



# Report of a risk based inspection of Cork child protection and welfare services

Name of service area:	Cork
Name of provider:	Tusla
Type of inspection:	Follow-up
Date of inspection:	24 – 26 November 2020
Lead inspector:	Ruadhan Hogan
Support inspector(s):	Sharron Austin, Susan Talbot

## 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 and Youth Affairs under section 8(1)(c) of the Health Act 2007, to monitor the quality of service provided by the Child and Family Agency to protect children and to promote the welfare of children.

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:

<b>Theme 1: Child-centred Services</b>	<input type="checkbox"/>
<b>Theme 2: Safe and Effective Services</b>	▪
<b>Theme 3: Leadership, Governance and Management</b>	▪
<b>Theme 4: Use of Resources</b>	<input type="checkbox"/>
<b>Theme 5: Workforce</b>	<input type="checkbox"/>
<b>Theme 6: Use of Information</b>	<input type="checkbox"/>

## 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 five principal social workers
- focus groups with social work team leaders
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of 32 children's case files

The aim of the inspection was to assess compliance with national standards related to children who have been assessed at ongoing risk of significant harm and are in the child protection conference process/ child protection notification system (CPNS).

### **Acknowledgements**

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

## Profile of the child protection and welfare service

### **The Child and Family Agency**

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

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

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services

- domestic, sexual and gender-based violence services.

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

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

### **Service area**

The Cork service area is one of 17 service areas in the Child and Family Agency. Geographically, it is the largest county in Ireland with significant urban population (second largest in the country) and rural spread.

Census figures (2016) show that the overall population for the area was 542,868, representing 11% of the national population. Based on the 2016 census, Cork city grew by 5.4% and Cork County by 4.4% from the 2011 census. The total child population of Cork is 134,015 (24.6%) representing 45% of the South region total child population and 11% of the national child population. It is the highest child populated area in the Child and Family Agency.

The child protection conferencing service was delivered by three principal social workers (PSWs) and administration staff had been employed to assist in the delivery of service. The social work service was delivered through four offices throughout the Cork service area, each based in the locations of Skibbereen, Mallow, Blackpool- covering north of the river Lee and St Finbars Hospital- covering south of the river Lee.

In each child protection and welfare service office, there were teams of social workers that reported to team leaders who in turn reported to principal social workers. Some teams also included childcare leaders and family support workers. There were administrative staff based in each office. The area was under the direction of the service director for the Southern Region.

According to data returned to HIQA prior to the inspection, there were 89 children whose names were entered onto the child protection notification system and who were subject to a child protection safety plan.

## Compliance classifications

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

Compliant	Substantially compliant	Moderate non-compliant	Major non-compliant
The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.	The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.	The service is not compliant with the standard. Where the non-compliance (moderate) does not pose a significant risk to the safety, health and welfare to children using the service, the provider must take action <i>within a reasonable time frame</i> to come into compliance.	The service is not compliant with the standard. Where the non-compliance poses a significant risk (major non-compliance) to the safety, health and welfare of children using the service the provider responds to these risks in a timely and comprehensive manner.

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

### 1. Capacity and capability of the service:

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
24 November 2020	09:30 – 15:30	Ruadhan Hogan Sharron Austin Susan Talbot	Inspector Inspector Inspector
25 November 2020	09:30 – 15:30	Ruadhan Hogan Sharron Austin Susan Talbot	Inspector Inspector Inspector
26 November 2020	09:00 – 13:30	Ruadhan Hogan Sharron Austin Susan Talbot	Inspector Inspector Inspector

## Capacity and capability

In January 2020, HIQA undertook a risk based inspection of the child protection and welfare (CPW) service in the Tusla Cork Service area. The focus of that 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.

The findings of the inspection were of significant concern to HIQA. Children on the CPNS are those children who are assessed as being at most risk within a child protection service. As a result, the checks and balances in place to safeguard these children needed to be strong and focused on how children would be kept safe.

At the time of that January 2020 inspection, the Tusla Cork service area had weak governance arrangements. Methods of assurance were underdeveloped with deficiencies in case supervision, risk management and quality assurance. This resulted in an inconsistency of service provided to children on the CPNS.

