once new legislation has been enacted. This inspection took place in the context of these imminent changes taking place within services, both in terms of new structures and systems and technical supports.

In accordance with section 8(1)(i) of the Health Act 2007, the Health Information and Quality Authority (the Authority) will provide a copy of the finalised report to the Minister for Children and Youth Affairs on whether or not the service provider has the necessary arrangements in place to safeguard children. The findings of this inspection are set out under six themes from the Authority's *National Standards for the Protection and Welfare of Children*. The first two themes relate to the dimension of quality:

- **Child-centred services** – how services place children at the centre of what they do. This includes the concepts of supporting families, access, equity and protection of rights.
- **Safe and effective services** – how services deliver best achievable and safe outcomes for children and families, using best available evidence and information.

Delivering improvements within these quality dimensions depends on services having capability and capacity in four key areas:

- **Leadership, governance and management** – the arrangements put in place by a service for clear accountability, decision making, risk management as well as meeting their strategic, statutory and financial obligations.
- **Use of resources** – using resources effectively and efficiently to deliver best achievable outcomes for children and families for the money and resources used.
- **Workforce** – planning, recruiting, managing and organising staff with the necessary numbers, skills and competencies.
- **Use of information** – actively using information as a resource for planning, delivering, monitoring, managing and improving care.

The inspection findings highlight areas of good practice as well as areas where improvements are required. The inspection report is available to children, parents,

service providers and the public, and is published on www.hiqa.ie, in keeping with the Authority's values of openness and transparency.

**Acknowledgements**
The Authority wishes to thank the children and parents for their cooperation with the inspection process. HIQA inspectors also wish to acknowledge the cooperation of the members of HSE Children and Family Services, members of community and voluntary sectors and external agencies.

# 2. Profile of HSE Carlow/Kilkenny

The HSE is in a process of structural change. Currently, HSE children and family services are delivered at local health area level. There are 32 local health areas (LHAs) which have been merged into 17 integrated service areas (ISAs) and are managed under area managers.

These functions will transfer into the new Child and Family Agency (CFA) once established and a decision will subsequently be made on how these services will be delivered in the future. Pending this decision, child protection and welfare services will be inspected by the Authority at LHA level with governance inspected at an area manager level.

The following information indicates the socio-economic environment in which child and family services are provided. Carlow/Kilkenny Local Health Area is part of the integrated service area of Carlow/ Kilkenny/South Tipperary. It has a population of 130,315 people, including 33,790 children (Census 2011). There are Revitalising Areas by Planning, Investment and Development (RAPID) areas in Carlow town and Kilkenny city as well as Ceantair Laga Árd-Riachtanais (CLAR) programmes which target investment programmes in areas of rural disadvantage. There are also significant levels of disadvantage in North Carlow and North East Kilkenny. Both counties have experienced high population growth and immigration in recent years and the 2011 census for Carlow highlighted that there was a higher youth demographic than nationally. Education levels remained somewhat below national levels and there was also marginally higher numbers of children with a disability than the national average (County Carlow Children and Young People's Services Committee Children and Young People's Plan 2011-2013).

There were 1,156 reports of child protection and welfare concerns for the 12-month period October 2011 – 2012. At the time of the inspection, there were 684 children receiving services from the social work department team. Eighty-three children were subject to child protection plans. There were 78 initial assessments ongoing at the time of the inspection and 42 children were awaiting further assessments.

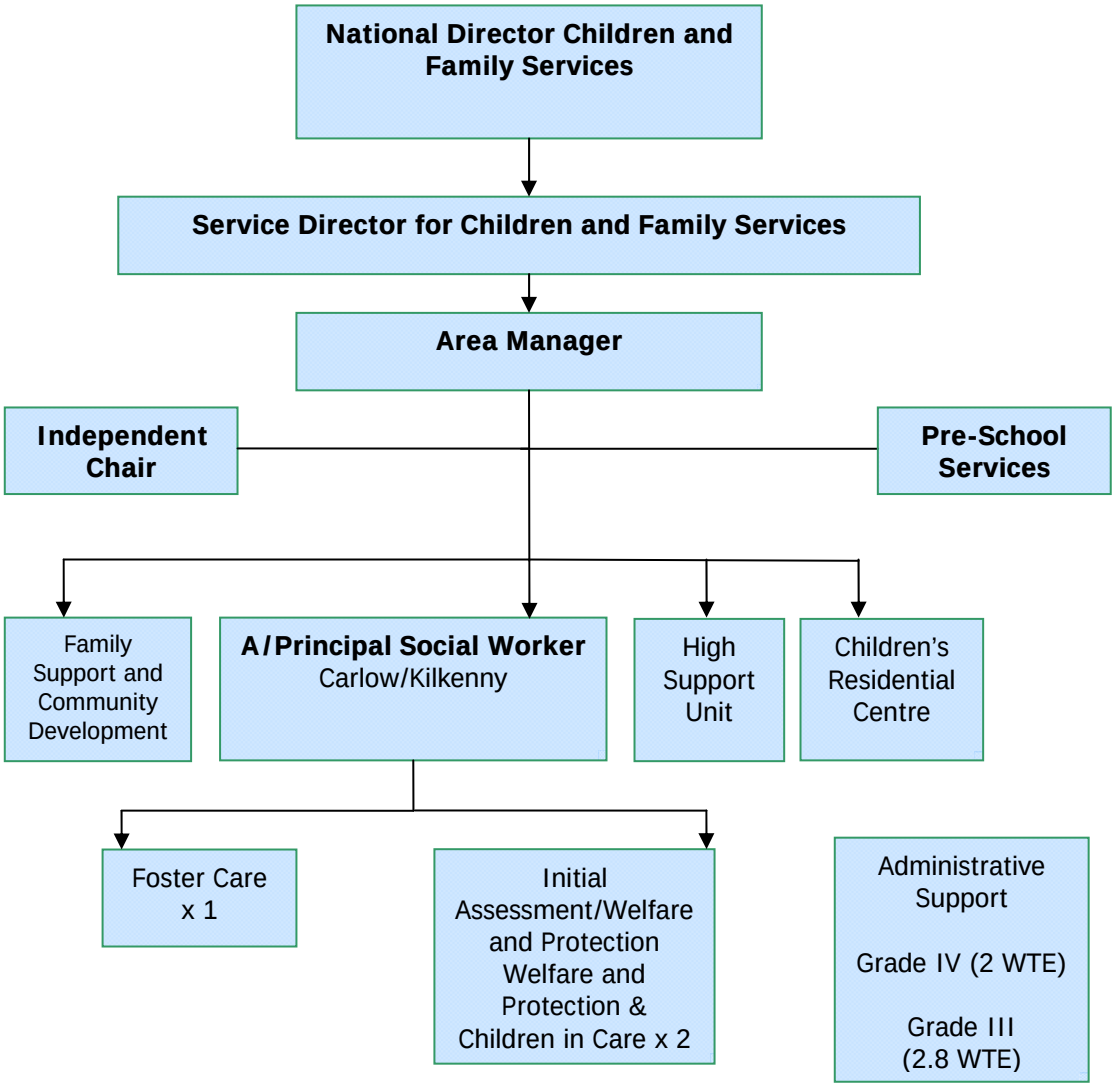
Children and family services were provided in the two main urban centres. In Carlow, the social work child care and family support staff were based on the campus of St Dympna's Hospital. In Kilkenny, the social work child care and family support staff were based in St Canice's Hospital. There are six family resource centres in the area.

In the LHA, the Health Service Executive (HSE) child and family service was provided by four separate teams. Two of the teams, one in Carlow and the other in Kilkenny, provided child protection services to children and families. There was no specific duty team. However, social workers from the two child protection teams were rostered to undertake duty roles periodically. Two duty team leaders, one in Carlow and one in

Kilkenny, managed this system. The third team, the fostering team, recruited, trained, assessed and supported foster carers in the LHA. It worked with the other teams by sourcing placements for children and assisting with their placement. This team also provided ongoing support to foster carers through the link social worker role. The fourth team, of eight family support workers, provided ongoing support to families.

Child and family services are currently the responsibility of the HSE. However, these services will be separated from the HSE into a new agency, the Child and Family Agency (CFA), in 2013. The children and family services in Carlow/Kilkenny is located within the HSE South Region. The LHA is managed by the Area Manager, who reports directly to the Regional Service Director. The Area Manager has line management responsibility for the Principal Social Worker, Independent Chairperson of the Child Protection Case Conferences, Social Care Managers and Pre-School Service Officers. Five Team Leaders report to the acting Principal Social Worker and social workers and family support workers report to the social work team leaders.

**Figure 1. Organisational structure of the Child Protection and Welfare Service, Carlow/Kilkenny LHA in the HSE South Region***




* Source: HSE.

# 3. Summary of findings

Overall, the Health Service Executive Carlow/Kilkenny Local Health Area provided services to children which were safe. A generally well experienced and long standing workforce provided services to children and families, but the systems in which they operated were not robust and some poor outcomes were identified for children. The standard of social work practice and the quality of the child protection and welfare assessments were good.

The LHA was experiencing a period of change, with the establishment of the Child and Family Agency, the integrated service areas (which are replacing the local health areas) and new business processes. Whilst taking this into account, inspectors found that there were a significant number of the National Standards that were not met. Most noteworthy were the non-compliances relating to safe and effective services and leadership, governance and management.

The LHA did not follow procedures set out in *Children First: National Guidelines for the Protection and Welfare of Children* (2011) and the *Child Protection and Welfare Practice handbook* (2011). There were waiting lists for assessments and for cases to be allocated to social workers but these were not effectively managed. Social workers used their individual judgment rather than any guidance to assess risks to children. Some waiting lists had not been accurately prioritised and there was a possibility that high priority cases might not receive the attention they required. The Child Protection Notification System (a record of all children in the LHA who are considered to have unresolved child protection issues, including neglect) was not accurate and up to date.

The Authority found that there were deficits in the governance arrangements in the LHA, in terms of accountability and responsibility. There was little evidence of proactive planning, while risk management was not of good quality. The workforce had not received up-to-date training and there was no robust case management system. Although social workers were familiar with Children First (2011) guidance, they were not aware of other national policies for children and family services.

The LHA did not focus on quality improvement. Few audits were carried out and there was no consultation about the service with children and families although many who spoke to inspectors were positive about the service they received. There was no evaluation of the effectiveness of the service in terms of its outcomes for children.

The LHA did not use the information available to plan and make improvements in the child protection and welfare service. Data on assessment and allocation activity, waiting lists and prioritised cases was collected but no analysis took place and no changes were made as a result. Some welfare services were underutilised whilst

some parents who spoke to inspectors believed that delays in receiving help and support had contributed to a deterioration in their ability to care for their children safely.

The findings from this inspection are described in Section 5 of the report. Section 6 provides a summary of the judgments under each Standard. The related non-compliances and required actions are set out in an Action Plan at the end of the report to assist the LHA to drive improvement within the services. The LHA responses are also included in the Action Plan.

# 4. Methodology

The aim of on-site inspection fieldwork is to gather further evidence of compliance with the National Standards through document review, meetings and interviews and observation. The inspection focuses initially on one particular part of the child's journey: the point at which the child is referred to children's social care services because they are believed to be at risk of, or actually suffering, harm or have welfare needs.

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

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

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

The key activities of this inspection involved:

- the interrogation of data
- the review of policies and procedures, minutes of various meetings, 12 staff files, audits and service plans
- the review of 71 children's case files by both tracking and sampling information contained within their files
- meeting with 21 children and young people, 26 parents and two carers
- meeting with 10 social workers, four team leaders, the information officer, the RAISE information change manager
- interviewed the acting independent chair of child protection case conferences, the acting principal social worker, the area manager and the regional services director
- meeting with five external stakeholders and 12 external professionals including school principals, Clinical Psychologist, acting Director of Public Health Nursing, Risk Advisor, clinical nurse/ midwife managers and An Garda Síochána.
- observing staff in their day-to-day work
- observing practice in two multi-agency meetings, one professional meetings, four child protection/review conferences and one child protection notification management team meeting.

# 5. Overall findings

**Theme 1. Child-centred Services**

Under this outcome measure, services working with children promote a child-centred approach through recognising children's rights, clear, open and honest communication and providing supports that children and family require as early as possible. Children's services value diversity and are inclusive of all groups of children. Child-centred services place children at the centre of what they do.

Related reference:

- Standard 1:1 – Children's rights and diversity are respected and promoted.
- Standard 1:2 – Children are listened to and their concerns and complaints are responded to openly and effectively.
- Standard 1:3 – Children are communicated with effectively and are provided with information in an accessible format.

## Standard 1:1 – Children's rights and diversity are respected and promoted

**This standard was met in part.**

Social work practice promoted children's rights. As a result, children understood their rights and felt supported in exercising them. Social workers interviewed by inspectors were cognisant of children's rights to access personal information and this was actively encouraged. Inspectors saw evidence on case files of young people being supported to read their personal records and relevant reports. Children told inspectors that social workers upheld their rights to education, their right to have their voices heard and their rights to safety and protection. Several children spoke of improved educational outcomes including increased school attendance following social work support. Children told inspectors that they felt safer as a result of social work intervention.

The LHA did not have any policies in relation to the promotion of children's rights and staff did not have any written guidance to inform practice, although inspectors found individual social work practice actively supported children's rights. As a result, there was a risk of natural deviation from what was a common understanding, as exemplified by the participation of children in child protection conferences. Social workers identified the importance of children having an input into the decision-making process. However, in practice, very few children attended child protection case conferences or were supported to tender a written submission.

Staff were not aware of any anti-discriminatory policies to support social work practice. They had not received training in working with children and families from diverse backgrounds. Social workers interviewed told inspectors that they relied on their professional experience and social work values to guide their work with families from different ethnic, cultural and religious backgrounds. Social workers advocated strongly for the rights of vulnerable groups and inspectors saw examples of sensitive and meaningful engagement with members of minority cultures. Inspectors found evidence in case files of exemplary engagement with these families on an individual level but this was dependent on the knowledge and experience of individual social workers and was not a service wide approach directed by clear policy guidelines.

The service endeavoured to meet the needs of specific children and families from different ethnic, cultural and religious backgrounds and was largely successful in this regard. Inspectors saw evidence of members of the Travelling community being linked in with local advocacy groups within the LHA. Social workers actively promoted a positive sense of identity amongst young people and selected services that were culturally appropriate for their needs. Interpreters were used, when available, to support children and families to actively engage with the service and to ensure their views were represented. Children and parents from minority cultures felt they had equal access to services and were treated with sensitivity and respect. However, inspectors found that the LHA did not have a strategy to identify and engage with vulnerable groups.

### Standard 1:2 – Children are listened to and their concerns and complaints are responded to openly and effectively

**This standard was met in part.**

Children were listened to and their views were sought in relation to key decision making that affected their lives. Social workers were committed to listening to children and routinely met them in private, often outside the family home. A review of case files showed children were encouraged to attend statutory care reviews and their participation was actively facilitated. Some children were also facilitated to attend court proceedings where appropriate. In the event that they did not attend court or a significant meeting, social workers endeavoured to illicit the child's wishes in advance and subsequently kept them updated in relation to decisions made. Children told inspectors that they felt listened to and they felt that their views were taken into consideration. However, following a review of initial assessments undertaken by social workers, inspectors found that the child's view was not always recorded at early stages of intervention.

Whilst efforts were made by individual social workers to ensure children with communication difficulties or those of different nationality were facilitated to express their views and report abuse, the overall system was weak in this regard. Some families had regular access to interpreters during social work visits and meetings.

However, there was at times a dearth of available interpreters in the geographical area. Social workers made concerted efforts to ensure children were not asked to interpret for their parents. The lack of appropriate interpreters sometimes resulted in appointments being rescheduled or a number of different interpreters being used for one family. This was not conducive to the continuity of service provision and families experienced several people being privy to their personal information. Some social workers accessed alternative therapies such as play therapy and equine therapy to facilitate children to communicate, where appropriate, but the allocation of resources for such alternative therapies was limited due to budget constraints and this was of concern for parents and social workers. The service did not have access to Braille or a loop system to facilitate the active participation of children and families with visual or hearing impairment.

Children's complaints were dealt with effectively and in a child-centred manner. Inspectors saw evidence of social workers encouraging young people to make complaints in relation to perceived deficits in service provision. When a child or parent made a written complaint it was forwarded to the principal social worker for a formal response. Inspectors found the response to these complaints generally involved a personalised letter from the acting principal social worker to the complainant acknowledging their concerns and suggesting ways of remedying the matter to mutual satisfaction. The responses were lengthy and well thought out to ensure that children were encouraged to express their views and were fully informed of the outcome of the complaint. Inspectors reviewed a complaint from two young people who were dissatisfied with an impending change of social worker. Their complaint was upheld and a decision was made not to change their allocated social worker.

However, many children and parents were not aware of their right to make a complaint or the process involved. Inspectors viewed information leaflets outlining the HSE's national complaints service "Your Service Your Say" available within the social work departments. This included a standardised form on which to submit a complaint or comment. Children remained largely unaware of this service and informed inspectors it had not been brought to their attention by social workers. The form was not child-centred and was not seen by social workers or young people as accessible to children. Children did not know who they could complain to if they were dissatisfied with their social workers' response to a complaint. In spite of this, children remained confident that their grievances were taken seriously by individual social workers and said that they felt able to complain.

