Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Louth/Meath
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	25 - 27 April 2023
Lead inspector:	Sabine Buschmann
Support inspector(s):	Grace Lynam Caroline Browne Saragh McGarrigle
Fieldwork ID	MON-0039690

About monitoring of child protection and welfare services

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

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

The Authority monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children* and advises the Minister for Children and Youth Affairs and the Child and Family Agency.

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

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

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

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

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- focus group with two principal social workers
- interview with the child protection case conference chairperson
- focus group with nine social workers
- the review of local policies and procedures, minutes of various meetings, and service plans
- the review of 24 children's case files
- phone conversations with four parents
- phone conversations with three children.

The aim of the inspection was to assess compliance with national standards the service delivered to children who are subject to a child protection case conference and whose names are entered onto the Child Protection Notification System.

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

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

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

Service area

Louth Meath is situated in North Leinster, on the east coast of Ireland and in close proximity to Dublin and is part of the North South Axis. While Louth is the smallest county in Ireland, it has a high population density composed of the first and third largest urban areas (Drogheda and Dundalk) outside of designated cities. The Louth Meath area is a large geographical area with distances of 115kms at its broadest which has an impact on accessing resources and responding to need.

The total population (Census 2016) of Louth Meath is 323,928. The population was 307,032 in 2011 and 274,090 in 2006. The preliminary results of the 2020 census suggest a population increase of 25,252 for the county of Meath alone: a 13% increase in the population. The Louth Meath service area comprises three of the largest and fastest growing towns in Ireland. Louth Meath's population is increasing and there is likely to be an increased demand for children's and young people's services over the next decade.

The service area is under the direction of the regional chief officer for the Tusla Child and Family Agency Dublin North East Region. There is an area manager and three principal social workers with the responsibility for the delivery of child protection and welfare services. There is also a senior manager in place for Prevention Partnership and Family Support (PPFS).

Children listed on the child protection notification system (CPNS) were case managed by two assessment and intervention teams in counties Louth and Meath and the teams were based in Drogheda, Dundalk and Navan. The area manager delegated child protection conferencing responsibilities to one principal social worker who was the child protection conference (CPC) chairperson. Administration staff were employed to assist in the delivery of this service.

At the time of the inspection there were 29 children listed as active on the CPNS comprising of 14 families. In addition 47 children had been removed from the CPNS in the 12 months prior to this inspection.

Compliance classifications

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

- **Compliant**: A judgment of compliant means the service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.
- **Substantially compliant**: A judgment of substantially compliant means the service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.
- **Not compliant:** a judgment of not compliant means the service has not complied with a standard and that considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk-rated red (high risk) and the inspector will identify the date by which the provider must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of children using the service, it is risk-rated orange (moderate risk) and the provider must take action within a reasonable time frame to come into compliance.

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
25 April 2023	09.30 - 17.00hrs	Sabine Buschmann	Inspector
25 April 2023	10.00 -17.00hrs	Grace Lynam Saragh McGarrigle Caroline Browne	Inspector Inspector Inspector
26 April 2023	09.00 -17.00hrs	Sabine Buschmann Grace Lynam Saragh McGarrigle Caroline Browne	Inspector Inspector Inspector Inspector
27 April 2023	09.00 -16.30hrs	Sabine Buschmann Grace Lynam Saragh McGarrigle Caroline Browne	Inspector Inspector Inspector Inspector

Views of people who use the service

As part of the inspection it is important that inspectors listen to the views of children and families who receive a service from Tusla. This helps form an understanding of whether the service has met the children and family's needs and improved their lives.

Inspectors spoke with three children about their experience of the Child Protection Conference (CPC) and the related processes. The children said they understood why the social work department were involved with their family.

All of the children reported that their social worker visited them in their home and explained to them what was happening. One child said their social worker "is really good with everyone". The children spoke about how they participated in the CPC process. Two of the children attended their CPC and described how they felt listened to by the adults. One child said "all the adults were very open to me giving my opinion ...It's good to be able to have your say". While another child reported "there were notes being written when I talked so it was taken on board." A child who did not attend their CPC described how her social worker made her feel included by seeking her views in advance of the CPC; "She (the social worker) asked me for suggestions that would help". The children reported that social work involvement had helped their family, with one child commenting "It has made some difference in the family".

Inspectors spoke with five parents who had experienced the CPC process and whose children had been, or were at the time of inspection listed on the Child Protection Notification System (CPNS). The views of parents who spoke of their experiences of attending CPC's were mixed.

All parents spoke positively about social workers visiting their home and speaking with them and their children. One parent highlighted that their social worker changed a lot and said "the changes were difficult for the children". Another parent said that when their allocated social worker went on leave the home visits stopped and it was difficult to get a response when they made phone calls to Tusla to see if anyone was going to visit the family.

All of the parents reported that they had an opportunity to speak at the CPC and that their views were heard. However, one parent said she felt she wasn't truly heard and stated she "felt listened to at the conference, but I wasn't heard, but the decision was made before we went to conference". One parent stated that she felt more needed to be done to reassure parents who attend CPCs. She described the experience of the Initial CPC as "like a courtroom", and she felt "cross-examined". Though she reported the Review CPC was a better experience as she "came in with my network people" and

was “stronger in myself”. In contrast another parent outlined that their views were taken on board and “when they didn’t agree they would explain why”.

All of the parents felt that their family circumstances had improved with one parent stating “things have improved in my family’s circumstances”.

Capacity and capability

Overall the Louth/Meath service area needed to improve and strengthen governance arrangements in order to provide a consistent safe service to all children listed on the CPNS. This inspection found non-compliances in the service’s ability to perform its functions in line with relevant legislation, national policies and standards. This inspection found deficits in the monitoring and oversight of children on the CPNS including their safety planning and home visits. Inspectors found that three of the 29 children on the CPNS did not have an allocated social worker for an extended period of time, with two cases unallocated for a period of two months and a third child was unallocated for a period of six weeks. Improvements were needed in uploading of documentation to Tusla’s case management system (TCM) in order to to provide accurate assurances to the area manager. The service area indicated that they did not have the necessary staffing resources to effectively manage their child protection service. However staffing resources had not been prioritised sufficiently to ensure that the children listed on the CPNS had an allocated social worker and as a result they did not receive an adequate service.