Following that inspection, HIQA sought assurances from Tusla in relation to the governance arrangements in place for children on the CPNS in the Cork Service Area. Assurances were subsequently received; the details of which were outlined in the compliance plan completed by Tusla, in response to the findings of that inspection.

This follow up inspection looked at the progress made by the Tusla Cork service area on the actions outlined in the compliance plan, and whether those actions had a positive impact on the service provided to children on the CPNS. Overall, HIQA found that significant improvements had been made. Inspectors found better governance arrangements and a corresponding improvement in the consistency of social work service.

Staff who spoke with inspectors said there had been a much greater focus on children on the CPNS. As a result, they said that the implementation of the actions outlined in the compliance plan had a positive impact on service delivery. Nonetheless, the area manager along with the principal social workers told inspectors that that the rate of change required was a significant challenge to implement. They said they believed the Tusla Cork service area was not appropriately resourced and their capacity to implement and sustain changes over the long term for children on the CPNS would inadvertently impact on service delivery in other functions.

Roles and responsibilities for managing children who were subject to a multi-disciplinary case protection conference (CPC) remained the same since the last inspection. When children were assessed as being at on-going significant risk, their social worker requested that a multi-disciplinary child protection conference would be held. The child protection chairpersons were responsible for reviewing these and approving where appropriate that a CPC would be held. The scheduling, organising and facilitation of CPCs was delegated by the area manager to the child protection chairpersons, while the social worker and their respective managers were responsible for the case management, including the implementation and monitoring of the child protection safety plans. All of these staff ultimately were accountable to the area manager of the service area.

There had been an improvement in the governance arrangements in place for the management of children who were subject to a multi-disciplinary case conference. The area manager still primarily depended on governance meetings, informal communication (telephone calls and conversations), and through the group supervision of principal social workers and case conference chairs. However, additional measures had been put in place since the last inspection. These included a complex case forum, better quality case supervision and auditing of cases.

Governance meetings were held on a monthly basis where the entire Tusla Cork service was discussed. Discussion relating to children on the CPNS took up a small proportion of that meeting. Inspectors were informed that additional bi-weekly meetings were held during March- June 2020 in response to the Covid-19 pandemic. A range of issues were discussed including children on the CPNS and actions to address service risks related to the pandemic were agreed. For example, social work visits and scheduling of CPCs during restrictions. Quarterly CPNS governance meetings were held and attended by the CPC chairpersons, the area manager and representatives from the social work teams. Records showed that these meetings looked at procedural and practice matters, such the format of reports and facilitation of family and professionals. The meeting agendas also included the requirement for the CPC chairs to review of CPC timelines, in line with actions set out in the compliance plan. This was intended to provide an additional assurance for the area manager. However, at the time of the inspection, this had not yet been actioned due to a lack of appropriate permissions on NCCIS for the CPC chairs.

At the time of the last inspection HIQA found that group supervision that the area manager carried out with the PSWs was ineffective at providing assurance on the effectiveness of service delivery for all children on the CPNS. There had been some improvements to this process since the last inspection. Records showed that principal social workers met as a group prior to their meeting with the area manager in order

to identify the relevant issues to be brought to the group supervision. Recording of group supervision had also improved. Despite the improvements and greater efficiencies, the process remained an ineffective assurance method as there was a limited focus on children on the CPNS and they were not consistently discussed. However, given a range of other governance measures were put in place, this reduced the reliance on the group supervision process to provide assurance to children on the CPNS.

Since the last inspection new systems were put in place to identify and review children who were subject to multiple CPC reviews, a pattern of being active on the CPNS over time. For example, when children were active for a period of 12 months or more, the relevant principal social worker was required to audit the case file on Tusla's electronic case record system- NCCIS. When children were active on the CPNS over 18 months, CPC chairs were required to notify the relevant principal social workers so that the case would be presented at a complex case forum. A review of children's NCCIS records by inspectors showed that both of these actions had been taken where required. This meant that the area manager could assure himself that actions were taken in a timely and effective manner to support the provision of an appropriate service to meet children's individual needs.

A complex case forum had been established since the last inspection. This forum was held as required when relevant cases were referred for review. The forum was attended by the area manager and principal social workers of each of the departments. A terms of reference was in place which defined the type of cases to be reviewed. As stated, children who were active on the CPNS over 18 months were required to be referred to the forum. Cases were presented by the social work team leader along with the allocated social worker. Actions were agreed and recommendations were made. All the managers who spoke to inspectors acknowledged that it was hugely beneficial initiative. Inspectors found that it facilitated objective review of cases and scrutiny of the effectiveness of child protection plans.