Whilst it was evident that complaints were managed in a child-centred manner, the overall system for recording, evaluating and measuring trends in complaints was poor. Complaints were not recorded in a central log and there was no analysis of common causes for complaints or any developing trends. Inspectors were informed that there had been no evaluation of the information received through the complaints process in the previous 12 months and there had been no direct improvement to overall service provision in response to complaints. Complaints records were fragmented and not accessible to the wider social work team; as a

result the opportunity for shared learning and enhancement of individual practice was not facilitated. The service had not engaged in any formal consultation with children and the voice of young people had not contributed to service improvements. The LHA had not undertaken any evaluation of the child protection and welfare service.

### Standard 1:3 – Children are communicated with effectively and are provided with information in an accessible format

**This standard was not met.**

No written information was provided to parents and children at their point of initial contact with the service and inspectors found information generally was disseminated on an ad hoc basis. Parents told inspectors they would welcome clear, easy to understand written information outlining the role and function of the service and general processes involved. Children and families were not aware of the structure of the social work department and some were unsure who to contact if the allocated social worker was unavailable. A written guide to child protection case conferences was available to parents, but this required updating. There was no written information provided to parents or young people in relation to the child protection notification system and parents expressed a limited understanding of the significance of this for their children. Children and families informed inspectors that they would feel better informed if information was more widely available across the service.

The LHA did not actively campaign to raise awareness of child abuse and neglect. The HSE information officer provided ongoing training to voluntary and community groups in relation to Children First (2011). Social workers advised inspectors that they did not regard raising awareness of abuse as a priority for them as they were busily engaged in meeting the needs of children already identified as being at risk of abuse and neglect. There had not been any regional or national campaigns in the 12 months prior to inspection aimed at raising awareness of these issues. As a result it remained difficult to quantify the level of public awareness in relation to child abuse and neglect in the LHA. Parents told inspectors that prior to their involvement with the service they were not aware of the level of support or intervention available.

Communication with children and families was lacking in key areas and required considerable attention. Children informed inspectors that social workers made a concerted effort to communicate effectively with them and spoke in simple, straight-forward language. However, all communication was verbal and children did not receive letters or written information about their individual cases. They did not receive written outcomes of meetings and some children felt this would enhance their understanding of the key decisions being made about their lives. Parents identified significant difficulties in accessing a social worker either by phone or in person. There was considerable frustration amongst parents at their inability to access support in a timely fashion and they felt that this had a detrimental impact on their relationships with their children and their ability to cope. Parents informed

inspectors that they felt unsupported at meetings and their request to bring an advocate or family member had on occasion been declined. There was no clear policy encouraging parents to bring an advocate or family member to support them at key meetings.

**Theme 2: Safe and effective services**

The safety and welfare of the child is paramount in all children's services. A safe and effective service endeavours to protect children from the risk of harm through effective interventions that protect children and support families. Children First (2011) is consistently implemented by the service and timely and effective actions are taken to protect children. The service regularly monitors its service to children and families, to identify safe practice, minimise risks and learn from adverse events.

Related reference:

- Standard 2:1 – Children are protected and their welfare is promoted through the consistent implementation of Children First.
- Standard 2:2 – All concerns in relation to children are screened and directed to the appropriate service.
- Standard 2:3 – Timely and effective action is taken to protect children.
- Standard 2.4 – Children and families have timely access to child protection and welfare services that support the family and protect the child.
- Standard 2:5 – All reports of child protection concerns are assessed in line with Children First and best available evidence.
- Standard 2:6 – Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.
- Standard 2:7 – Children's protection plans and interventions are reviewed in line with requirements in Children First.
- Standard 2:8 – Child protection and welfare interventions achieve the best outcomes for the child.
- Standard 2:9 – Inter-agency and inter-professional cooperation supports and promotes the protection and welfare of children.
- Standard 2:10 – Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.
- Standard 2:11 – Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice.
- Standard 2:12 – The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

## Standard 2:1 – Children are protected and their welfare is promoted through the consistent implementation of Children First (2011)

**This standard was not met**

Children First (2011) was not consistently implemented in the LHA. Inspectors found that the assessment and management of child protection and welfare concerns were not in keeping with Children First (2011). For example, the LHA was not adhering to the timelines in regard to the screening and initial assessment of referrals as set out in the HSE Child Protection and Welfare Practice Handbook., Child protection case conferences did not always take place in a timely manner and relevant notifications were not consistently made to An Garda Síochána. The area manager and acting principal social worker confirmed this.

Not all staff understood all of their responsibilities under Children First (2011). There was confusion amongst social workers about screening referrals and what thresholds were used to determine further actions required. Inspectors found that social workers were not clear about the role and purpose of the Child Protection Notification Management Team (CPNMT) and the role it played in the management of risk associated with individual cases.

Children First (2011) processes were not consistently followed. An Garda Síochána was not always formally notified of suspected physical or sexual abuse, or wilful neglect of a child. There was evidence that the social work department consulted with other relevant professionals to determine whether grounds existed for suspected abuse as part of the screening process. However, inspectors found evidence that in a number of instances, social workers awaited confirmation of abuse before notifying An Garda Síochána, although there was evidence of informal contact with An Garda Síochána in some instances. Social workers told inspectors that the only formal notification to An Garda Síochána was issued by the CPNMT. This could hinder a Garda investigation and present a risk to children as information might not be shared at a critical early stage.

The LHA had not fully implemented all the HSE business processes which support the functioning of Children First (2011), but some progress had been made. The LHA was in the process of developing systems to support the operation of Children First (2011) and had appointed an independent chair of child protection case conferences. The area manager and acting principal social worker were also reviewing the structure of the social work teams to ensure that referrals were addressed in a timely manner and initial assessments were completed in line with Children First (2011). Inspectors found that currently the timelines identified in the Guidance for screening and initial assessments were not always being met.

National policies did not guide practice and local policies did not reflect Children First (2011). On the ground, staff were not fully informed about national policies and so were not able to follow them. They were not aware of how to access policies and it was unclear if staff were following existing local policies or draft national policies.

## Standard 2:2 – All concerns in relation to children are screened and directed to the appropriate service

**This standard was met in part**

Social workers did not complete screening of all concerns in line with Children First (2011) and there were shortcomings in the effectiveness of the duty system in this regard.

There were screening systems in place. Inspectors were told by social workers and managers that the majority of child protection and welfare referrals were received by post and directed to the acting principal social worker who sent them to the relevant duty team leader. The duty social work team leaders in Kilkenny and Carlow were responsible for managing screening but had different systems in place. In one office, preliminary enquiry checks were undertaken by social workers under the direction and supervision of the duty team leader. They completed network checks as part of the screening process. In the second office, the duty team leader undertook screening, checks and made preliminary enquiries. Inspectors found that there were significant delays in the screening of referrals in this office and that the system in place was overly dependent on the duty team leader's availability.

The duty system was overly reliant on the duty team leaders. Inspectors found that during the absence of one of the duty team leaders, preliminary enquiries had not been made in relation to new referrals, although issues of immediate risk had been considered. The referrals remained on a 'duty list' awaiting the return of the duty team leader. These referrals had not been prioritised in any other way and there was a potential for risks to children to be overlooked. Inspectors were told by the duty social work team leaders that when they were on annual leave or sick leave another social work team leader or the acting principal social worker received referrals and managed the screening process. Inspectors were told by social work team leaders that there were no written procedures to guide them in the management of referrals. Inspectors found there were inconsistencies in the approach of the team leaders in the screening process. There was no evidence of a shared understanding about thresholds of risk or prioritisation criteria.

Some initial actions had been taken to develop a system to address the current deficits. The area manager and acting principal social worker told inspectors that the LHA was in the process of restructuring the duty system across the two offices and that one dedicated team was to be established under the management of one social work team leader. Inspectors were told by social work team leaders and social workers that preliminary discussions had taken place about a 'duty system' model. Inspectors were advised by the area manager that the LHA intended having this revised system in place by the end of 2012.

Inspectors found that there was a system in place for making preliminary enquiries about children and their families once the case was assigned to a named social worker. The LHA had an electronic intake record system which generated some of

the suite of documents that supported the gathering of information about children and families. Inspectors observed the process whereby the duty team leader and the social workers on duty sought specific information relating to the child, the family composition and the referrer. The category of concern and the action to be taken were recorded by social workers in a template document. The social worker also recorded further actions such as the need to undertake an initial assessment and or the closing of the file. The option for emergency action, notification to the Garda Síochána, referral to another agency was also recorded in the intake record template. The duty team leader agreed and approved the outcome of the screening and the actions proposed by the social worker. This system was being utilised by the social workers but there were significant delays at times in both duty teams commencing information gathering. Inspectors were told that it was usual practice for social workers to be rostered to work duty for two or three days over a four- to six-week period. This meant that a number of social workers could be involved in carrying out preliminary enquiries into a single referral, resulting in a fragmented approach. This undermined the robustness of the system.

As part of the preliminary enquiry, social workers gathered information about children and families and exercised their professional judgment to inform decisions. However, decision making was not guided by a clear understanding of thresholds of harm. Inspectors observed checks being undertaken by social workers with Gardaí, public health nursing departments, referring teachers and other professionals and there was also evidence of contact with parents and visits to children in their homes and in school. This information was used to inform decision making, but there was no evidence that consideration had been given to defined thresholds of harm. This meant that potential risks to children were not being consistently managed.

In the majority of cases, limited written feedback was provided to members of the public as appropriate or professionals who made referrals to the social work department. Standardised letters were issued to referrers by the social work team leaders, acknowledging receipt of the referrals. Professionals, community and voluntary group representatives confirmed that the standard process was to receive a written acknowledgement of the referral. Inspectors were told by the social work team leaders and social workers that in many instances the social worker would indicate that the referral was placed on the duty list awaiting assessment. Representatives from local schools, hospital, community and voluntary groups told inspectors that this response was not satisfactory. In some acknowledgement letters which inspectors viewed, it was stated that *'if in your opinion, this family requires a service as a matter of urgency please contact the duty social worker by return'*. Hospital staff told inspectors that the referral would not have been made in the first instance unless there were concerns and the letter placed a further onus on the referrer to manage and monitor the risk which was in many cases outside of their control as children and pregnant women may have subsequently been discharged home.

## Standard 2:3 – Timely and effective action is taken to protect children

**This standard was met in part**

The duty team leaders prioritised cases using their own experience rather than agreed criteria. There was a national prioritisation framework, the HSE's *Framework for Measuring the Pressure* document, and this included a prioritisation scale, guidance for the analysis of risk and risk assessment questions. Staff were either not aware of or were not implementing this framework. The area manager and the acting principal social worker told inspectors that the purpose of the framework was to report on intake activity and waiting lists. They did not see it as a guide to operational activity. Within this framework there were tools to guide the social worker, social work team leader and acting principal social worker to manage intake, assessment and allocation activity but these were not in use. Rather, decision making was based on the experience and skills of the individual social worker under the direction of the social work team leader. Whilst staff members were experienced, this approach was not safe or sustainable in the medium to long term.

There was the possibility that an inconsistent approach could be taken in identifying and managing risk to children. The HSE *Framework for Measuring the Pressure* provided key principles to guide social workers in the consistent application of risk assessment processes, but as stated, this document was not in use. Inspectors were told by social workers that they were guided by the practice notes in the *Child Protection and Welfare Practice Handbook,* although it did not contain a risk assessment framework, by their professional knowledge and by the advice and direction of the social work team leader. Team leaders said that they were informed by their experience and Children First (2011) when prioritising referrals. Inspectors found there was the potential for a number of approaches to be used within the social work department and this did not lend itself to a consistent and agreed approach to decision making and prioritisation.

Decision making was not always timely. Within *the HSE Child Protection and Welfare Practice Handbook,* timelines are set out for the screening of referrals. These should take place, where possible, within 24 hours of being made. Initial assessments should take place where possible within 20 days following the receipt of the referral. Inspectors were told by social workers, and found from review of files, that these timelines were not always met. Some of the delays were as a result of the way in which the duty system was structured. Inspectors were concerned that the outcome for some children could be poor as critical decisions might be delayed.

Inspectors found that there was good quality information gathered to inform decisions regarding children. The content of the initial assessment process in the LHA was in line with Children First (2011) and this process was integrated into the electronic information system. Inspectors reviewed files where assessments were completed and they included direct contact with family members, external agencies, and a range of professionals. There was some evidence that the views of the child, parents and carers were sought as part of the assessment. Inspectors also found

some evidence that family members' strengths and other protective factors were identified and taken into consideration as part of the assessment. A suite of welfare concern options was provided on the electronic information system for social workers to consider as part of the process. Further actions were identified by social workers, which could include a strategy meeting, notifying cases to the An Garda Síochána, referring to other professional agencies for alternative/support services or to providing information and advice only.

Legal proceedings were initiated to protect children. Inspectors found evidence through case file review and observation of child protection case conferences that care and supervision proceedings were instigated to protect children from further harm and neglect. Data provided to the Authority identified that there were 199 children in care at the time of the inspection. Three children in the LHA were at home under a care order and the LHA reported that 14 children were at home under supervision orders.

There was a waiting list for initial assessments, further assessments and allocation to a social worker and there were risks in the way in which this was managed. Inspectors were informed by duty team leaders of 178 referrals that were held on the duty list awaiting or in the process of initial assessment. The potential risks associated with some of these referrals were not known. Inspectors were told by the duty team leaders that these cases were reviewed and prioritised on a regular basis. Inspectors found evidence of this practice in one of the social work offices where the duty team leader reviewed the duty list on a weekly basis to determine levels of risk, assigned cases for action and provided direction to social workers on how to mitigate any risks identified. In the other office, it was not clear how referrals were prioritised on an ongoing basis or how pieces of required work were assigned. Inspectors were concerned about the levels of risk associated with this duty list. They requested the area manager and the acting principal social worker to assure them that all risks were identified and that the appropriate actions were taken to address these. Prior to the completion of the field work inspection, the area manager informed inspectors that they had initiated a full review of the duty lists for both social work department offices. By the end of the fieldwork four cases were re-prioritised as a result of the review; the review was due to continue the following week.

There was no quality assurance process in place to ensure that decisions focused on safety and did not leave children at risk. There was no system in place to review decisions or consider any trends in the child protection and welfare system. Team leaders told inspectors there was no system in place to consider the outcomes of their interventions. Inspectors were told there was no analysis undertaken of closed cases and whether cases were re-referred on an ongoing basis. Inspectors were told by duty team leaders and the acting principal social worker that information relating to the number of cases on the duty list was submitted to the area manager as part of the *'Managing the Pressure'* monthly report. However, there was no evidence that analysis of this information generated any actions to mitigate risks such as length of time a family or child had to wait until their case was assessed or allocated to a social worker.

## Standard 2:4 – Children and families have timely access to child protection and welfare services that support the family and protect the child

**This standard was met in part.**

There was no formal model of service to respond to the needs of children and families. The delivery of child and family services were provided in a number of ways, through a range of settings including family support, community development and after-school projects, school, youth and community settings, and direct intervention by the social work department. Some of these services were provided to children and families by community and voluntary groups in the LHA. These services were procured by the HSE through service level agreements, in an attempt to specify the exact services to be delivered. The regional services director showed inspectors the proposed national model for service delivery. However, this had not been implemented and was not the model in current use in the region; social workers on the ground were not aware of it.

Inspectors found that social workers had a good understanding of the need for the LHA to intervene early and provide a crisis management response to children and families. They were able to describe some of the services to which children and families had access but social workers themselves were unable to describe the service delivery model. Furthermore, social workers informed the inspectors that the LHA did not have a central directory of available services. They said individual staff members developed their own individual contact list of services. Social workers told inspectors that one of the local voluntary organisations had developed a directory of services for the general public which some social workers used. This meant that staff members might not always be aware of all resources available in the LHA to best meet the needs of children and families.

Early intervention services were effective but referrals were not made in a timely manner and some services had more capacity than was used. Where early interventions took place, children, parents and carers told inspectors that these interventions were effective and resulted in positive outcomes for them. Child care leaders undertook direct work with parents to enhance parenting skills as part of a wider approach to maintain children within the home environment. Community and voluntary groups addressed welfare concerns with parents to prevent more complex problems developing. Early intervention programmes were also provided by family support services from within the social work department. LHA community child care leaders and family support workers engaged directly with children and families to explore and resolve areas of difficulty. Inspectors were told by two parents that the family support worker played a significant role in supporting them during difficult times. For example, one family support worker supported a parent to send their children out to school each day. The support workers provided advice and direction around practical issues including budgeting and routines. Parents told inspectors that without this level of support, there was a genuine risk that they would be unable to cope and as a consequence the children would be placed in foster care.

However, the duty system did not facilitate timely referrals to early intervention services and other professionals commented that welfare referrals were not always acted upon. The threshold for welfare referrals to be accepted and allocated to social workers was high. Professionals felt earlier interventions could have prevented an escalation of welfare issues which then became child protection concerns. Parents told inspectors about the challenges they faced in caring for their children and the lack of support they felt was available to them. In one instance, a parent believed that his/her children might not have been placed in care, had early intervention services been made available. During interviews, social workers told inspectors that they did not think that the LHA was proactive in terms of accessing early interventions and would welcome more preventative strategies. While a family welfare conference facility commenced in May 2012, the family welfare conference steering group believed that there was unused capacity in this service and was trying to address this issue. The acting principal social worker also noted the lack of referrals to the family welfare conferencing service at the meeting with team leaders. It appeared that some opportunities for early intervention were being missed.