Inspectors sought a provider assurance report with regard to the failure to ensure the safety of some children on the CPNS. Furthermore, the area was required to outline their governance and oversight arrangements to ensure the provision of a safe service for children on the CPNS. A detailed response was returned that all children listed on the CPNS will be allocated to a social worker and visited in line with Tusla policy. It also outlined plans to strengthen the governance and oversight of cases on the CPNS through improved supervision and monitoring systems. In addition, the area planned to implement updated guidelines regarding the CPC conference process and minimum requirements for visits to children on the CPNS.

The focus of this inspection was on children placed on the CPNS who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per *Children First 2017: National guidelines on the protection and welfare of children* when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families, then Tusla is required to organise a Child Protection Conference (CPC). In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is placed on the Child Protection Notification System (CPNS). This meant that children on the list were closely monitored by the social work department to ensure they are safe and interventions were provided to children and families to reduce risks to children. Children who have child protection plans continue to live at home, unless it emerges that a child is at ongoing risk, or if the child protection plan is deemed not to be working. These cases may result in a decision to remove the child from the home. This inspection also reviewed children's files, whose names had recently been made inactive on the CPNS in the last six months. These children had been assessed as no longer being at risk of significant harm.

The child protection notification system comprised of a confidential database of children in the area who had been identified as being at ongoing risk of significant harm. Inspectors reviewed the CPNS register and found that the register was secure and well maintained in line with Children First. Children's names were updated on the register following a decision made at the Child Protection Conference. Access to the CPNS was strictly confined to Tusla social workers, and members of An Garda Síochána. Out-of-hours general practitioners and hospital medical social work and nursing staff, could make an enquiry to Tusla's out-of-hours service, and would be informed of whether the child was listed on the CPNS, and relevant details such as the child's name and address, allocated social worker and primary reason for being listed on the CPNS, in order to assist professionals make decisions about the safety of a child.

During this inspection, the area manager and senior managers identified that there were a number of challenges impacting upon the delivery of a consistent child protection and welfare service to children listed on the CPNS. They told inspectors that the challenges and risks to the service included 29 vacant social work, senior social work practitioner, and team leader posts, a high turnover of staff, increased caseloads, securing legal orders for children and the increased work load associated with court attendance. They said that this posed significant challenges in the provision of consistent child protection services and that these issues were escalated from the regional chief officer to Tusla's national management team in 2022. In addition, the service area had migrated from Tusla's National Child Care Information

System to a new case management system (TCM) in February 2023, which brought challenges in migrating all the information and documents across to the new system. This required arranging system training for an already reduced workforce as staff had to learn the new system as well as training staff in using consistent naming conventions for documents such as home visits for example.

The service had policies and procedures in place to guide social workers on the application of thresholds for a CPC, safety planning and maintaining the CPNS. These national policies reflected the requirements of Children First Act 2015 and Children First guidance. Tusla National Guidelines on Child Protection Conferences and The Child Protection Notification System was developed in 2018. This interim national guidelines on child protection case conferencing and the child protection notification system had been subject to review and was up-dated in 2022 and subsequently implemented in the area in September 2022. All staff demonstrated knowledge of relevant legislation, policy and standards as they related to the management of children listed on the CPNS and inspectors reviewed evidence of workshops held with social workers to embed the new policy in practice.

Inspectors found that governance systems required significant improvements. Overall accountability for the child protection notification system lies with the area manager. The area manager held responsibility for providing assurances to the Regional Chief Officer and the Director of Services and Integration about the safety and quality of the CPNS in the area. However, inspectors found that significant improvements were required in order for the mechanisms used to provide these assurances to be adequate. The area manager told inspectors that management meetings, supervision and quality, risk and safety meetings provided her with assurance on the safety of the service. The area manager said she convened monthly area management meetings and area governance meetings in order to communicate and manage issues relevant to all teams across the service. Inspectors reviewed minutes of meetings held in 2022 and 2023 and found standing agenda items associated to quality and risk management as well as the management of performance, HIQA inspections and relevant compliance plans. During these meetings, the child protection chairperson also provided analysis of data relevant to the oversight and management of cases on the CPNS to the area manager. While the CPNS service was routinely discussed at management meetings or quality, risk, safety and information (QRSI) meetings, inspectors reviewed minutes of these meetings and found that performance data or reports on the CPNS service were not discussed at these management forums. In addition, it was not recorded if all children on the CPNS were allocated a social worker, if safety plans were monitored or if home visits to children had occurred in line with policy. Therefore, governance meetings did not provide assurance to the area manager on the quality or safety of the service.

The Louth Meath service area management team was evolving at the time of the inspection. While the area had a defined management structure in place, the area manager had only been in post since late November 2022. She was supported in her role by a business support manager and two principal social workers who had oversight of the day-to-day service delivery of the assessment and intervention teams and were responsible for the oversight of the CPNS. One of the principal social workers was appointed in February 2023. While the senior management team were committed to continually improving the services they delivered to children and families, the service area did not have a sufficient number of team leaders in post to effectively manage a child protection service. For example, the two assessment and intervention teams in Louth/Meath who were responsible for managing children on the CPNS should have had seven team leaders in post, however this inspection found that five of these posts were vacant and a sixth post was not covered due extended leave at the time of this inspection. Social workers told inspectors that while they receive some support and supervision from principal social worker the lack of social work team leaders had a significant impact on their work loads.

The area manager delegated conferencing duties to a principal social worker who was the CPC chairperson and commenced their position in 2018. She was independent in her role and did not have direct management oversight of cases. The chairperson was responsible for managing requests for CPC's from social workers and determined if the referrals met the threshold for a CPC. The role of the CPC chairperson included scheduling, organising and facilitating the CPC meetings. In addition, they ensured the CPNS register was updated and maintained. The chairperson used a tracker to monitor timelines of both CPC's and RCPC's and to record delays when they occurred. She said that two CPC's were delayed due to children not being allocated to a social worker as the area has a significant number of staff vacancies. The CPNS chairperson delegated some duties to two administrators who sent out CPC invites and the subsequent CPC records to relevant professionals. They also updated the CPNS following a conference. Inspectors found that there were good levels of consultation between the chairperson and social work teams. Cases reviewed by inspectors were appropriately referred for CPC. However, inspectors found that not all CPC records were completed in a timely manner and were not uploaded to TCM. In addition, this inspection found that the quality of CPC minutes were mixed and required improvement. In some cases the recording of discussions was poor and the system in place to review CPC minutes was not robust. The area manager told inspectors that a second administration person had been appointed to assist with a more timely completion of CPC minutes and that a quality assurance system will be implemented to ensure that the minutes of CPC's are of good quality going forward.