At the time of the last inspection, there was a lack of timely progress in addressing child protection concerns for some children on the CPNS. During this inspection, all 16 cases sampled for review by inspectors had a proactive and timely response from the social work department. For example, one case reviewed by inspectors showed there were difficulties in arranging social work visits, safety planning meetings and effectively engaging with parents to address child protection concerns. Case records showed supervision was held regularly and outlined actions by the social work team leader, which the social worker was required to follow up. When it became apparent that the approach was not working, a new social worker was allocated to the case. From then on, steady progress was evident. The case was later presented at a complex case forum where the plan to address the risk was ratified by the forum. This showed that actions were taken when required by the social work team and that systems put in place since the last inspection were effective at addressing drift in cases.

The quality of individual supervision on children's case records improved since the last inspection. Inspectors found that supervision was held more frequently and was clearly recorded on children's files. At the time of the last inspection, supervision was found to lack sufficient rigour. In response to this finding, the Tusla Cork service area identified key areas that were to be addressed by social work team leaders with social workers during supervision. Inspectors found that this change to supervision practice was underway and while not evident on every case sampled, there were improvements in the oversight and analysis; the quality of which was far more thorough. This meant that the principal social workers and area manager had a more reliable baseline to assure themselves that case management for children on the CPNS had a better structure and there was a consistent implementation and monitoring of the child protection safety plans.

Auditing was used effectively to provide assurance to the area manager for children on the CPNS and to ensure the consistent implementation of changes to supervision practice on children's files. At the time of the last inspection, the Cork service area did not carry out any formal quality assurance auditing of children on the CPNS. At the time of this inspection, over half of the children active on the CPNS had been audited by social work team leaders and principal social workers, with individual findings compiled into reports for each of the four social work offices. The audits found inconsistencies in how case supervision was implemented by social work team leaders and how social workers monitored and implemented child protection safety plans. The findings were presented at governance meetings were used to change these practices in order to ensure a more consistent service to children on the CPNS. This meant that gaps in supervision identified by inspectors on this inspection were already known to the area and the service area management team were in the process of addressing them.

At the time of the last inspection, inspectors found that some risks to the service were not appropriately identified while other risks to children and the service had not been escalated in line with Tusla risk management processes. Where some risks had been escalated, risk escalations were not effective at resolving the issue. Since the last inspection, the Covid-19 pandemic had impacted service delivery and large amount of time was given to putting contingency plans in place to address the risk to service delivery. This planning impacted the entire service and it was evident that plans were effectively implemented to ensure a consistency in practice for children on the CPNS. The risk register related to CPCs and the CPNS had two risks recorded. One related to administration staffing on the CPC conferencing teams which impacted capacity to schedule and facilitate CPCs. The other related to CPC chairs permissions on NCCIS and the inability to track timelines for the scheduling of initial CPCs. Both risks had not been resolved at the time of the inspection.

At the time of the last inspection, two serious incident reviews undertaken in the area were inadequate. It was also of concern to inspectors that the outcome and learning from review reports were not shared with all relevant staff. In response, a working group was established in the Cork Tusla area to share learnings from reviews. However, at the time of this inspection, it had not yet concluded its work. Principal social workers told inspectors that there remained challenges in knowing how much information could be shared with staff and as a result, this action had not been completed at the time of this inspection. While work was on-going, this was of concern to HIQA as shared learnings from reviews should be shared in a timely manner.