There was equitable access to services for children and families and there was no evidence of discrimination on any basis. Families were referred to services such as parenting classes and there was also evidence of support provided to Traveller families, for example, in accessing crèche facilities. However, there was no formal system in place to identify vulnerable groups of children and families. Social workers responded to and worked with families who were referred to the duty system. Social work team leaders did not believe they had sufficient resources to undertake a needs analysis as their staff were engaged primarily in responding to referrals, carrying out assessments and working with children and families at risk or children in care.

Some child welfare and family support plans did not fully comply with the requirements of Children First (2011) although good practice was noted in this area. The welfare cases allocated to social workers had support plans agreed with families and risks to children were identified as part of this plan. Inspectors were informed by the area manager and acting principal social worker that the LHA had not fully implemented phase two of the HSE business process plan. Inspectors reviewed files and found that some informal and formal reviews had taken place but in other cases these had not been carried out. Some cases were not closed in a timely manner once the support plan had been completed. This limited the capacity of the team to take on new work. Professionals involved with the families were not always informed when cases were closed.

### Standard 2:5 – All reports of child protection concerns are assessed in line with Children First and best available evidence

**This standard was met in part**

An initial assessment process was in place and assessments were carried out by qualified social workers in line with Children First (2011). Inspectors viewed

children's files on the electronic system and in hard copy and found that social workers had carried out the assessment and completed the required documents. Where a student had undertaken direct work as part of the assessment process, inspectors saw that the supervising social worker had reviewed and co-signed the documentation. There was a tool in place to support the social workers' assessment, and identified risks were recorded on it as well as the actions to be taken.

The initial assessment process identified children's and families' needs and strengths, as well as associated risks, but it was not robust. Within this process, social workers determined positive elements within the family structure to mitigate areas of concern. This process was central to the duty assessment function of the social work department, but inspectors found it had shortcomings. No formal risk assessment tool was used by social workers although the results of each assessment were recorded on a standard form. There was a danger that social workers would not determine thresholds of harm consistently and this could then affect the prioritisation of referrals. The way in which the duty system was operated did not lend itself as an efficient assessment process.

The assessment system was fragmented. In one social work office, social workers completed initial assessments of some cases assigned to them by the social work duty team leader when working their three-day duty roster. However, if the assessment had not been completed at the end of this time, work on it ceased until the individual social worker returned to do a further duty assignment. In the other social work office, social workers were not assigned cases for assessment. Inspectors were told that the focus of this system was for social workers to work the cases prioritised by the social work team leader on a day-by-day basis. This meant that either several social workers could be involved in the same assessment or that assessments could take a considerable period of time.

As previously stated, initial assessments were not carried out in the required timeframes. Data provided to the Authority by the LHA showed in the 12 months prior to the inspection 1,156 referrals were received. Of these referrals the LHA determined that 644 initial assessments were recommended. Arising from these referrals, 266 were completed and a further 78 were ongoing. Fifty-six were completed within the timeframe recommended in Children First (2011).

There was evidence that An Garda Síochána were involved when there were concerns about a child, but not always at the appropriate stage as outlined in Children First (2011) and the recording of communications needed improvement. From documentation reviewed by inspectors, there were 33 formal notifications to the Gardaí from the LHA between January 2012 and April 2012 and these had been made once an allegation of abuse had been confirmed. The notifications were part of the interagency process outlined in Children First (2011). Inspectors were told that there was informal communication between the social worker and An Garda Síochána following a report to the LHA when there were concerns about suspected physical or sexual abuse, or wilful neglect of a child. Inspectors found evidence that sometimes these contacts were recorded but were concerned that this was not always the case.

Social workers and team leaders told inspectors that notifications to An Garda Síochána was only possible through the CPNMT and the notifications made between January 2012 and April 2012 received by An Garda Síochána were issued in this way. During the fieldwork, the area manager directed social workers to formally notify An Garda Síochána where there were suspected concerns and not to await the decision of the Child Protection Notification Management Team (CPNMT) Meeting.

Strategy meetings were not effectively used in the LHA. The *Child Protection and Welfare Practice Handbook* cites the importance of securing a Garda Síochána representative, but also recommends that other professionals including paediatricians, general practitioners (GPs) and teachers are necessary, as appropriate, subject to the level of assessment undertaken. The handbook describes the strategy meeting as a forum where professionals agree an initial plan and next steps in the enquiry when addressing an urgent child protection concern. Inspectors found that the interpretation used by the social work department of the use of a strategy meeting to be narrow and limiting. They were told by social workers that the purpose of strategy meetings was to meet An Garda Síochána to discuss a particular concern or share information about a notification. Very few strategy meetings took place and they did not take the form of multidisciplinary meetings to share information effectively. This use of the strategy meeting could limit the inter-professional working and information sharing required for effective decision-making.

Further comprehensive assessments were completed by social workers and other professionals following initial assessments and were found to be of good quality. Files contained detailed assessments undertaken by social workers, clinical psychologists and mental health services. There were also assessments undertaken by specialist services for families and children and non-statutory agencies. Some of the assessments were of a forensic nature and related to specific areas of concern and others were carried out on foot of direction from the courts. The assessments supported staff in making decisions to protect children and support their welfare. However, the area manager outlined the challenge in sourcing funding for these assessments as they were aware of the financial constraints on the LHA to meet budgetary requirements.

Social workers coordinated inter-professional and inter-agency assessments. Inspectors viewed case files where contact with personnel involved in assessments was recorded. Some social workers told inspectors that updates were provided to them, such as the attendance of parents at parenting assessment meetings and progress made by a child attending a psychologist. One young person told inspectors how his/her social worker and the child and adolescent mental health team worked together to help him/her to remain at home.

## Standard 2:6 – Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare

**This standard was not met**

Case conferences were not always appropriately convened when children were identified as being at risk. If an emergency case conference was requested by the social worker team leader, the area manager and more latterly the independent chair of child protection case conferences prioritised the meeting. However, there were delays in convening some child protection case conferences as the structure in place prior to the appointment of the independent chair did not support the ongoing availability of the chairperson as required. Inspectors found evidence of requests by social workers for case conferences which did not occur and social workers believed this was due to the other work demands of the chairperson. Some requests were not made in a timely way. Inspectors were concerned that the delay to hold child protection case conference could lead to poor outcome for some children and families.

The systems in place to support the development of child protection plans in accordance with Children First (2011) were not robust. Inspectors were told by the area manager that the very recent introduction of the independent chair of the child protection case conferences would support the development of child protection plans for children and families. Inspectors were told by the chair of the child protection case conference that their intention was to ensure that child protection plans were developed as part of the child protection case conference process. These plans would be reviewed in line with Children First (2011). The chair was new to the post and planned to develop a streamlined local management system in this regard.

Services and agencies involved with the child and family contributed to child protection plans. Inspectors found that the information provided by services and agencies formed the basis of the plans to safeguard and protect the child, which were coordinated by the social worker. The case conference chair requested reports from agencies and services and they were invited to contribute to the child protection case conference process. Inspectors found reports from schools and other professionals on children's files. During the child protection case conferences attended by inspectors, there were some examples of good information sharing by agencies to inform child protection plans.

The child protection plans developed in the LHA focused on the safety of children. Some of these took the format required by Children First (2011) and as such were a new development in the LHA. Inspectors reviewed files, observed case conferences and spoke with a small number of families. The plans considered the risks associated with the child and the protective measures to be put in place to address the risks. In some cases, the short-, medium and long-term goals for the children were identified. Inspectors attended child protection case conferences where plans were developed. The independent chair and attendees focused on, and prioritised, children's safety. The meeting considered relevant legal options.

During interviews with families, inspectors were told how they found the involvement of the social workers and the development of plans difficult at the time. On reflection they believed that good decisions were made to ensure their children were safe. During meetings with children, inspectors were told how the children appreciated the role of the social workers and other people in keeping them safe.

The child protection notification system (CPNS) in the LHA did not comply with Children First (2011). The area manager was the designated person responsible for managing the CPNS for the LHA and held a record of children about whom there were unresolved child protection issues although inspectors found some errors in this record. For example, only two of three children from one family were listed on the system. There was a list of children's names on an Excel database and inspectors viewed the information which related to 2011 and 2012. At the time of the inspection, there were 87 cases on the list which were categorised as 'open' by the LHA. Of these, 27 were open to the CPNS since 2011 and inspectors were concerned that risks may not have been sufficiently addressed for these children.

The system in place for the management of ongoing child protection and welfare concerns was not adequate. Inspectors found that the child protection notification system (CPNS) had not been updated since 25 September 2012. The area manager reported that no formal communication had been issued to the social workers during this period in relation to children whose names had been added to or removed from the CPNS. Inspectors did not see evidence of a system in which all enquiries about a child were recorded, whether on the CPNS or not. The CPNS was not available on a 24-hour basis as required by Children First (2011). Inspectors were told by the area manager that during office hours An Garda Síochána could contact her office to confirm if specific children were on the CPNS. Inspectors were told that the local hospital could check during office hours with the duty social worker to determine if a named child was on the CPNS. During a review of children's files and the interview with the acting principal social worker, inspectors found that information on whether a child's name was placed on the list or removed was not routinely recorded by the social worker on the electronic system. As a consequence, information provided by social workers to any professionals, including An Garda Síochána or the local hospital may not always be correct.

There was a Child Protection Notification Management Team (CPNMT) in place whose role it was to consider the appropriateness of notifications made to the CPNS and determine if and when a child's file should be closed to the system. This was not in adherence with Children First (2011) as its responsibilities belonged to the independent chair of the child protection conferences. The CPNMT was not able to proactively manage the system and ensure that reviews took place in a timely manner. Inspectors observed a team meeting and noted that the team had a tendency to manage cases at a distance. The area manager stated at this meeting that they would undertake a full review of all open cases on the CPNS in January 2013. The future role of the CPNMT in the LHA was unclear. Following the establishment of the independent chair of the child protection conferences,

inspectors were aware that some children's protection plans were due for review but the area manager had no clear strategy or process in place to address the transition from the CPNMT to the child protection case conference review. Inspectors were concerned that in time of transition there was the potential for errors to be made in relation to the management of ongoing risks to children.

There was not always evidence of effective engagement and information sharing with children and their families at child protection case conferences. Children were not involved in the case conferences and did not have any opportunity to directly or indirectly express their views. The newly appointed independent chair, the acting principal social worker, team leaders and social workers told inspectors that they recognised that there was a need to improve their engagement with children and families on this issue. Inspectors observed through attendance at four child protection case conferences and review of case files that generally there was good multidisciplinary attendance. However, on occasion's inspector found that decisions had been predetermined which did not support effective engagement with parents. Some parents told inspectors they were not offered the opportunity to have an advocate at the meetings. This potentially limited participation by a parent/parents in the decision-making process about the welfare and protection of their children.

Parents did not always understand the significance of their child's name being placed on the CPNS. Inspectors observed child protection care conferences where parents were informed for the first time that their child's name was being placed on the CPNS. No additional information was provided about the seriousness or the consequence of this action. The LHA's information leaflet on child protection case conferences did not contain any information in this regard. The independent chair of the child protection case conference told inspectors that he/she was prioritising the review of this leaflet which was out of date and did not meet the needs of parents.

### Standard 2:7 – Children's protection plans and interventions are reviewed in line with requirements in Children First

**This standard was not met**

Child protection plans were not reviewed in line with Children First (2011). Part of the role of the independent chair for child protection case conferences was to ensure that reviews of child protection plans were held. Inspectors were present at child protection case conferences when review dates were identified and agreed. However, there were 87 children on the CPNS and there was no system in place to determine which cases required a review.

The child protection case conference reviews did consider the effectiveness of the intervention on improving the lives of children. Inspectors attended reviews and examined case files. Inspectors found that verbal and written updates were provided by social workers and other services in relation to previously agreed actions. There was evidence of progress made by families on some issues. Inspectors observed

reviews which identified the need to develop new protection plans including the initiation of care proceedings to maintain children's safety. The formal review process of child protection plans as outlined in the Children First (2011) was at an early stage of implementation in the LHA. It was not possible to determine if the review process focused on the risks and safety of children. However, the review case conferences which the inspectors attended provided evidence that the risks and safety to children were considered.

During the reviews, the case conference chair set time frames for interventions to be carried out and identified persons responsible for them. At one review, the meeting decided that some direct work with a parent was to take place and time frames and persons responsible were agreed. In another review, supports were put in place for children to attend counselling and after-school projects. Inspectors observed the attendees considering and agreeing the need to secure supervision orders under the Child Care Act 1991 at the child protection case conference review.

There was no evidence of a robust system or agreed criteria to close cases based on the outcome for children. Inspectors observed a CPNMT meeting, and also reviewed minutes of previous meetings, where new notifications were considered. Inspectors identified that there was no agreement reached as to when cases open to the CPNS were to be reviewed.

### Standard 2:8 – Child protection and welfare interventions achieve the best outcomes for the child

**This standard was met in part**

Some parents believed that their children's lives had improved following involvement with the service. Inspectors met with two families who outlined the involvement of the social work department and challenges they experienced. The parents informed inspectors that the intervention of the social workers had improved the lives of their children. One set of parents described how they had not been able to care safely for their children. They said that some of the children were placed in the care of the HSE and others placed with relatives. They highlighted the process they went through to address their own needs and how the children were reunited with them. Another family described their ongoing challenges in addressing mental health issues and the role of the social worker in supporting the family to stay together safely while addressing the issues.

On the other hand, parents also told inspectors of difficulties they experienced with the social work department and they believed that their children's lives had not always improved following involvement with the service. They said that on occasions they could not tell social workers about their own problems and difficulties as they were worried that this would be seen as a threat to the safety of their children. They told inspectors of specific concerns they had that access meetings with their children would be cancelled.

Some children interviewed said that they had achieved good outcomes following child protection and welfare interventions. They said that they saw the role of the social worker as important in their lives. Inspectors were told by one child that without the involvement of the social worker s/he would not have been able to attend secondary school and prepare for third-level education.

Inspectors found the LHA were unable to provide information about trends or the pattern of the outcomes resulting from interventions. The community and voluntary group services in the LHA provided positive examples of supports in place for children and families. However, there was no systematic review to assess the effectiveness of these or any other interventions for children and families. As a consequence, the inspectors found no clear evidence base for decision making in order to attain best outcomes for children.

There was no robust system in place to consistently consider and respond, as appropriate, to changes in the level of risk to children or where there was a lack of progress with interventions. Inspectors observed core meetings where increasing levels of risk to the child were considered by the multidisciplinary group and plans amended. Inspectors also saw some evidence in case files viewed where decisions were reviewed by social workers and team leaders which resulted in changes to the family support or child welfare plans. However, this was not in line with Children First (2011) as there was no evidence of inter-agency involvement when considering changes to these plans. Some representative of community and voluntary groups told inspectors that they would often hear retrospectively that cases with which they were involved had been closed by the social work department.

### Standard 2:9 – Inter-agency and inter-professional cooperation supports and promotes the protection and welfare of children

**This standard was met in part**

There were some procedures for inter-agency and or inter-professional cooperation. Children First (2011) was cited by social workers to inspectors as the guiding procedure for agencies and professionals in their engagement with the social work department which promoted the best interest of children. Inspectors found there was a process in place for ongoing engagement between the area manager, the acting principal social worker and An Garda Síochána to discuss children missing from care and instances where there were risks to children. There were formal meetings held quarterly between An Garda Síochána and the LHA to discuss these issues.

Social workers and social work team leaders told inspectors that there were good inter-agency and inter-professional partnerships, but inspectors found that clear procedures needed to be established to support good effective working relationships. Local general practitioners, school principals and medical consultants played a significant role in the ongoing screening and assessments by social workers of

concerns and risks associated with children and families in the area. Other professionals such as psychologists, public health nurses, and speech and language therapists also supported the service delivered to children and families through their attendance and information sharing at child protection case conferences.

While there was some good inter-agency working between social workers and the voluntary groups, this was highly dependent on the individual relationship between the social worker and the external agency, voluntary and or community group. Representatives from voluntary and community groups told inspectors that they had good working relationships with individuals within the social work department who facilitated the opportunity for specific concerns to be addressed quickly. This point was also reinforced to inspectors by other professionals who had regular contact with the social work department. However, parents, other services and other agencies told inspectors that when contact was made with the social work department via the duty system, there were often delays and this led to levels of frustration. Due to the changing personnel on the duty system, they found that there were inconsistencies in approach and communication was problematic.

### Standard 2:10 – Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children

**This standard was not met**

Not all children in the LHA had allocated social workers and children and families did not experience continuity in this regard. There were 17 cases which previously were allocated to social workers. However, due to long-term leave, these cases no longer had a named social worker. The social work team leaders told inspectors that this figure was to significantly increase as two social workers were due to go on leave, resulting in their caseloads being unallocated. The acting principal social worker told inspectors that team leaders were obliged to have caseloads due to the shortage of social workers. Inspectors were told that if concerns arose about children or families who did not have an allocated social worker, either the team leader or the social worker assigned to the duty system would address the specific issue. Some families had been allocated a number of social workers in a two- to three-year period and this posed a challenge to social workers in forming trusting relationships. Inspectors found that overall this situation was not tenable on a long-term basis and was potentially unsafe.

Each of the social workers carried a caseload for which they were responsible and there was some evidence that these were proportionate to social workers' experience and the complexity of cases. Social workers told inspectors their caseload averaged between 22 and 26 cases. There were some exceptions to this with new social workers holding a reduced caseload as per HSE national policy. Initially, the caseload allocated to the new social worker was 12 and this was increased to 16 over a three-month period. One experienced social worker held a reduced caseload as one of the cases was deemed to be exceptionally complex. However, there was no formal

caseload allocation system in place. There was no effective procedure in place locally to identify and manage complex cases. Inspectors were told by the acting principal social worker and team leaders that when cases were deemed to be complex this was discussed by the team leader and the social worker and a decision to reduce a caseload was considered.