Systems to monitor the CPNS process including visits to children required improvement. The two principal social workers for assessment and intervention had responsibility to maintain oversight of the day-to-day implementation of child protection safety plans and monitoring of children listed on the CPNS. Inspectors found there was no system in place to track or monitor home visits to children who were listed on the CPNS. Social workers told inspectors that home visits to children listed on the CPNS were recorded on TCM but principal social workers did not have a tracker to ensure that these visits have occurred. The principal social workers told inspectors that social work team leaders are usually responsible to ensure that home visits have occurred through the case supervision process. They said due to staffing capacity issues, 60-70% of their social workers work was taken up by filling the role of five vacant team leader posts, which included chairing child-in-care reviews, attending court and preparing court reports. This impacted on the PSW's ability to maintain oversight of the day-to-day implementation of child protection safety plans and monitoring of children listed on the CPNS.

This inspection found deficits in the monitoring of children on the CPNS, including child protection safety plans, as not all children on the CPNS had been visited as required. In addition, three children listed on the CPNS had not had an allocated social worker for six to eight weeks. Inspectors sought a provider assurance report with regard to the failure to ensure the safety of some children on the CPNS. Furthermore, the area was required to outline their governance and oversight arrangements to ensure the provision of a safe service for children on the CPNS. A detailed response was returned which assured inspectors that all children listed on the CPNS will be allocated to a social worker and visited in line with Tusla policy. It also outlined plans to strengthen the governance and oversight of cases on the CPNS through improved supervision and monitoring systems. In addition, the area planned to implement new procedures regarding the CPC conference process and minimum requirements for visits to children on the CPNS.

The monitoring and oversight of the use of information systems required improvement. The National Child Care Information System (NCCIS) to record children's records was replaced by Tusla's case management system (TCM) in February 2023. The service area, like all other service areas nationally had migrated to the new national recording system and was one of the last service areas to implement this in February 2023. It was acknowledged by the area management team that improvements were required in the integrity of data on the area's information system and plans were in place to address this. The area manager and her team were in the process of implementing and standardising the recording of information on TCM. Inspectors found that there were delays in the inputting of information on TCM, therefore the data could not always be relied on to provide an accurate and up-to-date assurances to the area manager.

While there were risk management systems in place to ensure that all risks in the service were reported on and managed, this system was not effective in the reduction of prolonged and persistent risks to the service. Risks recorded on the area risks register, which affected the quality and safety of service provided to children listed on the CPNS, included high levels of staff vacancies and the high number of unallocated cases in the area. They did not include risks relating directly to children listed on the CPNS such as infrequent home visits for example. Actions were not effective in reducing these risks, some of which were listed on the area risk register for five years. Inspectors found that the area had experienced a prolonged shortfall between the demand for child protection services, and the resources to meet that demand for a number of years. Prior to this inspection, the systemic risk relating to the lack of staffing was identified following a CPW inspection in June 2020. The resource issue was addressed again in January 2022 following a foster care thematic inspection where insufficient capacity and resources were considered to be at the highest level of risk for the service area. Actions to address these risks at a regional and national level, such as recruitment campaigns, social work graduate programmes, assurances of 18 additional positions to meet the demand of the service, approval for the use of agency staff, and international recruitment campaigns had made no significant difference, on the contrary, the number of vacant social worker posts had increased and the area continues to experience a significant staffing crisis.

The organisational culture in the service encouraged open communication and team working. Inspectors found that the communication systems in place required improvement to ensure all deficits relating to the service were communicated adequately. Social workers outlined that the service was well-led and described managers as supportive and approachable and said that they provided good management and leadership. They said case load management was considered but described staffing as a challenge in the area.

Strategic management systems were developed in the area. There were strategic and operational plans in place which were aimed at delivering a good quality service. These plans were aligned with Tusla's national corporate plan 2021-2023 and outlined the key objectives for the whole service area. The area also had a quality improvement plan which focused on findings from previous HIQA inspections of the child protection and welfare service. This was monitored, tracked and reviewed at management meetings in conjunction with performance and activity data and reports. However, ongoing and persistent risks to the service, such as information not being uploaded to TCM and staffing shortages posed a challenge in the area's capacity to implement all of Tusla's national business plan actions. This is set out in detail further on in the report.

A complex case forum was used in the area to discuss referred complex cases in detail, and examine interventions, progress and risks as appropriate. The forum was attended by senior managers throughout the service who reviewed cases and offered support, advice and additional oversight to social workers with challenging and complex cases. Cases were referred to the complex case forums on a monthly basis and it was routine practice to put cases on an agenda that were listed longer than 18 months or cases on its third review in addition to, reactivated and unallocated cases, for review within this forum. Managers and social workers who spoke to inspectors said that these meetings were a strong mechanism for assurance and accountability in relation to practice and service delivery. Actions were agreed at the forum to ensure that appropriate measures were in place in response to risks posed to the safety and welfare of children on the CPNS. Inspectors reviewed minutes of complex case meetings and found that they reflected open and transparent discussion, social workers were asked to account for their decisions, and suggested interventions to improve progress or alternative actions were offered to promote better outcomes for the children.

Local monitoring and auditing systems were in place to identify gaps in service provision and ensure compliance with policy and procedures required improvement. The CPNS chairperson conducted some monitoring of the quality of the service through a formal feedback system offered to all professionals and families who attended CPCs. The chairperson had provided training sessions to social workers on the CPC process, safety planning, mapping and scaling and the implementation of the new CPC policy. Two principal social workers who managed social work teams told inspectors that they had completed some auditing of files of children on the CPNS, however, they acknowledged that further auditing was required. Audits reviewed areas such as safe and effective services, child centred services and record keeping. However, inspectors found that the level of auditing on files was limited and that

these systems required further development in order to assure managers of the service being provided to children on the CPNS.