The operational structures and systems did not always support social workers to spend the majority of their time on work which directly benefited children. Social workers told inspectors that they tried to prioritise such work and inspectors saw examples of this. Social workers visited families, facilitated access between parents and children and attended meetings with agencies and or other professionals working with the children. However, they told inspectors that on the days they were rostered to work the duty system they were unable to do any direct work with children or families to whom they were allocated. Some social workers also highlighted the time required to prepare for and attend court as a demand that reduced their availability to work directly with children.

There was no robust system in place to monitor and review the case management process and evaluate the standards of service provision. There were team meetings held in both social work offices which were facilitated by the social work team leaders. The main focus was on information dissemination and administrative issues. Inspectors attended team meetings and found that there was no discussion about practice or service effectiveness. While there was evidence of some reflective practice occurring within the individual case supervision process, there was little other focus on reflective practice.

### Standard 2:11 – Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice

**This standard was met in part**

The LHA used the national incident management policy and risk and incident escalation procedure when reporting serious incidents. One of the key responsibilities of the National Incident Management Team (NIMT) is to ensure where a death or a serious incident relating to children in care or children known to the child protection system has occurred, that a review is undertaken. The HSE National Office refers these incidents to the chair of the HSE National Review Panel (NRP). The area manager notified serious incidents to the NIMT in line with this procedure. However, not all serious incidents were reported in a timely manner to the National Office. The area manager identified that one case was not referred to the National Office due to an oversight but it was subsequently referred once the matter was noted. Two incidents had been referred to the NRP by the National Office and the panel has initiated a review of one of these incidents. The LHA was in the process of providing information to the reviewers as part of the process.

The NRP had completed, and the HSE had published, reports relating to 16 serious incidents between March 2010 and September 2012. These reports identified areas of learning and made recommendations towards the improvement of services and practices to children and families known to the HSE child protection and welfare services. The area manager told inspectors that he/she had presented some of the recommendations from these reviews and other case reviews to some of the heads of discipline in the area as part of multidisciplinary learning and development. Inspectors were also told that the principal social worker had also provided a summary of these reviews to the social worker team. However, there was no evidence throughout the inspection that recommendations from reviews had impacted on local social work practice.

### Standard 2:12 – The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to

**This standard was met in part**

The area manager had an informal process in place for the assessment of risk in relation to allegations of organisational and institutional abuse and this practice included the evaluation of risk to other children. The area manager told inspectors that s/he received reports as the designated person of alleged organisational and/or institutional abuse. S/he determined, with the assistance of the acting principal social worker and the social work team leaders, what action was required and there was evidence that practice was guided by Children First (2011). While some social workers were aware of the practices for managing cases of organisational and institutional abuse, including the requirement that An Garda Síochána be notified of all cases, others were not. Should the area manager be absent, there was a risk that such cases might not be appropriately managed in a timely manner.

There was a notification system in place between the area manager and An Garda Síochána where written information was shared about suspected organisational or institutional abuse. Inspectors attended a meeting where details of concerns were shared and a plan established to address potential risks to children. The options of other services, example psychology, being available to children and families were agreed.

As part of the sample of cases reviewed, inspectors examined cases of alleged organisational and institutional abuse and found they were assessed and managed by social workers. However, not all of the requirements of Children First (2011) were met. While cases were complex and required careful management, inspectors found that the process was dependent upon the positive individual relationships between senior Gardaí and senior LHA managers rather than following any procedure. HIQA inspectors also found examples of sensitive cooperation between the LHA and An Garda Síochána.

**Theme 3: Leadership, Governance and Management**

Under this theme, a well governed service directs and manages activities using objectivity, accountability and integrity and supports the delivery of effective and safe services to children and families. Overall accountability for the delivery of the services is clearly defined with ongoing audit and monitoring of its performance.

Related reference:

- Standard 3:1 – The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
- Standard 3:2 – Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.
- Standard 3.3 – The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
- Standard 3:4 – Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards.

## 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

**This standard was met in part.**

The service was not consistently performing its functions in accordance with national policies and standards to protect children and promote welfare. Although staff members had a good knowledge of relevant legislation and national guidance, their knowledge of the *National Standards for the Protection and Welfare of Children* and national policies was inadequate.

Inspectors spoke with social workers and reviewed social work practice. They found that social workers' knowledge and practice in relation to legislation was of a good standard. However, social workers' theoretical knowledge of Children First (2011) did not always direct their practice as described in Theme 2. Social workers' knowledge of national policies and the Standards was not sufficient and this impacted on aspects of their practice. It was not clear from interviews that staff in the LHA were aware of and consistently implemented all policies and procedures at all times to ensure a consistent, high quality service to children and their families including those on protective disclosure, inter-area transfers, risk management and information and

communication technology.

Overall, the management team was not learning from issues arising at a national level. Minutes of other staff and management team meetings were reviewed and on only one occasion did the minutes reflect discussion about national recommendations or findings from the regulatory body's reports in other regions. Minutes showed that the area manager had requested the management team to review the *Report of the Independent Child Death Review Group* (Shannon and Gibbons, 2012). There was no evidence of changes in service delivery as a result of their review of this report.

There was no evidence to show that an effective process was in place to assimilate new policies into practice and it was not clear how this was to be done.

### Standard 3:2 – Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability

**This standard was not met.**

Leadership and governance arrangements were found not to have been sufficiently robust. Systems were not in place to ensure that all children received help and protection when they required it. When children required statutory intervention, inspectors found that the response was not always sufficient to address the risks and needs identified. Not all children and young people had been sufficiently well protected when they had needed help and support. Inspectors found that weaknesses were present in the delivery of front-line safeguarding services, but also in other parts of the service. As a consequence, these shortfalls in practice gave rise to concerns about the leadership and management within the LHA, particularly as these practice issues had not been identified prior to the inspection taking place. These failures in managerial oversight meant that poor practice was neither identified nor challenged and led to children potentially experiencing ongoing risk of serious harm.

The LHA was undergoing significant changes to its management structure. Some senior managers demonstrated an understanding of their roles and responsibilities and how they contributed to the overall delivery of service. However, the lines of authority and accountability at individual, team and department level were not clear. Inspectors found, through interviews and the review of team and management meeting minutes, that staff were uncertain about their role and level of responsibility and problem areas that should have been managed at a local level were escalated to the senior management team on a regular basis for a solution. Minutes of meetings did not reflect clear actions, the person responsible for carrying out those actions and agreed timelines for completion. Inspectors found that certain areas of work were of poor quality and these issues had not been addressed by the relevant managers. Some systems were not sufficiently embedded in the work of the LHA and this was acknowledged by managers.

The LHA provided the Authority with a document which outlined the purpose of the children and family service, including the service's basis in legislation. However, it did not describe how the service protected children and promoted their welfare or the service's objectives, its models of service delivery and the aligned resources necessary to protect children and promote their welfare.

Nationally, the 2012 service plan identified a number of priorities for children and family services including:

- promoting the major culture change required in planning and delivering services to children and their families
- implementing consistent child protection procedures in line with the revised Children First national guidelines (2011).
- continuing the reforms necessary to provide a comprehensive range of high quality services for children in care
- improving effective multidisciplinary shared practice and efficient community engagement.

The area manager advised inspectors that the primary focus for the local operational plan was to support the implementation of the comprehensive national change programme which had consolidated all the reform initiatives arising from recent reviews into a coordinated change programme. The LHA had committed to a number of priorities for 2012 including:

- implementing child protection procedures in line with the revised Children First national guidelines (2011)
- implementing phase 2 of the standardised business processes.

At the time of the inspection neither of these had been fully implemented. It was unclear how the service was monitored and evaluated against strategic objectives or who was held to account for them.

Performance management and quality assurance processes were inadequate. There was a significant amount of information available to front line managers and social workers, but it had not been used systematically to drive improvement and gain a comprehensive understanding of the demand for services. The dataset submitted as part of the inspection process identified risks in relation to a number of stages of the child protection and welfare reporting process. This information was already available in the LHA but had not been used to bring about improvements in the service, especially at the intake phase of the process.

Auditing of social work practice took place infrequently. Audits were not completed to an adequate standard and there was a lack of findings, analysis and actions agreed to ensure that case work was of a good standard. The audits did not inform service improvement or aid social workers' development and practice. The LHA had been included in an audit of 40 case files at a regional level. The audit looked at a number

of different areas including safe and effective practice, strategy meetings, care plans, child protection, workforce, child-centred service and family support. The area manager and acting principal social worker also audited 10 case files in September 2012. The area manager identified that the findings of the first audit had been discussed at a team meeting. The minutes of an integrated service area (ISA) meeting with principal social workers, team leaders and administrative staff reflected a small number of the issues. It was not evident from the minutes how this learning was to be disseminated to the full team and learning taken forward. There was no quality improvement plan to address deficiencies identified in either audit.

There was no robust risk management system in place to identify, assess, and manage risk at a strategic level. Staff members were not aware of their roles regarding quality, safety and risk management or their reporting responsibilities. Social workers were unaware of the HSE *Quality and Risk Standard (2009)* document or the risk management policy. Risk assessment was only carried out in relation to casework but there was no system in place to ensure that this was done consistently. Inspectors were shown the LHA's corporate risk register which was administered at a regional level. This system utilised a 5 x 5 risk matrix to identify the probability and consequence of the risk. It was acknowledged by the area manager and general manager for the region that the children and family services risk register at a regional level was being separated out from the HSE's overall corporate risk register and that the system was in a state of flux. The regional risk register identified five major risks for the LHA: financial/budgetary constraints, the recruitment moratorium, the lack of information and communication technology and training deficits. Also outlined were the initial and additional controls. However, staff on the front line, and in middle management roles, were unaware of this register and there was no risk register at local, departmental level. Staff had not been provided with adequate quality, safety and risk management training appropriate to their role and there was a disconnect between the formal system and themselves. There was no managerial oversight of quality, safety and risk management issues and inspectors formed the view that the LHA did not prioritise the management of risk at anything other than at case level. For example, while the number of cases on the waiting list was significant, staff had not identified the existence of these waiting lists as a collective risk.

## 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

**This standard was not met.**

The LHA did not have a system in place to review and assess the effectiveness and safety of child protection and welfare service provision and delivery. The Area reports annually through the national Review of Adequacy for HSE Children and Family Services under Section 8 of the Child Care Act, 1991. The purpose of the report is to review the performance of the HSE Children and Family Services. However, the most recently published report relates to national service delivery in 2010.The LHA, at the time of the inspection, had not undertaken a self-assessment of its service in relation to the Standards. Nor had the managers engaged in any formal consultation with key stakeholders to inform service improvement. The service did not publicly report on its compliance with policy, legislation and regulations.

Robust systems were not in place to monitor and evaluate the service. When children and young people required help and protection, there was no clear process of identifying, assessing and managing risk. Incident reports were not completed regularly by staff and near miss events went unrecorded. This meant that some children did not always receive a timely service and potentially were left at risk of harm. Complaints were not recorded centrally and there was no management oversight of them. There was no quality assurance system in place to evaluate the effectiveness of the service. These ineffective systems meant that the LHA missed opportunities to learn from trends and therefore the necessary service improvements were not enabled.

## Standard 3:4 – Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards

**This standard was met in part**

Voluntary and community groups were well utilised by the LHA in the main and they provided a range of services for the child protection and welfare service in both Carlow and Kilkenny. These included early intervention programmes, family support and specialist family assessments, early years services, after-schools programme, a teen parent support programme, a resettlement programme, a moving on programme targeted at young vulnerable mothers, a mentoring programme for young people, individual and group work, counselling and a youth-at-risk programme.

Formal agreements were found to be in place for externally sourced child protection and welfare services. These agreements had a range of corporate governance requirements built into them including submission of a set of annual accounts and a statement of compliance with legislation as well as the requirement to account for

their activities and undergo monitoring. Each agency was required to complete a self-governance questionnaire and submit a number of documents including an application form, copy of their service activity, annual report, insurance certificate and taxation clearance certificate.

The LHA did not monitor the external providers on a consistent basis to be assured that the service provided to children and families was compliant with legislation, regulations, Standards and national policy. Inspectors viewed agreements with community and voluntary groups which identified monitoring and governance arrangements. The area manager told inspectors that he/she met with community and voluntary groups periodically. However, there were no evidence that these monitoring arrangements were sufficiently robust for the LHA to be assured that external providers were providing a safe and quality service.

**Theme 4: Use of Resources**

A well run service uses resources effectively to deliver best achievable outcomes for children and families for the money and resources used.

Related reference:

- Standard 4:1 – Resources are effectively planned, deployed and managed to protect children and promote their welfare.

## Standard 4:1 – Resources are effectively planned, deployed and managed to protect children and promote their welfare.

**This standard was met in part**

The system in place to effectively plan, deploy and manage resources to protect children and promote their welfare was not robust. The LHA had not undertaken a needs analysis for the child protection and welfare service in 2012. However, it utilised the work of other relevant authorities within the two counties to inform service delivery.

The area manager told inspectors about the Social Inclusion Measures (SIM) working group, a sub-group of the Carlow County Development Board of which the area manager was a member, which had undertaken a needs analysis. As part of its role in promoting a more efficient delivery of services, the SIM wished to be able to target services at those who experienced social exclusion. Their aim was to integrate the work of the voluntary and statutory agencies to ensure there were no gaps or overlaps in service delivery in the county. The area manager advised that this needs analysis had informed the County Carlow Children's Services Committee service plan.

There was an initiative in place to deliver integrated services to meet the needs of children and families. The County Carlow Children's Services Committee was established in 2011 by the HSE; one of its objectives was to keep children safe from accidental or intentional harm and secure. They aimed to meet the needs of the most marginalised children and young people in the Carlow community, deliver a strategic approach to inter-agency collaboration and resource sharing within the county. They also aimed to coordinate initiatives and services by all agencies and organisations working with children and young people across County Carlow in order to achieve better outcomes and more accessible services for children and young people. The Committee was chaired by the area manager and had representatives from the primary school sector, HSE services for people with disabilities, An Garda Síochána, County Carlow VEC, Barnardos, Carlow regional youth services, the National Education Welfare Board, Carlow County Childcare Committee, St Catherine's Community Services Centre, Carlow local authorities, probation services

and Carlow County Development Board. The Committee was in its infancy but showed potential to use resources in an effective and coordinated manner.

In Kilkenny, there was no such initiative, but the Revitalising Areas by Planning, Investment and Development (RAPID) programme provided an alternative. It reported into the SIM working group of the Kilkenny County Development Board. This programme had informed service delivery. For example, a joint local authority/HSE funded youth café and drop-in centre had been established in the eastern part of the town to meet an identified service need. The area manager also gave an example of a Garda Síochána youth diversion project which identified key risk times for the youth of Kilkenny being between 16:00-20:00hrs on Fridays and up until 02:00hrs on Sundays. The area manager was in ongoing discussions with a community agency which could provide a service to meet this need.

There were examples of effective commissioning and delivery of services from different agencies. The voluntary and community sector provided a range of universal and targeted services within the LHA. For example, a teen parent support project, 'Moving On', aimed to empower young mothers, enrich their lives and those of their children, and 'Folláine counselling service', a free and confidential service for young people to help them come to terms with problems in their lives. Services were being commissioned to provide focused programmes which met local need. However, in the absence of a needs analysis of the vulnerable children and families in the area, it was difficult to determine whether their capacity had been sufficiently developed or utilised.

Efforts were being made by the LHA to achieve value for money in the use of commissioned services. At the time of the inspection, grant aid agreements under Section 39 of the Health Act 2004 were being reviewed by the area manager. As part of the inspection, inspectors met with a focus group from the voluntary and community sector. Participants identified that they had had to put a lot of work into making their service well known and utilised by the social work department, including attending staff meetings. Two participants identified that their services were not being well utilised.

Arrangements were in place to monitor and evaluate financial performance. Budgets and staffing reports were provided to the regional and national office on a monthly basis. The LHA was facing particular challenges with the 2012 budget. The area manager reported that the children's social care budget (€12.2 million) had a projected overspend of €1.9 million. Inspectors viewed the corporate risk register which identified failure to deliver on the 2012 service plan as a result of budgetary constraints, as a major risk for the LHA. The area manager told inspectors that he/she attended monthly finance meetings with the service director and finance manager where procurement activities, monthly expenditure and service delivery were monitored. The area manager identified where the financial overspend had occurred and where the discrepancies were in the current system. S/he told inspectors that spending was being curtailed in certain areas. Social workers

confirmed this, saying the lack of funding for access to specialised services, such as psychological assessments, was due to budgetary constraints.

There were vulnerabilities in the way in which workforce planning was carried out. There were deficits in the management team in place as not all members had sufficient management experience, skills and knowledge to effectively manage the challenges involved in meeting the child protection and welfare needs of children in the Area. While overall there were sufficient numbers of posts and balance of suitably experienced and qualified social workers and ancillary staff in place, there were six social workers on different types of leave. The area manager and acting principal social worker told inspectors that these temporary vacancies had not been filled due to the current moratorium on recruitment. Inspectors found that this reduction to the staff complement had not been well managed as the caseloads for some social workers had become unfeasibly demanding and complex. Inspectors were also concerned about other unmet service needs including cases placed on waiting lists. While the service had prioritised some cases from the caseloads of those on leave, a significant proportion had been placed on a waiting list. The area manager and acting principal social worker told inspectors that there was a national directive whereby more than 20% of posts must be vacant before approval would be given to recruit or replace staff. The area manager told inspectors that the LHA was currently operating at a reduced staff complement of 19% at the time of the inspection and that the complexity of cases did not impact on this directive.

**Theme 5: Workforce**

The service organises and manages its workforce to ensure that staff members have the required knowledge, skills, experience and competencies to protect children and promote their welfare and to provide an effective service to children and families.

Related reference:

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

## Standard 5:1 – Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare

**This standard was met in part**

The current recruitment process was found to be safe and robust but significant deficits were found in the vetting of members of staff who had been in the service prior to the HSE centralised recruitment system.

The LHA adhered to the HSE national recruitment policy; recently appointed staff had gone through a centralised interview process and had been selected from a national panel in order of merit. Inspectors found records of interviews and the decisions made on many staff files. These files also contained job descriptions and signed contracts for all recently appointed staff. Inspectors also found evidence of appropriate qualifications, Garda Síochána vetting and three verified references in place for all staff appointed within the last five years. The acting principal social worker told inspectors that the LHA did not use agency or relief staff.

However, staff personnel records were not well organised, in a poor physical state and some lacked the requisite vetting. Staff records were stored in paper folders which were not strong enough to safely hold all of the documentation contained within. There was a risk that important documentation might be lost due to the poor quality of the files. Records were not in chronological order or divided into sub-sections and as such inspectors found them difficult to navigate and to retrieve

information with expedience. References were stored in brown envelopes stapled to the paper folders and again there was a risk of these being mislaid.

Many staff files required considerable updating and inspectors found 40% of staff files audited did not contain the requisite Garda Síochána vetting. These files pertained to long-standing members of staff, including some of the management team. The absence of Garda Síochána vetting was of significant concern and indicated a serious deficit. The area manager told inspectors that the LHA had commenced a re-vetting process for relevant staff. Most files contained the three necessary references, but not all of these had been independently verified.

There was no standardised, consistent formal induction programme in place across the service although some good practice was found. One social worker described an informal induction process that included visiting the department in advance of commencing employment. They received a written induction pack and were introduced to relevant agencies. Core training was provided including Children First (2011), courtroom skills, fire safety and manual handling. This social worker was given a protected caseload, more frequent supervision and was initially accompanied by another social worker whilst on duty. Another social worker had not received supervision within the first five months of service and did not have a protected caseload. As previously stated, information about local resources and services of direct benefit to children and families was not routinely available. The expectation that social workers would build up their own catalogue of resources as their knowledge and experience grew could have a negative impact on their ability to engage families with the most relevant services, in a timely fashion and provide them with services they needed. The lack of a formalised induction programme led to significant variations in the experience of new social workers to the service.

### Standard 5:2 – Staff have the required skills and experience to manage and deliver effective services

**This standard was met in part**

Staff retention was high and there was a long-standing, experienced staff team in place. Information provided to the Authority identified that the staff team was stable and a significant number of social workers had been in post for many years. As a result, there was a continuity of staffing which had a direct benefit for children and families. Through case file review, observation of practice and interviews with parents, inspectors found social work practice to be of a good standard across the service. Overall, inspectors found that staff were skilled and competent to meet the needs of the children and families with whom they engaged. All staff were professionally qualified. The rate of absenteeism was notably low at 2.4%. Of the 32.3 whole-time equivalent posts available to the service, there was one permanent vacancy at the time of inspection and six members of staff were on long-term leave; this had a direct negative impact on service provision.

Managers within the service had significant social work experience but they lacked managerial training. The acting principal social worker told inspectors that the provision of formal management training had been intermittent and was not provided to all staff who took up a managerial role. Some of the management team had attended an eight-day training course which aimed to develop practical skills in the management of people, including supervision. The acting principal social worker told inspectors that this training was no longer available due to financial constraints. However, he/she believed the training was of significant benefit and was cognisant that some of the team leaders had not had any formal management skills training. Inspectors were informed by the acting principal social worker that no further training was planned to address this deficit at the time of inspection and professional development opportunities remained limited. This had the potential to impact upon the LHA's ability to deliver the optimum service to children and families.

No training needs analysis had been undertaken by the LHA and there was no formal programme for the provision of ongoing training to staff. Managers were unable to readily identify the training needs of their team and a review of training needs did not form an integral part of supervision. The lack of oversight and comprehensive needs analysis resulted in an uneven distribution of training and development across the staff team. Inspectors found there was limited emphasis on continuous professional development which was largely left to the individual staff member to pursue. Through interviews with social workers, inspectors found that individual staff members identified gaps in their knowledge and skill base and applied for training to address this deficit accordingly. However, this approach relied entirely on the motivation of staff to pursue relevant training. Social workers were not always confident that resources would be made available to meet their need for continuous professional development. The LHA did not effectively ensure staff continued to be appropriately skilled to meet the needs of children and families and inspectors found an over-reliance on the professional training provided to social workers during qualification.

### Standard 5:3 – All staff are supported and receive supervision in their work to protect children and promote their welfare to children

**This standard was met in part**

The service adopted the HSE national policy on supervision although this was not always fully implemented, particularly in relation to the timelines set down for supervision. National policy states supervision should occur ideally every four weeks. In a number of case files reviewed, inspectors found that supervision was not occurring regularly or at recommended intervals and this included supervision for new social workers and staff requiring additional oversight.

Inspectors found the primary focus of supervision was case management. It was not reflective and did not focus on the strengths and risks of how the case was being managed and any outstanding needs of the social worker in order for them to

manage the case more effectively. There was little emphasis on training needs or continuous professional development. Whilst many staff spoke positively about the supportive aspect of supervision, inspectors found little evidence that supervision captured the learning from casework to improve social workers' skills and knowledge. Some staff told inspectors they would welcome a broader focus in supervision in addition to case management. Supervision was not used effectively to improve individual performance and develop professional knowledge.

Inspectors found that records of supervision were not comprehensive. While social work team leaders told inspectors that they had received training in supervision, a review of documentation showed written records of supervision was poor and there were no written records of cases not discussed at supervision. Discussion was largely task-centred and there was little focus on the quality of the work or the social worker's management of the case. Analysis of the quality of recording in case files was limited. On the positive side, social workers informed inspectors they were expected to prepare case summaries prior to supervision and a number of cases were discussed in detail at each session. They generally found this to be of benefit.

The majority of social workers spoken with reported that they felt well-managed and supported by their managers. They viewed line managers as approachable, accessible and supportive in helping them to manage the complexities and challenges of the work. Staff stated that managers had an open door policy and were responsive to their needs for consultation, direction and guidance outside of formal supervision.

There was no system in place to conduct annual performance appraisals of staff or to manage under-performance. All staff members interviewed told inspectors they were held accountable by their line managers primarily through the supervision process. However, the area manager identified some performance issues that had gone unaddressed. The lack of a formal system to address under performance in an expedient and transparent manner could potentially impact on the service provided to children and families.

There were a number of policies in place to support the safety of staff. Staff told inspectors of the HSE dignity at work policy and that they felt confident they could address any safety issues that arose with their line manager. A number of staff informed inspectors that managers promoted the safety of social workers and they gave examples of case management strategies employed to ensure the safety of individual workers. Team leaders told inspectors that they discouraged home visits taking place after hours and that two social workers sometimes undertook home visits together if any personal risk was identified. This was found to be an informal procedure used by certain line mangers. However, staff were not aware of a formal policy or procedure in relation to this. As such, practice was found to vary across the service in this regard and the associated risks had not been formally recorded in a risk register with the mitigating controls to protect staff.

Knowledge and understanding of the protected disclosure policy amongst the staff team was exceptionally limited. Social workers were not able to identify where to locate this policy and had limited or no knowledge of it. They told inspectors that they were not always willing to raise issues of concern with managers, with the notable exception of individual risks to children, as it could have a potential negative implication for them. Inspectors were concerned about this and raised the requirement for promoting an open and accountable culture throughout the service with the area manager and regional service director. They emphasised the need to implement the HSE's protected disclosure policy.

### Standard 5:4 – Child protection and welfare training is provided to staff to improve outcomes for children

**This standard was not met**

The service did not have a comprehensive or robust training programme to enhance the knowledge and skills of staff in the area of child protection and welfare and the training provided had been limited. All staff had received a briefing on Children First (2011) and most staff had attended joint training with An Garda Síochána. Social workers told inspectors this was of some benefit to them. However, the majority of staff relied upon their professional experience and familiarity with Children First guidelines (1999) to inform their practice.

The service had not conducted a training needs analysis in the 12 months prior to inspection and staff had limited and sporadic access to ongoing training. Apart from the core Children First (2011) training, not all social workers had access to relevant and current training to enhance their skills and knowledge. There had been no formal evaluation of training provided in order to determine the impact of training on practice. Team leaders identified that there was no schedule of training and social workers told inspectors that they often received short notice of relevant training and were unable to attend due to prior work commitments. Inspectors observed an example of this during the inspection when training was advertised on a Thursday for the following Monday in another geographical area. No member of staff availed of this training. The absence of a structured schedule of training resulted in a lack of coherent planning to enable all staff to access the most relevant training for them.

Staff had limited knowledge of the *National Standards for the Protection and Welfare of Children* and there had been no forum for discussion or shared learning following the launch of the Standards. Whilst staff knowledge and awareness of Children First was proficient, their lack of familiarity with national standards and other policies and procedures limited their ability to deliver an optimum service to children and families.

Training had been organised to facilitate inter-agency networking. The area manager, acting principal social worker and the chief superintendent informed inspectors that joint HSE/Garda Síochána training had taken place in 2012. The acting director of public health nursing also advised that her/his team had

participated in a joint training initiative. The regional HSE information officer told inspectors of the ongoing child protection training programme he/she provided to community and voluntary groups in the LHA. There was a strong emphasis on inter-agency work within the service and this had a direct benefit to children and families. Parents and children told inspectors they felt increasingly supported with the involvement of a multidisciplinary team.

**Theme 6: Use of Information**

Quality information and effective information systems are used to plan, deliver, manage and improve the quality of child protection and welfare services.

Related reference:

- Standard 6:1 – All relevant information is used to plan and deliver effective child protection and welfare services.
- Standard 6:2 – The service has a robust and secure information system to record and manage child protection and welfare concerns.
- Standard 6.3 – The service has a robust and secure record-keeping and file-management system to manage child protection and welfare concerns.

## Standard 6:1 – All relevant information is used to plan and deliver effective child protection and welfare services

**This standard was not met**

Overall, inspectors found that the quality of information governance within the LHA was poor and did not support the planning and delivery of an effective child protection and welfare service. The LHA did not have effective arrangements in place to support its immediate and future operational and risk management requirements.

Good information governance enables personal health information, such as that contained in a social care record, to be handled legally, securely, efficiently and effectively in order to support the best possible care to people who use social care services. It also includes the appropriate sharing of relevant personal health information between health and social care professionals involved in the provision of care with a view to informing the development of this care.

Data provided, both in advance and in the course of the inspection, by the LHA, was found to be unreliable and incomplete. The dataset, requested in advance of the inspection, was found to be incomplete on two occasions. Over the course of the inspection, inspectors identified that most of the data was available on the information system used by the LHA. However, the acting principal social worker told inspectors that he/she only became aware that this information was available during the inspection. Inspectors found that the failure to use the quality information undermined effective decision making for planning and service delivery purposes.

The LHA used an information system to gather information in relation to the service provided. This system supported the collection and protection of personal data as the system was password protected. However, the overall information management

system was not implemented in full and did not support the collection of quality data. The acting principal social worker told inspectors that some data was not inputted into the system consistently by the social workers in the LHA. Social workers told inspectors that they were not aware of the consequences for planning and delivering the service if they failed to input the relevant information that was available to them. This resulted in a system could not support effective decision-making for planning and service delivery in a safe way.

Inspectors found that standardised information was being collected in relation to intake, assessment and allocation activity and collated at a regional level and national level. This report included the number of referrals over the month and the number of open cases at the start and end of the month. The LHA was also required to submit information in relation to unallocated cases including how many there were, for how long had they been unallocated and how they had been reviewed while awaiting allocation. The LHA also submitted information on the prioritisation of allocated cases. Open cases were categorised into three priorities – high, medium or low – using nationally agreed definitions. Inspectors reviewed the reports produced by the LHA and spoke to the acting principal social worker, social work team leaders and social workers. It was not clear how this information had been captured and managed as the prioritisation system was not consistently used in the day-to-day management of open cases and social workers were not all aware of the nationally agreed definitions. The service director and the area manager had not identified the potential risk associated with the unallocated open cases and therefore had not developed any strategy to mitigate it. Nor was there evidence that the LHA learned from the information collected to improve the quality of the service provided. This again impacted on the safe delivery of an effective child protection and welfare service.

There was poor awareness of information governance and staff were not aware of their responsibilities and their accountability in this regard. Staff were not aware of any policies or procedures and had not received any recent training in relation to current legislation, national and international standards or evidence-based guidance. Some staff interviewed were aware of the Freedom of Information Acts 1997 and 2003 and identified that they facilitated children and families to have access to personal information held by the service in compliance with this legislation and in the best interests of the child. Others were not familiar with the provisions of these Acts, and the absence of a policy meant that there was a risk of inconsistent practices in relation to children and families accessing personal information held by the service.

The service did not have a process to regularly assess its compliance with relevant legislation, national Standards, evidence-based guidance and its own policies and procedures in order to ensure that information governance practices remained a priority and were regularly reviewed and improved.

## Standard 6:2 – The service has a robust and secure information system to record and manage child protection and welfare concerns

**This standard was met in part**

The LHA had a secure information system to record and manage child protection and welfare concerns. Inspectors used the information system and found that it had the potential to support the proactive management of child protection and welfare concerns. Inspectors found that when cases were allocated, the information within the system was generally detailed. However, inspectors also found that the templates were not consistently completed and did not contain all information required in Children First (2011).

Inspectors found that the LHA was not using this system to manage its waiting lists. Instead, it was creating additional documents off which to work. This meant that a case could inadvertently be erased from a list and not tracked within the child protection and welfare system.

As previously stated, the information system in place for listing children at ongoing risk of significant harm was not accurate or secure. Inspectors found that the child protection notification system (CPNS) was not up to date and there was the potential of inaccurate information being provided to social workers and other relevant professionals. Inspectors observed that the area manager's record of children on the CPNS was not secure as it was not password protected. Other deficits in the management of information in relation to the CPNS have been identified in Standard 2.6.

## Standard 6:3 – The service has a robust and secure record-keeping and file-management system to manage child protection and welfare concerns

**This standard was met in part.**

The electronic records system in the LHA was of good quality, but other aspects of the record keeping and file management system were not robust or secure to support the management of child protection and welfare information. Inspectors found that while there was a national policy for records management, staff were not aware of the policy and did not consistently implement it. Nor did staff consistently adhere to records management guidance as part of Children First (2011).

There was an electronic records system accessible to all social work team members. Inspectors reviewed a number of files and found them to be factual, accurate, updated regularly and dated and signed by the social worker. There was a requirement that the team leader signed off on screening and initial assessments. However, this was not done consistently in the files reviewed.

Hard copy files were found for families with an individual section for each child. The majority of the files reviewed as part of the sample were filed in chronological order and in the main entries were typed. Reports created by the allocated social worker were signed and dated. However, the LHA did not have a chronology of significant events representing the HSE's Child and Family Services involvement with a child/family, milestones reached and any known significant events, positive or negative, that would impact on the safety, care and wellbeing of the child.

The LHA identified archiving issues as a problem as they were unable to archive files. This had resulted in a backlog of files being held on site and inspectors observed hard copy files in a number of different locations, including in the acting principal social worker's office. Inspectors viewed filing cabinets containing closed referrals. There was an index card system in operation but not all files were indexed. Social workers told inspectors that they did not always review the index or previous contacts to the department when referrals were made. This practice had the potential to limit the robustness of the decision taken as part of the preliminary enquiry stage of the referral.

There was no process in place to regularly audit record keeping and file management systems and practices. As previously described, inspectors were provided with a copy of a limited audit of record keeping that had been carried out in September 2012. No other audits had taken place.

## Closing the fieldwork and next steps

On the final day of the fieldwork, a feedback meeting was held to report on the inspectors' findings, which highlighted both good practice and where improvements were needed. Following the fieldwork, a plan was received from the provider detailing its actions to address the areas of non-compliance. This action plan is published with this report.