Inspectors found that there was a lack of routine or systematic auditing to assure managers of the effectiveness of the services being provided. Inspectors reviewed two audits of seven CPNS cases and found that the recorded outcomes were mixed. While the audit of four children by the area manager included an action to share the outcome with the management team for the purpose of shared learning and service improvement, the audit was limited to safety planning and did not identify risks such as the infrequency of home visits. From a review of the second audit, inspectors found that the recorded outcomes were not clear and there was no action plan of how to address some of the issues, for example network meetings not being uploaded in a timely manner. The area manager told inspectors that the auditing of case files of children listed on the CPNS was not consistent due to time constraints caused by the current staffing crisis and would resume once vacant posts had been filled. However, given that the area only had 14 families on the CPNS in the area, this was an area of auditing that should have been prioritised, as these were the children the service area had identified as at ongoing risk of significant harm.

Inspectors reviewed 12 files and found the quality of social work supervision on children listed on the CPNS was mixed. The area management team were aware that improvements were required. The areas of improvement for supervision identified by inspectors included the frequency of supervision in cases generally and the need to ensure that all aspects of supervision were completed. Inspectors found gaps in supervision of three months on three files, two files indicated a gap of four months and a fifth file showed a gap of 12 months between supervision meetings. Inspectors also found, that actions arising from supervision were not always clearly recorded and subsequent supervision sessions did not always review their progress. In addition, in seven cases supervision records had not been uploaded to TCM in a timely manner. However, inspectors also found evidence of good supervision practice including good discussions of cases and clearly recorded managerial direction. The area manager told inspectors that the chronic staff shortages in relation to team leaders had an impact on the frequency and quality of case supervision.

There were some systems in place to review and assess the effectiveness and safety of service delivery but they required improvement. There was a culture of continuous learning and development promoted amongst the managers within the service and social workers told inspectors that they were supported and encouraged by all managers throughout the service. There was a system in place to manage complaints and feedback. Inspectors reviewed the complaints and feedback register and found that complaints were managed appropriately. The area had implemented an "anonymised casebook" on learning from feedback and complaints. From a review of management minutes inspectors found that complaints and feedback were a standing item on the agenda.

There was also a process in place to escalate individual risks within the service area through 'Need to Knows' which were reported to the area manager. There were six 'Need to Knows' relating to children on the CPNS. Inspectors reviewed one child on the CPNS and found there were detailed discussions and risk assessments completed and at the time of the inspection, this child was placed in an appropriate placement. From a review of team meeting minute's inspectors found there was learning from reviews and serious incidents and this was shared with staff to inform the development of best practice and service improvements through team meetings and supervision. However, as this was the last of the 17 Tusla service areas to be inspected as part of the CPNS thematic inspection programme, the level of non-compliances found indicated that learnings from previous CPNS inspections had not been effectively put in place.

All parents received feedback forms following their involvement in a CPC, providing them with the opportunity to relay their opinion on the CPC process. In addition, the views of external stakeholders were sought and considered as required to inform decision making as well as overall learning and service development. There was evidence of good working relationships with a wide variety of local external service providers including; Gardaí, schools, public health nurses, hospitals and crèche services, and joint learning and development initiatives were in progress.

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 inspection found non-compliances in the service's ability to perform its functions in line with relevant legislation, national policies and standards. There was a major capacity issue in staffing resources to meet the demands of the wider service, however children on the CPNS had not been prioritised sufficiently. Inspectors found that three of the 29 children on the CPNS did not have an allocated social worker for six to eight weeks.

Judgment: Not compliant

Standard 3.2

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

Monitoring systems were not robust to ensure the service was delivered in line with national guidelines and standards and the service did not align their resources to ensure all children on the CPNS were safe. Systems to monitor and track the service provided to children on the CPNS were not effective to ensure that all children were visited as required and their safety plans monitored appropriately. There was a lack of formal and systematic auditing of case files. The risk management system was not effective as not all risks were identified or assessed. The management of data on CPNS and TCM was not adequately monitored to ensure the data was accurate. There was a lack of an effective national and regional response to systemic risks to the service, such as vacant posts and this posed a serious challenge in the area's capacity to implement all of Tusla's national business plan actions in line with relevant standards and legislation.

Judgment: Not compliant

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.
There was a culture of learning across the service area and communication systems were in place to promote shared learning in relation to complaints and feedback from service users and external professionals. However, as this was the last of the 17 Tusla service areas to be inspected as part of the CPNS thematic inspection programme, the level of non-compliances found indicated that learnings from previous CPNS inspections had not been effectively put in place. While strategic objectives and operational plans were developed, ongoing and persistent risks to the service, such as information not being uploaded to TCM, posed a challenge in the area's capacity to implement all of Tusla's national business plan actions in order to set out clear direction for the delivery of a quality child protection service. While there were risk management systems in place to ensure that all risks in the service were reported on and managed, this system was not effective in the reduction of prolonged and persistent risks to the service such as prolonged insufficient resources to meet the needs of the service. In addition, actions to address these risks at a regional and national level, had made no significant impact.
Judgment: Not compliant

Quality and safety

Overall, the quality and safety of the service provided to children listed on the CPNS required improvement. There were gaps in respect of timelines for holding some CPC's from the point of referral. The monitoring of children listed on the CPNS and the relevant child protection safety plans through social work visits was poor. In addition, three out of 12 children listed on the CPNS did not have an allocated social worker for prolonged periods of times and inspectors found that two of these children remained unallocated for a period of two months.

While the cases referred for a child protection conference (CPC) met the required threshold, initial CPC's did not take place in a timely manner in all the cases reviewed on inspection. Inspectors found that in 12 cases reviewed, the time frames were ranging from three to 13 weeks from when the social work team requested the conference to when the initial CPC took place. Inspectors found that for three of the 12 children reviewed, initial CPC's were convened in a timely manner, within a month of the referral for the CPC. There was a gap of five weeks for one child between referral and convening of the CPC, and six weeks for two other children. However, significant delays were found in six cases, such as two months for three children, a gap of seven weeks for two children and a gap of 13 weeks for one child. The reasons for the delays in three of these cases, including the delay of 13 and seven weeks, were clearly recorded and related to logistics of attendance of parents, availability of professionals, and awaiting assessment outcomes, all of which were reasonable. However, three CPC's were not held in a timely manner which meant that these children did not receive a timely service despite their vulnerabilities.