**Report compiled:**

January 2013

# 6. Summary of judgments under each standard

| Theme | National Standards for the Protection and Welfare of Children | Standard Met, Met in Part and Not met |
|---|---|---|
| **Theme 1: Child-centred Services** | Standard 1:1<br>Children's rights and diversity are respected and promoted. | Standard met in part |
| | Standard 1:2<br>Children are listened to and their concerns and complaints are responded to openly and effectively. | Standard met in part |
| | Standard 1:3<br>Children are communicated with effectively and are provided with information in an accessible format. | **Standard not met** |
| **Theme 2: Safe and Effective Services** | Standard 2:1<br>Children are protected and their welfare is promoted through the consistent implementation of Children First. | **Standard not met** |
| | Standard 2:2<br>All concerns in relation to children are screened and directed to the appropriate service. | Standard met in part |
| | Standard 2:3<br>Timely and effective action is taken to protect children. | Standard met in part |
| | Standard 2:4<br>Children and families have timely access to child protection and welfare services that support the family and protect the child. | Standard met in part |
| | Standard 2:5<br>All reports of child protection concerns are assessed in line with Children First and best available evidence. | Standard met in part |
| | Standard 2:6<br>Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare. | **Standard not met** |

| Theme | National Standards for the Protection and Welfare of Children | Standard Met, Met in Part and Not met |
|---|---|---|
| **Theme 2: Safe and Effective Services** | Standard 2:7<br>Children's protection plans and interventions are reviewed in line with requirements in Children First. | **Standard not met** |
| | Standard 2:8<br>Child protection and welfare interventions achieve the best outcomes for the child. | Standard met in part |
| | Standard 2:9<br>Inter-agency and inter-professional cooperation supports and promotes the protection and welfare of children. | Standard met in part |
| | Standard 2:10<br>Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children. | **Standard not met** |
| | Standard 2:11<br>Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels. | Standard met in part |
| | Standard 2:12<br>The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to. | Standard met in part |
| **Theme 3: Leadership, Governance and Management** | Standard 3:1<br>The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare. | Standard met in part |
| | Standard 3:2<br>Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability. | **Standard not met** |

| Theme | National Standards for the Protection and Welfare of Children | Standard Met, Met in Part and Not met |
|---|---|---|
| **Theme 3: Leadership, Governance and Management** | Standard 3:3<br>The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery. | **Standard not met** |
| | Standard 3:4<br>Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards. | Standard met in part |
| **Theme 4: Use of Resources** | Standard 4:1<br>Resources are effectively planned, deployed and managed to protect children and promote their welfare. | Standard met in part |
| **Theme 5: Workforce** | Standard 5:1<br>Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare. | Standard met in part |
| | Standard 5:2<br>Staff have the required skills and experience to manage and deliver effective services to children. | Standard met in part |
| | Standard 5:3<br>All staff are supported and receive supervision in their work to protect children and promote their welfare. | Standard met in part |
| | Standard 5:4<br>Child protection and welfare training is provided to staff working in the service to improve outcomes for children. | **Standard not met** |
| **Theme 6: Use of Information** | Standard 6:1<br>All relevant information is used to plan and deliver effective child protection and welfare services. | **Standard not met** |
| | Standard 6:2<br>The service has a robust and secure information system to record and manage child protection and welfare concerns. | Standard met in part |

| Theme | National Standards for the Protection and Welfare of Children | Standard Met, Met in Part and Not met |
|---|---|---|
| | Standard 6.3<br>Secure record-keeping and file-management systems are in place to manage child protection and welfare concerns. | Standard met in part |

# 7. Glossary of Terms

**Care orders:** under the Child Care Act, 1991 there are a number of procedures, which the Health Service Executive (HSE) can use when dealing with children who are at risk or who are in need of care. The HSE may apply to the courts for a number of different orders, which give the courts a range of powers including decisions about the kind of care, and the access to the children for parents and other relatives. The HSE must apply for a care order if a child needs care and protection which he/she is unlikely to receive without an order. The district court judge may make an interim care order while the decision on a care order is pending. This means that the child is placed in the care of the HSE for eight days. It may be extended if the HSE and the parents agree. Generally the parents/guardians must be given notice of an interim care order application.

A care order may be made when the court is satisfied that:

- the child has been or is being assaulted, ill-treated, neglected or sexually abused
- or that the child's health, development or welfare has been or is likely to be impaired or neglected
- the child needs care and protection which he/she is unlikely to receive without a care order.

When a care order is made the child remains in the care of the HSE for the length of time specified by the order or until the age of 18 when he/she is no longer a child. The HSE has the rights and duties of a parent during this time.

**Child Abuse**: child abuse can be categorised into four different types; neglect, emotional abuse, physical abuse, and sexual abuse. A child may be subjected to one of more forms of abuse at any given time. For detailed guidance and signs and symptoms on each type of abuse, please refer to Children First (2011).

Child protection concern: the term 'child protection concern' is used when there are reasonable grounds for believing that a child may have been, is being or is at risk of being physically, sexually or emotionally abused or neglected.

***Children First: National Guidance for the Protection and Welfare of Children* (2011):** Promotes the protection of children from abuse and neglect. It states what organisations need to do to keep children safe, and what different bodies, and the general public should do if they are concerned about a child's safety and welfare. It sets out specific protocols for HSE social workers, Garda Síochána and other front-line staff in dealing with suspected abuse and neglect.

**Child protection conference (CPC):** a child protection conference (CPC) is an inter-agency and inter-professional meeting, convened by the designated person in the HSE. The purpose of a child protection conference is to facilitate the sharing and

evaluation of information between professionals and parents/carers, to consider the evidence as to whether a child has suffered or is likely to suffer significant harm, to decide whether a child should have a formal child protection plan and if so to formulate such a plan.

**Child Protection Notification System (CPNS):** the Child Protection Notification System (CPNS) is a HSE Children and Family Services' record of every child about whom there are unresolved child protection issues, resulting in the child being the subject of a Child Protection Plan. The decision to place a child on the CPNS is made at a child protection conference.

**Child welfare concern**: a problem experienced directly by a child, or by the family of a child, that is seen to impact negatively on the child's health, development and welfare, and that warrants assessment and support, but may or may not.

**Designated liaison person:** every organisation, both public and private, that is providing services for children or that is in regular direct contact with children should identify a designated liaison person to act as a liaison with outside agencies and a resource person to any staff member or volunteer who has child protection concerns.

**Designated person:** every HSE health area has a designated person within the HSE with responsibility for coordinating child protection services.

**Family Support:** activities for families that are developmental (e.g. parenting for the first time), compensatory (e.g. helping a child cope with a disability) and/or protective (e.g. ensuring safety of a young person).

**Screening:** the evaluation of a referral made for a child and/or family to assess which service the referral should be forwarded to.

**Serious incident:** a death or a potentially life-threatening injury or serious and permanent impairment of health, wellbeing or development. Defining a serious incident in child protection and welfare is extremely complex. The nature and number of serious incidents reported will inform any future revisions of this definition.

**Service:** the term in this document refers to the HSE Children and Family Services.

**Service level agreement:** is part of a service agreement or contract where the level of service is formally defined.

**Social worker:** the social worker assigned by the HSE to carry out its statutory responsibilities for the safety and welfare of a child.

**Staff:** the people who work in, for or with the service provider. This includes individuals that are employed, self-employed, temporary, volunteers, contracted or

anyone who is responsible or accountable to the organisation when providing a service to children and families.

**Support network:** friends, family, relevant agencies and others who provide support to children and families when they face difficulties coping and managing with their personal circumstances and day-to-day routines.

**Timely:** refers to action taken within a timeframe which meets the welfare and protection needs of any particular child and his/her circumstances. Particular time frames are outlined in Children First (2011) and HSE business processes.

**Health Information and Quality Authority**
**Social Services Inspectorate**

# Action Plan


**HSE response to report***

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| **HSE Area** | Carlow Kilkenny Local Health Area |
| **Service ID:** | 631 |
| **Date of inspection:** | 12 November 2012 |
| **Date of response:** | 26 April 2013 |

## Recommendations

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

### Theme 1: Child-centred Services

**The LHA was not compliant with the standard in the following respect:**

The LHA did not have policies in place to support children's rights and diversity being consistently respected and promoted.

**1. Action required:**

The LHA should put in place and implement policies to support children's rights and diversity being consistently respected and promoted.

* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

| **Related reference:**<br><br>Standard 1:1<br>Children's rights and diversity are respected and promoted. | |
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| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 1**<br><br>The LHA Child Protection Service will work with the National Office to develop Policy and Guidance on the UN Convention of the Rights of the Child and following that will develop a detailed local implementation plan. Managers and staff, including social work staff, will, through Team Meetings and supervision, understand their roles and responsibilities in relation to their practice with children and their families and will make sure practice reflects the UN Convention on the rights of the Child.<br><br>The implementation Plan will be monitored and reviewed by supervisors, Team Leaders and the PSW with case files demonstrating an increased awareness on behalf of staff, increased awareness by children and their parents and an increase in the number of children and parents exercising those rights, through increased input into and influence in Case Conferences and exercising choice.<br><br>An independent Review of the outcomes of this work will be carried out by the Chair of Case Conferences and through regular file audits.<br><br>The LHA will engage the Association for Young People in Care (EPIC) in this work.<br><br>Social Workers and Team Leaders will receive training from the local Integration Forum on working with children, their families and communities from diverse backgrounds. Good practice will be identified and shared and progress monitored through Team Meeting, Supervision and case file audit. | National Office will produce guidance by end of June 2013 Responsibility National Office<br><br>PSW, Team Leaders and the Independent Chair of Case Conferences.<br><br>Area Manager, PSW, Team Leaders by June 2013 |

| **Theme 1: Child-centred Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not have measures in place to address communication difficulties and facilitate all children in reporting concerns and complaints.<br><br>The LHA did not have an overall system for recording, evaluating and measuring trends of complaints. | |
| **2. Action required:**<br><br>The LHA should put systems in place to ensure all children are facilitated to express their concerns and complaints. | |
| **3. Action required:**<br><br>The LHA should ensure that a central record of all complaints is maintained that details the category, investigation and outcome of the complaint and whether or not the complainant was satisfied with the outcome. | |
| **Related reference:**<br><br>Standard 1:2<br>Children are listened to and their concerns and complaints are responded to openly and effectively. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 2**<br><br>The LHA will assess the needs of children and families for Interpreting Services and review current practice. The Area Manager and PSW will meet with the National Interpreting Service, review the services provided and agree a robust service that meets the needs of children and their families. This will include confidentiality, consistency and continuity. Children and family members/friends will | Area Manager, PSW and Team Leader By end June 2013 |

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| not be asked to interpret for those referred to or using services.<br><br>All communication methods including use of interpreters will be reviewed through case file audits and supervision. Progress will be reported through Team Meetings and good practice shared.<br><br>A robust system of recording and monitoring progress on complaints will be established and outcomes used to facilitate learning and inform practice through Team Meetings and regular reports.<br><br>**Action 3**<br><br>A register of complaints will be set up and located within each area team. Complaints will be logged on a central register to ensure oversight of the process showing details of category, investigation and outcome of complaint and whether or not complainant is satisfied with the outcome.<br><br>Progress on complaints, including the views and experience of those who make complaints, will be recorded and outcomes used to improve services through supervision and discussions at Team Meetings. | Area Manager, PSW and Team Leaders<br>By end June 2013 |

| **Theme 1: Child-centred Services** | |
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| **The LHA was not compliant with the standard in the following respect:**<br><br>The LHA did not communicate effectively with children and families, or provide them with information in an accessible format.<br><br>The LHA did not disseminate information to the public on child protection and welfare services. | |
| **4. Action required:**<br><br>The LHA should ensure that children and families are communicated with effectively and provided with information in an accessible format. | |
| **5. Action required:**<br><br>The LHA should disseminate information to the public on child protection and welfare services. | |
| **Related reference:**<br><br>Standard 1:3<br>Children are communicated with effectively and are provided with information in an accessible format. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 4**<br><br>Information on what services are provided to whom and on what basis will be designed, published and made available in all areas where children and their parents come into contact with services. This information will be in an accessible format to meet the needs of all the local population and will be provided, as a matter of course, to those referred or currently using services. The distribution will take place through Team Meetings and Supervision and will be monitored as part of case file audits and in Supervision. | Area Manager, Team Leaders and Social Work Staff End May 2013 |

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| Social Workers will ensure that all who use their services, including foster carers, will have access to their HSE office and phone contact details and contact details of alternative staff when they are not available.<br><br>Effectiveness will be reviewed through supervision and in Focus Groups with Children and Parents and with Foster Carers.<br><br>**Action 5** | |
| The HSE information detailing Children and Family Services and contact details will be sent to all GP's, Schools, Family Resource Centres and Section 39 Agencies. | Area Manager<br>By 30 April 2013 |
| Information leaflet for children and young people regarding Child Protection Conferences and their participation at conferences has been devised. | Completed by Chair CPCC |
| Information leaflet to children/young people regarding Child Protection Conferences will be issued where appropriate through allocated Social Worker. | By CPC Chair<br>By 31 March 2012 |
| The LHA will make sure social work staff and allied professional are aware of the National Campaign on implementing Children First and will respond to policies and procedures being developed to support other agencies to meet their responsibilities under Children First. | Area Manager, PSW<br>Ongoing<br>In conjunction with National Lead Children First |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respect:**<br><br>The LHA did not consistently implement Children First *(2011)* to protect and promote the welfare of children and staff were not sufficiently aware of their responsibilities in this regard | |
| **6. Action required:**<br><br>The LHA should ensure that the children are protected and their welfare is promoted through the consistent implementation of Children First *(2011)* | |
| **Related reference:**<br><br>Standard 2:1<br>Children are protected and their welfare is promoted through the consistent implementation of Children First. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 6**<br><br>The Area Manager and PSW will review understanding of Children First; identify gaps in understanding and hold briefing sessions, with input from the National Office. Robust action will be taken to ensure all staff and managers understand the principles of Children First and their roles and responsibilities in relation to Children First. The review will ensure that staff are carrying out their respective roles under Children First in a timely and consistent manner.<br><br>Part of the briefing will include the roles and responsibility of other agencies, referral routes and the timeliness and content and conduct of case conferences.<br><br>Review through Team Meetings, Case Discussion, Supervision, File Audit and monitoring by the Independent Chair of Case Conferences | Area Manager and PSW to lead, by end Aug 2013.<br><br>Area Manager, PSW and CPCC Chair |

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| The LHA will take part in the National Review of Standardised Business Processes and take robust and consistent action to make sure they are implemented effectively. | National Lead<br>Local implementation Phase 1 Completed<br>Phase 2 – April 2013 |
| In ensuring compliance with Children First National Guidance for the Protection and Welfare of Children 2011, facilitated learning has commenced and will continue with frontline Social Workers on initial assessments, CPC, interagency and child welfare and family support plans. | June 2013 PSW |
| All new staff will receive a copy of Children First and their understanding of the guidance and the implications for their roles and responsibilities will be monitored during supervision so that future sign off will be based on comprehension and implementation during daily practice. | Team Leaders and Supervisors end May 2013 |
| All Children on the CPNS will be monitored and reviewed in supervision and the CPNS monitored for effective delivery of timely and robust information to inform case work with children and their families and Case Conferences and Reviews. | Team Leaders and Supervisors end May 2013 |

| **Theme 2: Safe and Effective Services** |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not complete screening of all concerns in line with Children First (2011) and there were shortcomings in the effectiveness of the duty system.<br><br>The LHA's decision making process for screening was not guided by a clear understanding of thresholds of harm.<br><br>The LHA did not provide those who made referrals with appropriate feedback, in line with Children First (2011). |
| **7. Action required:**<br><br>The LHA should ensure that all concerns in relation to children are screened and preliminary enquiries undertaken so that children are directed to the appropriate service. |

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| **8. Action required:**<br><br>The LHA should ensure that there are clearly defined thresholds of harm to support children being directed to the appropriate service. | |
| **9. Action required:**<br><br>The LHA should ensure that all persons who make a referral are provided with appropriate feedback, in line with Children First (2011). | |
| **Related reference:**<br><br>Standard 2:2<br>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 with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 7**<br><br>A single dedicated Duty Team will be established that reflects the LHA CP Services responsibilities to local children and families under Children First, providing an informed and professional service that demonstrably improves consistency and transparency of services. This service will be established in April; 2013 reviewed on a quarterly basis [June 2013] to ensure a robust and timely response to all referrals.<br><br>The LHA CP Services will work proactively with referring agencies to ensure a shared understanding of the roles and responsibilities of each agency and to improve communication. The practice of keeping referring agencies informed of progress will improve so that the roles of The LHA CP Services for monitoring the risk to children is clarified and work with other agencies to support that is also clear, on a case by case basis.<br><br>The LHA CP Services will take robust and effective action to make sure that work with children and their families in relation to all CP cases has the impact of demonstrably reducing risk.<br><br>The national standardised framework for assessing risk and prioritisation currently being implemented will be reviewed for effectiveness and the relationship with Measuring the Pressures established as daily practice and reported to the PSW and Area | Area Manager, PSW, Team Managers and staff by end June 2013 |

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| Manager.<br><br>**Action 8**<br><br>An update on the National Work on Thresholds will be made available to the LHA and the implications for practice shared in Team Meetings and in supervision. The LHA will implement thresholds consistently across the area.<br><br>A review of implementation of thresholds will be carried out through supervision and in case files audit.<br><br>**Action 9**<br><br>Files will be audited on a regular basis and supervision of all case work and decisions following referral will include robust action that ensures referrers are kept informed of the outcome or progress on referrals and know who to contact if they have continued or escalating concerns.<br><br>The LHA will use local and national information to make sure families are assessed and directed to support services as appropriate. Duplication of services will be identified and reduced, children and their families will access support services that meet need at the earliest opportunity. The LHA will inform referrers (where appropriate) in all cases when work is complete and inform all relevant professionals making sure they are aware of routes back should circumstances change. | National Office, Area Manager, PSW and staff by end June 2013<br><br>PSW, Team Leaders and staff by end Aug 2013 |

| **Theme 2: Safe and Effective Services** |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA was not making decisions to protect children in a timely manner.<br><br>The LHA were not implementing the national prioritisation framework to ensure children were effectively protected in a consistent way<br><br>The LHA did not have quality assurance processes in place to ensure that decisions focused on safety and did not leave children at risk. |

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| **10. Action required:**<br><br>The LHA should ensure decisions to protect children are taken in a timely manner. |
| **11. Action required:**<br><br>The LHA should ensure the consistent implementation of a prioritisation framework to ensure children were effectively protected. |
| **12. Action required:**<br><br>The LHA should ensure that quality assurance processes are established and implemented to ensure that decisions taken are focused on safety and do not leave children at risk. |
| **Related reference:**<br><br>Standard 2:3<br>Timely and effective action is taken to protect children. |

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
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| **Action 10**<br><br>The LHA will review the merger of the two duty systems to ensure compliance is robust and outcomes for children consistent. The review will ensure that children and families are receiving a consistent service that reflects the Framework for Measuring the Pressure, cases allocated and Assessments completed in a timely manner. The application of the principles and guidance provided within Measuring the Pressure will be assessed through supervision and file audits. Action will be taken where improvement needed. | PSW, Team Leaders, Staff, by end of April 2013 |
| **Action 11**<br><br>Measuring the Pressure will be discussed at Team Meetings and in supervision and the relationship between that and practice decisions identified and implemented so that case files and case discussion reflects a clear and consistent understanding of the key principles of the Framework for Measuring the Pressure that is to make decisions in CP cases and reduce risk.<br>Additionally, action taken to reduce risk to children through making effective decisions in a timely manner will be demonstrably evidenced through case recording. | Area Manager, Team Leaders and staff by end April 2013 |

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| **Action 12**<br><br>A Quality Assurance System will be formalised that identifies, collates and uses all available information on pressures, response across the LHA , Case File Audit, and information from those who use services and their relatives as well as referring agencies. That information and analyses will mean the LHA knows local need, services available, pressures and the impact of the local response in identifying and reducing risk. The LHA CP Services will develop robust plans for improvement to measuring and managing service need and provision.<br><br>The resultant reduction of risk to children and their families will be demonstrated through case file audits and implementation of measuring the pressures in the context of Children First. Progress will be reported to Team Leaders and the PSW as well as the Area Manager and Service Director. | Service Director, Area Manager, PSW and Team Leaders by end of<br>August 2013 |

| **Theme 2: Safe and Effective Services** |
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| **The LHA was not compliant with the standard in the following respect:**<br><br>The LHA did not have a formal model of service delivery to respond to the needs of children and families.<br><br>The LHA did not make referrals to early intervention services in a timely manner.<br><br>The LHA had a high threshold for accepting welfare referrals, which meant that some children's needs might not be appropriately addressed.<br><br>The LHAs child welfare and family support plans did not fully comply with the requirements of Children First (2011). |
| **13. Action required:**<br><br>The LHA should agree and implement a formal model of service delivery to respond to the needs of children and families. |

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| **14. Action required:**<br><br>The LHA should review their process of referrals to early intervention services to ensure they occur in a timely manner. | |
| **15. Action required:**<br><br>The LHA should review and agree the threshold for welfare referrals to be accepted. | |
| **16. Action required:**<br><br>The LHA should ensure that child welfare and family support plans fully comply with the requirements of Children First (2011). | |
| **Related reference:**<br><br>Standard 2.4<br>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 with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br>**Action 13**<br><br>A formal model of response, compliant with Children First and in the context of the Measuring the Pressures Guidance and the National Service Delivery Framework Model will be established in the duty and referral service across the LHA that responds to the needs of children and families. This will include an assessment of need, capacity to meet need and a sharing of information about resources available across the area including Family support and community development. Information on those services will be shared with all children and families using or coming into contact with CP Services in the LHA.<br><br>The National Service Delivery Model including the established of formal Local Area Pathways will be implemented when delivered to local areas.<br><br>**Action 14**<br><br>The LHA will take an active part in the Review of Standardised Business Processes and use the outcome to support ongoing | National Lead on the National Service Delivery Model. Service Director, Area Manager, PSW and Team Leaders by end May 2013 |

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| implementation of the Business Processes.<br><br>The new duty and assessment system will proactively identify those children and families who could benefit from prevention, welfare and support services and will refer on as appropriate.<br><br>Social Workers and Team Leaders will be made aware of the importance of ensuring access to preventive services in a timely manner to children and their families and will seek to ensure that child welfare matters do not escalate to become child protection concerns wherever possible. Information and advice will be recorded and considered as part of supervision. | Area Manager, PSW, Team Leader, Social Workers by end May 2013 |
| The LHA area is currently engaged with key funded agencies and the Family Resource Centres in advancing the Local Area Pathways to create a collaborative network of community voluntary and statutory providers so as to improve access for children and families to support services at all levels of need. | Area Manager, PSW, Community Development Worker Q3 2013 |
| **Action 15**<br><br>The LHA will undertake a robust review of services referred to early intervention and ensure they consistently demonstrate an understanding of the application and meet thresholds for referrals to those services. Monitoring will ensure that cases are closed that consistently demonstrate an understanding of the application of and meet thresholds of referral when work is complete. Professionals working with families will be informed when cases are closed and provided with information to re refer if necessary. | Team Leaders and Social Workers by end June 2013 |
| **Action 16**<br><br>The LHA will review all services provided as part of child welfare and family support services to ensure services provided on their behalf to children and families are compliant with Children First. This will be carried out in the context of implementation of the Standardised Business Process and reviewed through supervision and Team Meetings as these become fully operational. | PSW and Team Leaders by end July 2013 |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA assessment system was fragmented, did not adhere to the required time frames and An Garda Síochána were not always notified of concerns in line with Children First (2011).<br><br>The LHA's assessment process was not supported by risk assessment tools to ensure that social workers made effective decisions, consistently to protect children and promote their welfare.<br><br>The LHA did not use strategy meetings effectively and in line with Children First (2011). | |
| **17. Action required:**<br><br>The LHA should ensure that the assessment process for all reports of child protection concerns are carried out in line with Children First (2011). | |
| **18. Action required:**<br><br>The LHA should ensure that risk assessment tools are developed and implemented to ensure that social workers make effective decisions, consistently to protect children and promote their welfare. | |
| **19. Action required:**<br><br>The LHA should ensure that strategy meetings are used effectively and in line with Children First (2011). | |
| **Related reference:**<br><br>Standard 2:5<br>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 with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 17**<br>The LHA will review referral and assessment processes to ensure | Area Manager, PSW |

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| they are effective, meet the needs of children and families, reduce risk and are consistent across the area as well as complying with Children First and demonstrating the use of guidance and tools available under Measuring the Pressures. Strategy Meetings, Core Group Meetings and Professionals' Meetings will take place on an ongoing basis. These meetings will contribute to the assessment process, enable intervention to be planned effectively and efficiently, ensure the delivery of services are child centred and identify the roles and responsibilities of the respective professionals.<br><br>Implementation of the robust processes will be monitored by the PSW and Team Leaders and progress reported to the Area Manager. | and Team Leaders By end June 2013 |
| **Action 18**<br><br>The LHA will review the effective use of risk assessment tools within the Measuring the Pressure Framework and the HSE Child Protection and Welfare Practice Handbook to make sure that a robust response is made in all cases to protect children and promote their welfare. | PSW and Team Leaders by end July 2013 |
| **Action 19**<br><br>The LHA CP Services will engage with all relevant agencies to increase attendance at Strategy Meetings in line with Children First.<br><br>The LHA CP Services will review the system for deciding when Strategy Meetings are necessary, who attends and will ensure social workers and other agencies attending are aware of the purpose of the meetings and their individual roles and responsibilities. The LHA will take action to ensure a robust approach is taken to attendance.<br><br>Action to improve this area of service will be monitored through file audits and supervision. | Area Manager, PSW, Team Leaders and Social Workers end of June 2013. |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not have systems in place to support the development of child protection plans to protect and promote children's welfare in line with Children First (2011).<br><br>The LHA's child protection notification system did not comply with Children First (2011).<br><br>The LHA did not sufficiently engage and support parents as part of the child protection conference process and parents were not clear about the significance of their child's name being placed on the child protection notification system. | |
| **20. Action required:**<br><br>The LHA should ensure that children who are at risk of harm have a child protection plan in place which is in line with Children First (2011), to protect and promote their welfare. | |
| **21. Action required:**<br><br>The LHA should ensure that the child protection notification system in place complies with Children First (2011). | |
| **22. Action required:**<br><br>The LHA should ensure that parents are engaged with and supported as part of the child protection conference process and that parents are provided with sufficient information to ensure they understand the significance of their child's name being placed on the child protection notification system. | |
| **Related reference:**<br><br>Standard 2:6<br>Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 20** | |

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| The LHA will review Child Protection Plans and take a robust approach to ensure children have an effective Child Protection Plan that complies with Children First. Provision of child protection case conferences, timeliness and reviews will include a reflection of the roles and responsibilities of Social Workers and their Supervisors in meeting the requirement of Children First. Child Protection Plans will demonstrably reduce risk and improve lives, and contain information on outcomes from planned reviews.<br><br>A consistent approach to obtaining and sharing information with parents, children and other agencies/professionals, consistent with Children First will be established by the PSW in consultation with the Independent Chair. Effectiveness of implementation will be reviewed. | Area Manager, PSW, Team Leaders.<br>by end June 2013 |
| **Action 21**<br><br>The LHA will review the CPNS, identify inconsistencies with Children First and take robust actions to ensure compliance. This will include an assessment of accuracy and identification of outstanding risk, which will be assessed and addressed.<br><br>Compliance with upkeep of the CPNS in the context of Children First will be reviewed at area management level, team meetings and case discussions with improvements in CPNS being demonstrated in Child Protection Cases and through establishment of an up to date, accurate and timely CPNS System. | PSW, CPCC Chair, and Team Leaders by end July 2013 |
| Once a child is no longer subject to a Child Protection Plan parents/ young people will be informed, similarly other relevant stakeholders such as the School, Gardai, GP, and Public Health Nurse in writing. | Area Manager, CPCC Chair |
| **Action 22**<br><br>An information leaflet on Child Protection Conferences which includes information about the purpose of child protection conferences and Child Protection Notification System has been revised and will be reviewed following implementation.<br><br>The LHA has reviewed its information leaflet. The revised version outlines what the Child Protection Notification System is, how CPC's are managed, who attends, how to participate and how to complain. The implication of the process will be explained.<br><br>Information leaflet to parents has been amended to ensure parents are aware that they can be accompanied by an advocate or family member to the CPC. | Area Manager, PSW, CPCC Chair, by end May 2013<br><br>Completed by Chair CPC March 2013<br><br>Completed by Chair |

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| The LHA will implement the recommendations, revised procedures and guidance on the operation of the CPNS including the National Guidelines for Area Managers, Social Work Managers and Practitioners for conducting Child Protection Conference when issued in 2013. | CPC March 2013 |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not review child protection plans in line with Children First (2011).<br><br>The LHA did not have a robust system in place to close cases based on the outcomes for children. | |
| **23. Action required:**<br><br>The LHA should ensure that all child protection plans are reviewed in line with Children First (2011). | |
| **24. Action required:**<br><br>The LHA should develop and implement a robust system to close cases based on the outcomes for children. | |
| **Related reference:**<br><br>Standard 2:7<br>Children's protection plans and interventions are reviewed in line with requirements in Children First. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 23**<br><br>All children at risk of significant harm have a child protection plan in place. Child Protection Plans are reviewed in line with Children First. A robust system will be established to ensure these will be reviewed in line with Children First. | PSW, Independent Chair of Case Conferences, Team Leaders and Social |

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| **Action 24**<br><br>The LHA will ensure that all cases where child protection issues have been resolved and/or work completed with children and their families are closed and other agencies involved notified. | Workers By end May 2013<br><br>Team Leaders, Social Workers by end June 2013 |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA had not undertaken a systematic review of child protection and welfare interventions to assess the effectiveness of these interventions for children and families.<br><br>The LHA had no robust system in place to consistently consider and respond, as appropriate, to changes in the level of risk to children or where there was a lack of progress with interventions. | |
| **25. Action required:**<br><br>The LHA should undertake a systematic review to assess the effectiveness of child protection and welfare interventions for children and families to ensure the best outcomes for children are achieved. | |
| **26. Action required:**<br><br>The LHA should implement a robust system to consistently consider and respond, as appropriate, to changes in the level of risk to children or where there was a lack of progress with interventions. | |
| **Related reference:**<br><br>Standard 2:8<br>Child protection and welfare interventions achieve the best outcomes for the child. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 25** | |

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| Reviews of the impact of interventions will be undertaken through supervision with social workers and an assessment of impact recorded on files and demonstrably used to guide further intervention. Learning and information about what works well with children and their families will be shared at case reviews, through Team Meetings and identified during file audits. | PSW, Team Leaders, Social Work Staff End June 2013 |
| When developed, the National Quality Assurance Strategy will be implemented in the LHA with all managers and staff meeting their responsibilities to improve quality. | Head of QA; August 2013 |
| **Action 26**<br><br>The LHA CP Services will ensure the systems established to review cases on a monthly basis where risk does not appear to reduce will be robust and where ongoing risk is identified an appropriate and immediate response will be planned. | PSW and supervisors, by end of June 2013 |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not have clear procedures to support good effective working relationships including inter-agency working relationships. | |
| **27. Action required:**<br><br>The LHA should establish clear procedures to support good effective inter-agency and inter-professional working relationships to support and promote the protection and welfare of children. | |
| **Related reference:**<br><br>Standard 2:9<br>Inter-agency and inter-professional cooperation supports and promotes the protection and welfare of children. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |

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| HSE response:<br><br>**Action 27**<br><br>The LHA will review work with interagency colleagues and ensure agreements are established that reflect the roles and responsibilities of all participants and ensure all cases where significant harm or neglect is identified are responded to appropriately. | Area Manager, PSW, End August 2013 |

| **Theme 2: Safe and Effective Services** |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA had not allocated a social worker to all children at risk of significant harm or neglect.<br><br>The LHA did not have a formal caseload allocation system.<br><br>The LHA did not have a robust system in place to monitor and review the case management process and evaluate the standard of service provision. |
| **28. Action required:**<br><br>The LHA should ensure that all children at risk of significant harm or neglect have an allocated social worker. |
| **29. Action required:**<br><br>The LHA should develop, implement and evaluate a formal caseload allocation system. |
| **30. Action required:**<br><br>The LHA should develop and implement a robust system to monitor and review the case management process and evaluate the standard of service provision and disseminate relevant learning to improve the management of child protection and welfare concerns and service delivery. |
| **Related reference:**<br><br>Standard 2:10<br>Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children. |

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
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| HSE response:<br><br>**Action 28**<br><br>All children who are at risk of significant harm are prioritised by Social Work Team Leader in accordance with the Measuring the Pressure Framework. It is now practice to have these cases reviewed and prioritised on a weekly basis by Social Work Team Leader. Case at risk of significant harm are prioritised for allocation to a Social Worker<br><br>All unallocated cases of Social Workers that are on leave will be reviewed by SWTL in accordance with the National Framework for Measuring the Pressure. These contingency plans will be reviewed on an ongoing basis.<br><br>**Action 29**<br><br>The LHA will continue to engage with the National Caseload Management System being developed by the National Office. In the meantime, Team Leaders will continue to assess risk, using tools available through Measuring the Pressure. A consistent approach to managing risk will be established in the context of pressure on resources and the need to respond to children who are at risk of significant harm.<br><br>Reflection on the content of cases and responses will be encouraged at team meetings, learning will be shared as will the use of local resources to resolve some parts of complex case work.<br><br>The allocation of all cases and the provision of continuity and a consistent service will remain a significant priority for Managers and for Social Work Staff.<br><br>**Action 30**<br><br>All open cases will continue to be monitored during supervision and the updated Supervision Policy will be implemented when available.<br><br>Caseloads and complexity of cases will continue to be part of the improved response to Measuring the Pressure so that decisions are informed by that guidance and cases are prioritised and managed | PSW and Team Leaders by end June 2013<br><br>PSW and Team Leaders Ongoing<br><br>Team Leaders and Social Work Staff By end July 2013<br><br>PSW<br><br>PSW, Social Work Team Leader, end June 2013 & ongoing |

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| consistently. Service delivery will be reviewed through supervision. | |

| **Theme 2: Safe and Effective Services** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA had not notified all serious incidents to the National Office and National Incident Management Team in a timely manner. | |
| **31. Action required:**<br><br>The LHA should ensure that all serious incidents are notified to the National Office and National Incident and Management Team in line with national policy. | |
| **Related reference:**<br><br>Standard 2:11<br>Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 31**<br><br>The National Protocol for notification of serious incidents will be followed robustly. Learning from case reviews will be shared and used during supervision and discussed at Team Meetings. This will inform the development of the Child Protection and Child Welfare Services. | Area Manager, PSW, Social Work Team Leaders by end May 2013 |

| **Theme 2: Safe and Effective Services** |
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| **The LHA was not compliant with the standard in the following respect:**<br><br>The LHA did not have a formal process in place to identify and respond to reported cases of organisational and institutional abuse. |
| **32. Action required:**<br><br>The LHA should introduce a formal process to identify and respond to reported cases of |

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| organisational and institutional abuse. | |
| **Related reference:**<br><br>Standard 2:12<br>The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 32**<br><br>All staff will be reminded through Team Meetings and in Supervision of the process for assessment of risk in relation to organisational and institutional abuse. The current process will be formalised between the Area Manager and the Gardaí so that the strengths of the system are consolidated. | Area Manager, PSW and Social Work Team Leaders end July 2013 |

| **Theme 3: Leadership, Governance and Management** |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>Staff members' knowledge of the National Standards for Child Protection and Welfare and national policies was inadequate.<br><br>The LHA were not disseminating learning from reviews and recommendations within child and family services. |
| **33. Action required:**<br><br>The LHA should ensure that the child and welfare service performs its functions in accordance with the National Standards for Child Protection and Welfare and national policies. |
| **34. Action required:**<br><br>The LHA should ensure that the service has a system in place to learn from reviews and recommendations within child and family services. |