Safety plans had been put in place while the initial CPC's were being organised, and the children's safety had been maintained, although social workers acknowledged that frequency of home visits to children may not always be in line with timeframes on safety plans, due to responding to emergencies on their caseload. However, in the remaining six of the 12 cases reviewed, while all six of these cases had safety planning in place, they were nonetheless identified as being at ongoing risk of significant harm and were waiting long periods for an interagency meeting to take place. As a result, there was delay in the formation of a robust interagency child protection safety plan for these children. Given that there was significant child protection concerns for these children, these timeframes were too long.

Child protection conferences were found to be well planned and inclusive of all participating family members. They was good attendance by all relevant professionals, as required, to ensure the needs of children were appropriately represented. Child protection conferences were comprehensively facilitated by an

independent and appropriately qualified chairperson. The chairperson had been in post since 2018 and although they had some other duties across the service, these duties did not include case management responsibility. Inspectors found that initial CPC's were well chaired and facilitated, ensuring every aspect of risk, as well as children's needs were discussed and plans agreed, where required. Participation of all attendees was encouraged and each person's views sought, considered and recorded within conference records.

Overall, inspectors found that initial CPC's were well chaired and facilitated, ensuring every aspect of risk, as well as children's needs were discussed and plans agreed, where required. However, social workers and parents who spoke to the inspector found that the CPC can take a long time to conclude and considered them to be very time consuming. The CPC chair told inspectors that this feedback had been received by her prior to this inspection and a plan was being developed to conclude CPC's in a timelier manner. Inspectors found that 11 out of 12 ICPC's records reviewed, a quorum was met in line with policy.

Parents were encouraged to attend and participate in their CPC meeting. Social workers told inspectors that they met with parents to explain the reasons for requesting a CPC. They also met with parents in advance of the CPC to discuss their report for the meeting. In line with good practice, the social worker consulted with children and their parents to explain the CPC process and to ascertain their views in advance of the initial CPC conference. Inspectors found that in the majority of files reviewed there was a good level of communication with parents about the CPC process. Parents were involved in the development of child protection plans and received copies of these in most cases. However, one parent found the CPC process intimidating and felt unsupported until their network was set up and following the RCPC they said they had a more positive experience. Inspectors found that there was a good level of attendance by parents at CPC's and records reflected that parent's views were represented at the conference.

There was evidence of the representation of children's views found on most files reviewed by inspectors. In line with policy, the underlying principal of a CPC must be that a child should participate in the CPC and should do so in a manner appropriate to their age, ability and developmental capacity whilst also taking into account the best interests of the child. In particular, the policy outlines that children's views should be sought prior to the CPC whenever possible. From a review of 12 files inspectors found that nine children were between pre-birth and four years old and attendance would have been inappropriate. The three older children were provided with the option to attend but declined. In most cases, inspectors found the use of child friendly tools to help social workers engage and gather information in a child friendly way.

In addition there was evidence of some direct work with children including observation of children over the course of visits to elicit views of children less able to articulate their wishes. From a review of the CPC's chairperson interim overview report, inspectors found that nine children over 12 had attended all or part of their CPC in the 12 months prior to this inspection.

At the CPC conference, once a child was listed on the CPNS, clear minimum requirements were identified that had to be in place in order for the child to continue in the care of their parents along with specific actions such as a safety plan. Following the CPC, a child protection safety plan is developed by the social worker at a series of meetings with parents, family and key professionals. A standardised template was used to provide a comprehensive record of the key components of the safety plan, including the existing strengths and safety, identified risks and actions to be completed. The child protection plan considers the child's long-term and immediate needs and decisions are clearly recorded. The plan identified lead persons responsible for completing each action. It was the responsibility of the allocated social worker to implement a CPSP in partnership with the family and to monitor the CPSP to ensure children were kept safe.

Inspectors reviewed 11 child protection safety plans and found they were of mixed quality. Positive findings included the use of standardised templates which provided a comprehensive record of each plan. The template prompted the social worker to reflect on key components of safety planning such as the identification of existing strengths and safety of the situation as well as the identification of short-term and long-term goals to be achieved, to secure the protection and welfare of the child. However, there was some a variance in the recording of specific actions on some child protection safety plans. Inspectors found that in 54% or 6 out of 11 child protection safety plans reviewed, there were detailed specific actions and clear arrangements of how the service, along with parents and identified safety network persons, ensured children were safeguarded and their needs were met. A review of these records showed that these child protection safety plans clearly set out the monitoring and review arrangements, including the frequency of network meetings and home visits by a social worker and check-ins with network members who were monitoring the safety plan. For example, in one case, the child protection safety plan specified that a child required fortnightly home visits by the allocated social worker and inspectors found that these visits had occurred.

However, in 46% or 5 out of eleven cases reviewed the recording of specific actions recorded in the child protection safety plan required improvement. For example, monitoring arrangements such as the frequency of visits and safety planning meetings were not specified and not clearly defined.

In two cases the minutes of the CPC had not been completed and in another two cases the safety plans had not been updated following the network safety plan meeting. In addition, due to differences in naming conventions inspectors were unable to locate network meeting minutes and safety plans that were not recorded on the CPCSP template. Additionally in seven cases of the 24 cases reviewed, inspectors found that that information had not been uploaded at all.

Where there was a network identified for children on the CPNS, safety plan network meetings were used to monitor the implementation of child protection safety plans. Inspectors found that the recording and frequency of network meetings required improvement. In three cases, network meetings were not held at regular intervals and it was not always clearly specified how frequently these meetings should be held. In two cases, network meetings were not occurring as regularly as the child protection safety plan specified. In addition, in seven of the eight cases reviewed for the frequency and quality of network meetings they could not be found on the information system and were provided to inspectors in paper format for review. The area manager told inspectors that there had been some migration issues moving from NCCIS to Tusla's new case management system (TCM) and some documents had not migrated due to technical difficulties with the migration process in addition to documents not being uploaded on to the system.

The monitoring of children listed on the CPNS and the relevant child protection safety plans through social work visits was poor and required improvement. In addition, not all children listed on the CPNS had an allocated social worker, while they were subject to CPC proceedings. Inspectors found that one child was unallocated for a fortnight and two children did not have an allocated social worker for a period of two months. In focus groups with inspectors, social workers said that children on the CPNS were to be visited every two weeks. They told inspectors that due to staffing shortages and the subsequent increase in competing demands particularly relating to court work and court attendance, home visits had not occurred as required or laid out in the child protection safety plan. The area manager and principal social worker told inspectors that they were aware that home visits for children did not take place as required because of chronic staff shortages and had tried to mitigate the issue by allocating home visits to social care leaders and duty social workers as a temporary measure, as this provided a level of assurance to the management team to ensure that children were met with and safe. However, inspectors found that there was no formal system in place to monitor home visits to children who were listed on the CPNS, and therefore deemed to be at ongoing risk of significant harm

Inspectors reviewed 10 cases for monitoring of children on the CPNS through home visits by a social worker. Inspectors found that records of home visits were evident in 70% or seven out of 10 files reviewed. It was evident that social workers were involved in monitoring child protection plans to some extent, however none of the children were visited within a fortnight. One child that was unallocated appeared to have had gaps in home visits of six months as the record of these visits had not been uploaded on to TCM. Another child appeared to not have been visited in five months and two other children were visited only every four to six weeks according to the records reviewed on TCM. In two cases, while it was evident that a social care worker was seeing the child, there were no records of visits to the child by their allocated social worker. Furthermore, three of the files reviewed for home visits had no evidence of any home visits on file. Social workers were able to provide hand written and verbal evidence in two cases confirming that some home visits took place. In one case the principal social worker was unable to provide any evidence of a home visit at the time of the inspection, as both the social worker and social work team leader were on extended leave and the records of home visits had not been uploaded to TCM. The only way to verify a visit to this child was from a supervision note that made reference to a home visit that had taken place. In addition inspectors found that some home visits were recorded following network meetings, under the network meeting heading and others were recorded as case notes as there was no universal naming convention for home visits implemented in the service area. Inspectors requested assurances in regard to the failure to ensure the safety of some children on the CPNS through regular home visits and a detailed response was returned that all children listed on the CPNS will be visited in line with Tusla policy. It also outlined plans to strengthen the governance and oversight of cases on the CPNS through improved supervision and monitoring systems.

Review CPC's were of good quality, and there was a focus on ensuring that all key professionals were in attendance. Review CPCs were usually held within six months of the previous CPC and were chaired by an appropriately trained chair person. Inspectors reviewed eight child protection conferences where a review CPC was held and found that seven of the eight reviews took place within the required timeframe. The reviews considered progress since the previous CPC and decisions were reached based on this progress. Inspectors found that attendees reviewed what has worked well since the last conference, the views of the child and parents since the last conference, the updates on progress since the last CPC, information from key professionals and there was clear discussions on whether the child needed to remain on the CPNS. However, a case that was unallocated for a three month period did not have the third child protection review within the required timeframe and was delayed by four months.

Inspectors reviewed 10 children's files that had recently been delisted from the CPNS. Inspectors found that there were clear rationales recorded for the decision to de-activate these children and all were de-activated appropriately. For example, inspectors found that four children had been delisted because the child protection plan was implemented by the social workers, was reviewed and found to be working well. The individual network members were supporting both parents and children and risks had decreased significantly to enable the social worker to delist the children from the CPNS. Inspectors found that closed cases were appropriately overseen, managed and monitored and there were comprehensive records to support decisions in each case. However, inspectors found that when cases were delisted from the CPNS they were not always allocated to a social worker. Inspectors found that three of the delisted cases were re-referred and there was no evidence found on TCM to confirm if case management had taken place since the de-activation of the cases and if the families received the support they required.

The service supported and promoted interagency and inter-professional cooperation and input to ensure children's safety needs were met. There was evidence of good working relationships between the social work department and An Garda Síochána. The area had regular liaison meetings with An Garda Síochána and strategy meetings took place with An Garda Síochána, when this was required, on specific cases to promote safety for the children and families. The CPC chair sought feedback from professionals following a CPC and collated this information to drive improvements in service provision. Social workers and team leaders told inspectors that there were effective working relationships with external professionals and information was shared as required. Professionals provided reports for CPC's and there was regular contact recorded on files to assist in effective case management. Roles and responsibilities were clearly defined and it was evident that external professionals shared appropriate information to support assessments and interventions. Interagency working was found in all of the cases reviewed and it was evident that this practice was embedded in the area. Managers in the service identified the need for child protection training for external professionals regarding the CPC process, Tusla's national approach to practice, and thresholds.

Standard 2.6

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

Child protection conferences were requested appropriately but improvements were required to ensure that all were convened within consistent timeframes. They were appropriately facilitated by an independent person. Parents and children were encouraged to attend and participate in their CPC meeting. Child protection safety plans were developed following the decision to list a child as active on the CPNS. Child protection safety plans were of mixed quality and were not monitored in line with the requirements of the safety plan in all cases. The majority of children had not been visited in line with Tusla policy to ensure their safety.

The CPNS register was updated and managed in line with Children First 2017.

Judgment: Not compliant

Standard 2.7

Children's protection plans and interventions are reviewed in line with requirements in Children First.

Review child protection conferences were chaired by an independent professional who ensured these RCPC's considered multi-disciplinary input and progress since the previous CPC. Seven of eight CPC reviews were carried out at regular intervals in line with Children First (2017).

The service ensured that the delisting of cases from the CPNS was planned and agreed by social work managers.

Judgment: Compliant

Standard 2.9
Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
There was a good level of interagency and inter-professional cooperation and supports within the service. Interagency and inter professional attendance was good at CPC conferences. Strategy meetings were occurring for cases where this was required and there was a good level of communication and consultation evident within the service. There were clearly defined mechanisms and procedures for sharing of information in place and professionals were clear on their responsibilities as part of child protection safety plans and the role and function of each agency was explained to children and families. Child protection and welfare training is provided on a multidisciplinary and an interagency basis to facilitate key learning and strengthen working relationships.
Judgment: Compliant

Compliance Plan Louth / Meath Child Protection and Welfare Service OSV – 0004410

Inspection ID: MON-0039690

Date of inspection: 25-27 April 2023

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for the Protection and Welfare of Children 2012 for Tusla Children and Family Services.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which Standard(s) the provider must take action on to comply.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	**Not Compliant**

Outline how you are going to come into compliance with 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.

Governance

Action:

Safety plans for children on Child Protection Notification System to be a standing agenda item and reviewed at supervision by Team Leader and Social Worker and escalated to Principal Social Worker if not progressing.

Person(s) Responsible: Each A&I Team Leader and Principal Social Worker
Completion: Team notified on 1st June 2023 at CPNS briefing and ongoing

Capacity- Staffing

Action(s):

The Area and Region are supporting teams to fill critical vacancies at team leader, senior practitioner and social work levels in the teams who provide a service to children on the CPNS.