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| **Related reference:**<br><br>Standard 3:1<br>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 with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br>**Action 33**<br><br>Facilitated learning will take place with Team Leaders and PSW and will become part of Team Meetings. This will include information on and shared learning regarding the National Standards and identifying implications for practice which will improve as a result.<br><br>**Action 34**<br><br>On an ongoing basis facilitated learning will take place with the Social Work Team and will become part of Team Meetings. This will include information on and shared learning regarding the case reviews and implications for practice. | PSW, Social Work Team Leaders, Social Workers by end May 2013<br><br>PSW commencing from June 2013 |

| **Theme 3: Leadership, Governance and Management** |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA's leadership, governance and management arrangements were not effective to ensure that all children received help and protection when they required it.<br><br>The LHA's Statement of Purpose did not describe how the service protected children and promoted their welfare, their objectives, model of service delivery and the aligned resources.<br><br>The LHA did not have effective systems in place to manage performance and quality assures the service being provided to protect children and promote their welfare.<br><br>The LHA did not have a robust risk management system in place. |
| **35. Action required:** |

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| The LHA should ensure that they establish effective leadership, governance and management arrangements with clear lines of accountability. |
| **36. Action required:**<br><br>The LHA should review their Statement of Purpose to ensure it describes how the service protects children and promotes their welfare, their objectives, model of service delivery and the aligned resources. |
| **37. Action required:**<br><br>The LHA should develop and implement effective systems to manage performance and quality assure the service being provided to protect children and promote their welfare. |
| **38. Action required:**<br><br>The LHA should develop and implement a robust risk management framework and supporting structures for the identification, assessment and management of all potential risks within the service. |
| **Related reference:**<br><br>Standard 3:2<br>Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability. |

| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
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| HSE response:<br><br>**Action 35**<br>The Service Director, Area Manager and Principal Social Worker will take accountability for the quality of the service, engaging with management meetings and driving improvement.<br><br>The LHA will provide clear briefings for all staff and will ensure that all staff understands their roles and responsibilities in the context of services provided at every level in the organisation. Briefings will make explicit reference to the importance and value of strong and robust governance arrangements in protecting children and promoting their welfare.<br><br>National policies and procedures will be introduction regarding child | Area Manager, PSW and Social Work Team Leaders, by end July 2013 |

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| protection and welfare as and when issued.<br><br>The LHA will be ready to comply with national policies and procedures when issued.<br><br>Team Meetings will move to monthly and policies and procedures will be provided in briefings, updated and discussed in Team Meeting along with an emphasis on implications for practice.<br><br>A standard assessment process will be implemented as part of Phase II of the Standardised Business Processes by 08/04/13.<br><br>Performance Information and data from audits will inform service delivery and service improvement. Key Performance Information will be discussed in Supervision and at Team Meetings, and used to inform services priorities.<br><br>Work will continue with external providers in the context of the implementation of local area pathways within the emerging National Delivery Framework. | Area Manager, PSW<br>Ongoing – completion by Q4 2013 |
| **Action 36**<br><br>A National Statement of Purpose and Function will be developed by the National Office, consulted on and implemented by the LHA when available. | Head of Policy National Office and Area Manager<br>End August 2013. |
| **Action 37**<br><br>The National Office Quality Assurance Framework is being developed.<br><br>Local intelligence available from Performance information; file audit and peer review of cases will be used along with Measuring the Pressure to monitor the quality of services and inform management decisions about the management of the service and reduction of risk. Improvement will be driven through explicit use of management information which will be discussed in supervision and at Team Meetings.<br><br>Data on RAISE will be cleansed to ensure reliability and staff will have access to information sessions about the use of the data. Case files will be audited on a quarterly basis and outcome of audits shared with the Area Manager and within and across teams, to develop skills and achieve a clearer understanding of the importance of accuracy. | Head of Quality Assurance by Aug 2013<br><br>Area Manager PSW and Team Leaders end June 2013<br><br>Area Manager and |

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| **Action 38**<br><br>Managers and staff will be reminded of the Quality and Risk Standard 2009 and the Risk Management Policy.<br><br>Focus Groups will be held with staff to explore their understanding of Governance and Roles and Responsibilities and gaps in their understanding will feed into ongoing input into Team Meetings and Supervision.<br><br>Training on Corporate Risk Management Framework will be provided to Senior Managers<br><br>Outcomes will be monitored and assessed in supervision and team meetings | PSW<br>End April & ongoing<br><br>Area Manager, PSW and Team Leaders end June 2013<br><br>Area Manager<br>May 2013 |

| **Theme 3: Leadership, Governance and Management** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not have a system in place to review and assess the effectiveness and safety of the child protection and welfare service provision and delivery. | |
| **39. Action required:**<br><br>The LHA should establish and implement a system to review and assess the effectiveness and safety of the child protection and welfare service provision and delivery. | |
| **Related reference:**<br><br>Standard 3.3<br>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 with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 39** | |

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| The LHA will implement a system to review the effectiveness of services in the context of the Standards and will ensure that services delivered are safe and children are safeguarded as a result.<br><br>Trends identified from feedback will be made available to managers and staff and will be used to identify service improvement priorities.<br><br>Area Manager to review implementation of recommendations and compliance with Standards in the context of Children First through the results of the file audit, case discussion, team meeting minutes and service user feedback. | Area Manager<br>By end Sept 2013 |

| **Theme 3: Leadership, Governance and Management** | |
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| **The LHA was not compliant with the standard in the following respect:**<br><br>The LHA did not monitor the external providers on a consistent basis to be assured that the commissioned services were providing services to children and families that were compliant with legislation, regulations, Standards and national policy. | |
| **40. Action required:**<br><br>The LHA should establish and implement an effective system to monitor external providers' compliance with legislation, regulations, Standards and national policy. | |
| **Related reference:**<br><br>Standard 3:4<br>Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 40**<br><br>This LHA will continue to operate under National HSE Procedures regarding the funding of Section 39 Agencies in accordance with the National Financial Regulations. The agencies that are commissioned | Area Manager,<br>by October 2013 |

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| on behalf of the LHA will be monitored for compliance with due regard to relevant legislation, regulations, and national protection and welfare standards. As part of this process it will monitor and review comments and complaints. | |

| **Theme 4: Use of Resources** | |
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| **The LHA was not compliant with the standard in the following respect:**<br><br>The LHA had not undertaken a needs analysis to effectively plan, deploy and manage resources to protect children and promote their welfare. | |
| **41. Action required:**<br><br>The LHA should undertake a needs analysis periodically to effectively plan, deploy and manage all resources to protect children and promote their welfare. | |
| **Related reference:**<br><br>Standard 4:1<br>Resources are effectively planned, deployed and managed to protect children and promote their welfare. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br>**Action 41**<br><br>The LHA will undertake a "needs analyses", will map services across the area and use the intelligence available to develop a consistent approach to "allocate resources" in response to need. This work will inform the implementation of the National Service Delivery Framework when complete.<br><br>The Area Manager will deploy resources based on the needs analyses ensuring a consistent approach to management of service across both areas. | Area Manager, PSW by end Aug 2013 |

| **Theme 5: Workforce** |
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| **The LHA was not compliant with the standard in the following respects:** |

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| The LHA had significant deficits in their vetting procedures for staff.<br><br>The LHAs staff personnel files were not well organised and were in a poor physical state.<br><br>The LHA did not have a standardised, consistent, formal induction programme for staff. | |
| **42. Action required:**<br><br>The LHA should ensure that the requisite Garda vetting is in place for all staff. | |
| **43. Action required:**<br><br>The LHA should carry out a review all personnel files and address any deficits including reorganisation of files to allow effective management and ease of access. | |
| **44. Action required:**<br><br>The LHA should develop and implement a formal induction process for new staff. | |
| **Related reference:**<br><br>Standard 5:1<br>Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 42**<br><br>The LHA will work with the National Recruitment Service to ensure all Garda Vetting is up to date and those in service prior to the HSE centralised recruitment system are processed as a matter of urgency and update files accordingly.<br><br>**Action 43**<br><br>The Area Manager will initiate a review of all personnel files with local HR and ensure compliance is achieved through addressing any deficits.<br><br>**Action 44** | Area Manager, PSW, National Recruitment Service by end July 2013<br><br>Area Manager local HR, by end Sept 2013 |

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| All new staff will receive an Induction Pack that includes information on their roles and responsibilities, risk management and governance within the service alongside current information.<br><br>Outstanding issues and gaps in information with current staff will be identified and addressed in supervision.<br><br>New staff will be subject to an induction process, a certificate of induction will become part of all personnel files. | PSW, Team Leaders and HR, immediate for new staff, |

| **Theme 5: Workforce** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA had staff vacancies and this had a direct negative impact on service provision.<br><br>The LHA had not supported the development of the management team to deliver an effective service. | |
| **45. Action required:**<br><br>The LHA should ensure, in as far as it is possible, that there are sufficient numbers of staff in place to provide effective and safe services to children and families. | |
| **46. Action required:**<br><br>The LHA should undertake a review of the development needs of the management team and implement a comprehensive development programme to support the management team in delivering an effective service. | |
| **Related reference:**<br><br>Standard 5:2<br>Staff has the required skills and experience to manage and deliver effective services to children. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response: | |

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| **Action 45**<br><br>The LHA area will continue to monitor staff ceiling and vacancies. The reconfiguration of teams, in the context of skill mix, experience and priorities within the LHA Social Work Service will ensure that appropriate and safe services will, as far as possible, always be available to children and families.<br><br>**Action 46**<br><br>A Training Needs Analysis will be carried out incorporating PSW, SWTL's, Area Manager and Service Director in conjunction with the training unit as part of the Regional and National Training Needs Analysis. Managers will ensure that all training and development needs are identified along with opportunities to learn and develop through peer review. | Area Manager, PSW Ongoing<br><br>Regional Service Director, Area Manager and PSW by end Nov 2013 and ongoing |

| **Theme 5: Workforce** |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA had not fully implemented the HSE national policy on supervision.<br><br>The LHA did not maintain comprehensive records of supervision.<br><br>The LHA did not have performance appraisal systems in place.<br><br>The LHA did not ensure that all staff were familiar with and understood protected disclosure legislation and policy. |
| **47. Action required:**<br><br>The LHA should ensure that the national supervision policy is fully implemented. |
| **48. Action required:**<br><br>The LHA should ensure that comprehensive records of supervision are maintained. |
| **49. Action required:**<br><br>The LHA should establish and implement a performance appraisal system. |
| **50. Action required:**<br><br>The LHA should ensure that staff are familiar with and facilitated to make protected |

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| disclosures about the effectiveness and safety of the service, in line with legislative requirements. | |
| **Related reference:**<br><br>Standard 5:3<br>All staff are supported and receive supervision in their work to protect children and promote their welfare. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br>**Action 47**<br><br>The LHA will ensure the National Supervision Policy is implemented and reflective supervision takes place and is recorded along with staff training and development needs. Information on the value and importance of performance and management information will be discussed where relevant as part of supervision.<br><br>**Action 48**<br><br>The LHA will undertake a review of supervision and take necessary action to ensure that robust adherence to the recording of supervision is implemented and maintained.<br><br>Reports on completion and ongoing monitoring will be made to the Area Manager.<br><br>**Action 49**<br><br>The LHA will work with the National Office when consulted about the developing Performance Management Framework and ensure that performance information on services is part of supervision and that all staff is aware of their roles and responsibilities in relation to policies and procedures currently established.<br><br>**Action 50**<br><br>The HSE Policy on Protected Disclosure will be re issued to staff, discussed in Team Meetings and due emphasis placed on the importance of the availability of the protective disclosure process if there are any concerns. | PSW and Team Leaders by end June 2013<br><br>PSW and Team Leaders by end July 2013<br><br>Area Manager, PSW and Team Leader by end June 2013<br><br>PSW by end March 2013 |

| **Theme 5: Workforce** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA had not undertaken a training needs analysis to inform their staff training programme.<br><br>The LHA did not have a comprehensive staff training programme in place. | |
| **51. Action required:**<br><br>The LHA should undertake a training needs analysis, informed by the child protection and welfare needs of the children and families accessing the service and the development needs of the staff, to inform their training programme. | |
| **52. Action required:**<br><br>The LHA should develop and implement a comprehensive staff training programme based on the training needs analysis to improve the outcomes for children accessing child protection and welfare services. | |
| **Related reference:**<br><br>Standard 5:4<br>Child protection and welfare training is provided to staff working in the service to improve outcomes for children. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 51** Please see Action 46<br><br>A Training Needs Analyses will be carried out in conjunction with the training unit as part of the Regional and National Training Needs Analyses. Managers will ensure that all training and development needs are identified along with opportunities to learn and develop through peer review.<br><br>**Action 52**<br><br>Please see also Action 46 and above<br><br>Additionally the LHA will ensure a robust approach to recording staff | Regional Service Manager, Area Manager and PSW by end Nov 2013 and ongoing<br><br>Training Unit, PSW |

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| trainings needs, identifying when they have been met, evaluating participant's experience of training and gaining their considered view of relevance and usefulness. These discussions will form part of supervision and inform feedback to training.<br><br>All staff, as outlined elsewhere, will be reminded of their roles and responsibilities in relation to Children First and supervised in the context of those roles and responsibilities. Team Meetings will discuss the role and responsibilities of social workers and other agencies in relation to Children First and ensure through supervision that they understand their roles and implications for their work. | and Team Leaders and Social Workers by end July 2013 |

| **Theme 6: Use of Information** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA's information governance arrangements were poor and did not support the planning and delivery of an effective child protection and welfare service. | |
| **53. Action required:**<br><br>The LHA should ensure there are effective information governance arrangements in place so that all relevant information is used to plan and deliver effective child protection and welfare services. | |
| **Related reference:**<br><br>Standard 6:1<br>All relevant information is used to plan and deliver effective child protection and welfare services. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 53**<br><br>The LHA will ensure that the value and use of currently collected information on complaints, consumer feedback and focus groups is understood by all staff. We shall also ensure that this information informs practice so that social work staff understands the implications of collecting accurate and timely data on a range of issues and use that intelligence in their work. | PSW and Team Leaders by end Aug 2013 |

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| Staff will receive data analyses during Team Meetings where the meaning and implications will be discussed.<br><br>The Area Manager will make sure that policies and procedures are understood by staff and ensure compliance with governance mechanisms. | Commencing May 2013<br><br>Area Manager by end Aug 2013 |

| **Theme 6: Use of Information** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not consistently complete templates used to record and manage child protection and welfare concerns. | |
| **54. Action required:**<br><br>The LHA should ensure that all templates used to record and manage child protection and welfare concerns are completed in full. | |
| **Related reference:**<br><br>Standard 6:2<br>The service has a robust and secure information system to record and manage child protection and welfare concerns. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |
| HSE response:<br><br>**Action 54**<br><br>A number of sessions with the Change Manager of RAISE will be undertaken to address the current challenges in relation to RAISE and to ensure that all staff are fully aware of the challenges when information is not completed comprehensively.<br><br>The LHA will on completion of data cleansing on RAISE, make sure that all staff who input information understand the importance of the information for the development and management of services. The Area Manager, the PSW and Staff will receive feedback on implementation and analyses of the information, as will be encouraged to make connection between their work and the | <br><br><br><br>PSW , SWTL Ongoing<br><br><br><br>Area Manager, PSW, Change Manager, Team Leaders and Social Workers end Aug 2013 |

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| management of cases.<br>Closed cases that have been archived will move to improved storage as soon as space is available. | |

| **Theme 6: Use of Information** | |
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| **The LHA was not compliant with the standard in the following respects:**<br><br>The LHA did not have robust record keeping and file management systems in place to support the management of child protection and welfare information.<br><br>The LHA did not have a chronology of significant events representing the HSE's child and family service involvement with a child/family.<br><br>The LHA did not undertake regular audits to evaluate the record-keeping and file-management system and practices. | |
| **55. Action required:**<br><br>The LHA should ensure that they have robust record keeping and file management systems in place to support the management of child protection and welfare information. | |
| **56. Action required:**<br><br>The LHA should ensure that a chronology of significant events is maintained representing the HSE's child and family service involvement with a child/family, milestones reached and any known significant events, positive or negative that would impact on the safety, care and well-being of the child. | |
| **57. Action required:**<br><br>The LHA should undertake regular audits to evaluate the record-keeping and file-management system and practices. | |
| **Related reference:**<br><br>Standard 6.3<br>The service has a robust and secure record-keeping and file-management system to manage child protection and welfare concerns. | |
| **Please state the actions you have taken or are planning to take with timescales:** | **Timescale & Post holder responsible:** |

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| HSE response:<br><br>**Action 55**<br><br>The LHA will establish a system to carry out regular files audits and discuss the outcome at Team Meetings and in supervision to ensure compliance and consistency.<br><br>PSW to report compliance to the Area Manager by end Aug 2013<br><br>**Action 56**<br><br>A chronology of significant events will form part of case files and be updated as significant events that impact on the child and/or their families are recorded. This will form part of the regular file audit system<br><br>**Action 57**<br><br>File audits will be carried out on a quarterly basis at a regional area and team level. They will be discussed in supervision. | <br><br><br>PSW<br>by end Aug 2013<br><br><br><br>PSW and Team Leaders by end of Aug 2013<br><br><br><br>Area Manager, PSW |

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