- Staff vacancies are noted as a risk on the regional risk register held by the Regional chief Officer.
- An overseas initiative has commenced – Recruitment Partners advertised globally – currently 40 successful candidates [May 2023]. Targeted initiatives to 1. Philippines and 2. Zimbabwe in progress.
- Ongoing campaigns such as graduate campaign, return to practice campaign and rolling Professionally Qualified Social Work positions are advertised on Tusla's website.
- Assurances from Regional Chief Officer of additional 19 WTE from the existing WTE ceiling from the April 2022 CP&W inspection should existing vacancies be successfully filled to meet the demand of the service. RCO and AM meet with Regional HR team to review and approve bespoke recruitment if needed.

- Following a successful graduate campaign, the area are due to have 4 new graduates commence employment over the following 3 months.
- All vacancies for Child Protection will be prioritised for filling by new staff in the area.

Persons Responsible: Area Manager & Regional Chief Officer
Completion By: Q4 2023

Capacity

Action:

To assist with increased demand due to staff vacancies on the Assessment & Intervention Teams, the Dedicated Point of Contact Teams will complete low to medium priority initial assessments where possible.

Persons Responsible: DPC Teams PSW
Completion: Commenced 1st June 2023 and ongoing

Supervision

Action:

All Social Workers receive case supervision specifically in relation to all children on the CPNS

The area does not currently have sufficient number of Team Leaders in post to meet our fully our service requirements. The area has interviewed recently for Team Leaders. A panel has been created and the current vacant posts have been prioritised and have been sent out to the panel by Tusla Recruit.

In the interim the following system is in place:

- (Louth) A Team Leader has taken on the supervision of two Social Care Workers,
- (Louth) Two Team Leaders have taken on the supervision of two additional Social Care Workers,
- (Louth) This has relieved pressure on the Principal Social Worker to focus on the supervision of the Social Work staff.
- (Meath) the Principal Social Worker has taken on the supervision of Social Worker staff in the absence of a Team Leader pending recruitment of same.
- Children on the CPNS are specifically listed on the child's case specific Supervision Record on the recently updated Supervision Template and discussed with both the

- Social Worker and Team Leader at all their respective Supervision sessions where it is a standing item on the agenda at all Supervision sessions.

The Principal Social Workers recognised the quality and frequency of supervision was mixed and one of the areas identified for improvement has been the frequency of supervision and the recording and uploading of actions in a timely manner. A briefing was organised by the Principal Social Workers and the CPC Chairperson for all Assessment and Intervention Teams and attended by all staff on 1st June 2023 during which all staff were briefed fully on the CPC guidelines and recording requirements in line with meeting professional standards.

Persons Responsible: Each Assessment & Intervention Principal Social Workers for Louth and Meath

Completion: By 1st June 2023 and ongoing

Allocation

All children listed on the CPNS are allocated a social worker and following direction by the area manager will continue to be priority for allocation to a social worker. If, for periods of extended leave, the allocated worker is unavailable to carry out visits to the child then a duty system is in place to ensure children are visited in line with their agreed safety plan. Visits by social workers to children on the CPNS will take place at least fortnightly initially and then at intervals as outlined in the child's specific safety plan. This visiting schedule will be tracked through business support and through supervision sessions.

Persons Responsible: Each Assessment & Intervention Principal Social Workers for Louth and Meath

Completion: Complete

Standard 3.2	Not Compliant

Outline how you are going to come into compliance with Standard 3.2: Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.

Governance

Action:

Safety plans for children on Child Protection Notification System to be a standing agenda item and reviewed at supervision by Team Leader and Social Worker and escalated to Principal Social Worker if not progressing.

Person(s) Responsible: Each A&I Team Leaders and Principal Social Workers
Completion: Team notified on 1st June 2023 at CPNS briefing and ongoing

Home Visit Schedule and Network Meeting Schedule

Action:

A trajectory outlining the frequency of home visits and network meetings will be agreed following each case conference with the family and identified network.
This trajectory will be reviewed at every network meeting and the frequency of visits will be adjusted according to the scaling and is agreed by the network. These will then be reviewed within planned audits.

Person(s) responsible: Each A&I Team Leaders and Principal Social Workers
Completion: Briefed at CPNS Learning Event on 1st June 2023 and ongoing

Action:

Business Support Managers for the area have set up a governance group to ensure they play a role in supporting local teams to maintain the visit tracker and upload records onto TCM. They are currently meeting fortnightly and this will reduce to monthly in Q2 2023.

Persons Responsible: Business Support Manager
Completion: Group established with TOR- complete & meetings ongoing

Monitoring and Reviewing Safety Plans

Action:

The monitoring and reviewing of safety plans will occur within the safety planning meetings. These will be convened regularly with the identified safety network.
These safety planning meetings will monitor the success of the plan in achieving safety for the child by reviewing the how the plan is working with each network member, scaling the safety for the child/ren based on the information mapped at the meeting.
This will be reviewed when Principal Social Workers are auditing files of children on CPNS through the recording of network meetings and scaling on the file.

Person(s) Responsible: Each A&I Team Leaders and Principal Social Workers
Completion: Team briefed at CPNS learning event on 1st June 2023 and ongoing.

Naming Conventions

Action:

Naming conventions has been circulated to all staff so that consistency can be achieved across teams in relation to the naming of case notes, attachments and other relevant reports and document relating the case on TCM. The use of this will be monitored through cases audits completed Principal Social Workers.

Person Responsible: PSW's for Assessment & Intervention Teams
Completion: Completed 15th June 2023.

Audits

Action:

Audits on the visiting schedules for children on the CPNS will take place every quarter for the next 12 months. These audits will be carried out by our Regional Quality Assurance and Service Improvement Manager for DNE. Dates for these audits for the upcoming 12 months are as follows;

- June 15th 2023 - complete
- September 12th 2023
- December 12th 2023
- March 12th 2024
- June 11th 2024

Principal Social Workers for Assessment & Intervention have also scheduled x2 further audit dates for the children listed on the CPNS for 2023. Learnings will be shared with the team leaders and all workers, good practice and areas for improvement identified with follow up actions.

Person Responsible: PSW's for Assessment & Intervention Teams & Regional QRSI Officer
Completion: Dates scheduled- completed 15th June 2023.

Standard 3.3	**Not Compliant**

Outline how you are going to come into compliance with Standard 3.3: The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery

Shared Learning

Action:

A departmental briefing took place on Tuesday 1st June, organised by the 2 Assessment and Intervention PSW's and the CPC Chairperson. This briefing was also attended by our TCM Lead who briefed Assessment and Intervention staff on the CPC guidelines and recording on TCM. The Area Manager opened the morning with learning regarding areas for service improvement.

Learning Morning reviewed current CPC & CPNS National Guidelines (June 2022) and the CPC Standard Operating Procedures (SOP) to support our practice.
It showcased good practice to model how CP Safety Plans should be prepared and recorded that clearly evidences work with children and families.

Person(s) Responsible: PSW's for Assessment & Intervention Teams & CPC Chair
Completion: Completed 1st June 2023.

Capacity- Staffing

Action(s):

The Area and Region are supporting teams to fill critical vacancies at team leader, senior practitioner and social work levels in the teams who provide a service to children on the CPNS.

- Staff vacancies are noted as a risk on the regional risk register held by the Regional chief Officer.

- An overseas initiative has commenced – Recruitment Partners advertised globally – currently 40 successful candidates [May 2023]. Targeted initiatives to 1. Philippines and 2. Zimbabwe in progress.
- Ongoing campaigns such as graduate campaign, return to practice campaign and rolling Professionally Qualified Social Work positions are advertised on Tusla's website.
- Assurances from Regional Chief Officer of additional 19 WTE from the existing WTE ceiling from the April 2022 CP&W inspection should existing vacancies be successfully filled to meet the demand of the service. RCO and AM meet with Regional HR team to review and approve bespoke recruitment if needed.
- Following a successful graduate campaign, the area are due to have 4 new graduates commence employment over the following 3 months.
- All vacancies for Child Protection will be prioritised for filling by new staff in the area.

Person(s) Responsible: Area Manager & Regional Chief Officer
Completion By: Q4 2023

CPC Safety Plans

Action:

A Signs of Safety Interim Safety Planning Workshops for all Assessment & Intervention Team Members has been organised for the 4th July 2023 which will include a review of the specifity of actions to create safety for children on the CPNS. A second date has been scheduled for the 31st August 2023 to ensure staff members on leave in July can attend.

Persons Responsible: Signs of Safety Practice Lead and Assessment & Intervention Teams
Completion By: 1st September 2023

Standard 2.6	**Not Compliant**

Outline how you are going to come into compliance with Standard 2.6: Children's protection plans and interventions are reviewed in line with requirements in Children First.

Supervision

Action:

All Social Workers receive case supervision specifically in relation to all children on the CPNS

The area does not currently have sufficient number of Team Leaders in post to meet our fully our service requirements. The area has interviewed recently for Team Leaders. A panel has been created and the current vacant posts have been prioritised and have been sent out to the panel by Tusla Recruit.

In the interim the following system is in place:

- (Louth) A Team Leader has taken on the supervision of two Social Care Workers,
- (Louth) Two Team Leaders have taken on the supervision of two additional Social Care Workers,
- (Louth) This has relieved pressure on the Principal Social Worker to focus on the supervision of the Social Work staff.
- (Meath) the Principal Social Worker has taken on the supervision of Social Worker staff in the absence of a Team Leader pending recruitment of same.
- Children on the CPNS are specifically listed on the child's case specific Supervision Record on the recently updated Supervision Template and discussed with both the Social Worker and Team Leader at all their respective Supervision sessions where it is a standing item on the agenda at all Supervision sessions.

The Principal Social Workers recognised the quality and frequency of supervision was mixed and one of the areas identified for improvement has been the frequency of supervision and the recording and uploading of actions in a timely manner. A briefing was organised by the Principal Social Workers and the CPC Chairperson for all Assessment and Intervention Teams and attended by all staff on 1st June 2023 during which all staff were briefed fully on the CPC guidelines and recording requirements in line with meeting professional standards.

Person(s) Responsible: Assessment & Intervention Principal Social Workers for Louth and Meath
Completion: By 1st June 2023 and ongoing

Monitoring and Reviewing Safety Plans

Action:

The monitoring and reviewing of safety plans will occur within the safety planning meetings. These will be convened regularly with the identified safety network.
These safety planning meetings will monitor the success of the plan in achieving safety for the child by reviewing the how the plan is working with each network member, scaling the safety for the child/ren based on the information mapped at the meeting.
This will be reviewed when Principal Social Workers are auditing files of children on CPNS through the recording of network meetings and scaling on the file.

Person(s) Responsible: Each A&I Team Leaders and Principal Social Workers
Completion: Team briefed at CPNS learning event on 1st June 2023 and ongoing.

Home Visit Schedule and Network Meeting Schedule

Action:

A trajectory outlining the frequency of home visits and network meetings will be agreed following case conference with the family and identified network.

This trajectory will be reviewed at every network meeting and the frequency of visits will be adjusted according to the scaling and is agreed by the network.
This will then be reviewed in scheduled audits.

Person(s) responsible: Each A&I Team Leaders and Principal Social Workers
Completion: Briefed at CPNS Learning Event on 1st June 2023 and ongoing

Audits

Action:

Audits on the visiting schedules for children on the CPNS will take place every quarter for the next 12 months. These audits will be carried out by our Regional Quality Assurance and Service Improvement Manager for DNE. Dates for these audits for the upcoming 12 months are as follows;

- June 15th 2023 - complete
- September 12th 2023
- December 12th 2023
- March 12th 2024
- June 11th 2024

Principal Social Workers for Assessment & Intervention have also scheduled x2 further audit dates for the children listed on the CPNS for 2023. Learnings will be shared with the team leaders and all workers, good practice and areas for improvement identified with follow up actions.

Person Responsible: PSW's for Assessment & Intervention Teams & Regional QRSI Officer

Completion: Dates scheduled- completed 15th June 2023.

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The provider has failed to comply with the following standards(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
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.	Not compliant	Red	09/06/2023
Standard 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Not compliant	Red	09/06/2023
Standard 3.3	The service has a system to review and assess the effectiveness and	Not compliant	Orange	30/6/2023

	safety of child protection and welfare provision and delivery.			
Standard 2.6	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Not compliant	Orange	30/6/2023