<p>At the time of the last inspection, HIQA found that working arrangements between the local service area, Tusla regional management, and the Tusla national residential services were not always effective at ensuring good outcomes for children. None of the cases reviewed by inspectors required agreement on funding by the Tusla regional management. Consequently, inspectors were unable to evidence if any improvements had been made to this process.</p>	
<p><b>Standard 3.1</b> The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.</p>	<p><b>Judgment</b> <b>Substantially compliant</b></p>
<p>While significant progress had been made in implementing the compliance plan, one action had not been completed. The monitoring and trending of initial CPC timeliness by CPC chairs had not yet been implemented. This was an additional method of assurance for the area manager and would allow better oversight of this process.</p> <p>Another action was on-going and required further work. Individual case supervision practices as outlined in the last compliance plan were not consistently implemented. While this had already been identified by the area management team, further work in this area would bring a more consistent service delivery for children on the CPNS.</p>	
<p><b>Standard 3.3</b> The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.</p>	<p><b>Judgment</b> <b>Substantially compliant</b></p>
<p>It was a concern to HIQA that learning from serious reviews had not been shared in a timely manner.</p>	

## Quality and safety

When a referral of a child protection nature met the threshold for a service from Tusla, an initial assessment was to be carried out by a social worker. According to Children First (2017) 'National Guidelines for the Protection and Welfare of Children', if the outcome of the assessment was that a child was at risk of on-going significant harm, then Tusla is required to organise a multi-disciplinary case conference or remove the child to alternative care.

The focus of the inspection carried out in January 2020, was on those children who were subject of a multi-disciplinary case conference (CPC) and reported mixed findings. HIQA found that CPCs were comprehensively facilitated with multidisciplinary participation and active involvement of children and families. Additionally, the content of child protection safety plans devised at CPCs were of good quality. As the findings related to the facilitation of CPCs were positive, this part of the CPNS service was not inspected in this follow up inspection.

HIQA also found poor practice and areas of risk which were not adequately addressed during the January 2020 inspection. Initial CPCs did not take place in a timely manner. There were mixed findings in how child protection safety plans were implemented and monitored by social work teams. The quality of safety planning for children on the CPNS widely varied from good to very poor quality. The monitoring of children on the CPNS was poor as social work visits to children was poor.

This follow up inspection specifically looked at whether the actions outlined in the compliance plan returned to HIQA following the January 2020 inspection made an improvement to the service delivered to children on the CPNS. Overall, inspectors found that while significant improvements had been made, further work was required.

Initial CPCs were not always held within required timelines. Inspectors reviewed cases where nine initial child protection conference (ICPC) had been held since January 2020. Three of the nine ICPCs were held within a few days of a CPC request approval as they had been assessed as requiring emergency CPCs. Of the six remaining, there were delays of between seven weeks and four months. Three cases had rationales for the delays outlined in case records. These included: one child not living in the household where there were risks, difficulty in scheduling the CPC meeting given restrictions related to the Covid-19 pandemic and an in-depth assessment was required for a third case. Of the remaining three, records did not indicate any rationale for delays. As stated, there had been staffing issues within the CPC service which impacted capacity to schedule CPCs in line with the demand.

The content of child protection safety plans devised at CPCs were of good quality. Child protection safety plans provided a template of next steps for the social worker to implement in order to ensure children's safety. The plans consisted of a list of actions, identified during the CPC, that were to be implemented and monitored by the social worker. The plans also outlined what safety measures were to be addressed following the CPC, during safety planning meetings; the frequency of which was also specified in some of the plans. Overall, actions identified on individual plans were comprehensive and addressed the assessed and identified risks, along with the supports to be provided.

The area manager outlined key areas in how child protection safety plans were to be implemented and monitored by social workers. According to the compliance plan returned to HIQA after the January 2020 inspection, supervision between the social worker and social work team leader was to take place within two weeks of the CPC. The purpose of this meeting was to ensure good quality and on-going monitoring of the child protection safety plan. Following this meeting, key areas such as the frequency of social worker visits and safety planning meetings, the assessment of parental capacity to safeguard and how risks were to be managed, was agreed and set out a trajectory for social work engagement.

Inspectors found that supervision was held more frequently and was a driving force at ensuring a better service for children on the CPNS. However, some of the key areas outlined in the compliance plan were not always addressed during supervision. For example, supervision did not always take place in a timely manner following the CPC and regular home visits were not always evident in cases. As stated, this was known to the area management team. As a result, the monitoring of child protection safety plans was not fully and consistently implemented in line with actions outlined in the compliance plan.

There was a considerable improvement in how child protection safety plans were implemented and monitored by the social work teams. Inspectors found that there was an urgency in addressing the risk identified at initial child protection conferences and in implementing child protection safety plans. For example, one case had an escalation of risk following the ICPC. Despite the social working being on leave, the wider social work team ensured that arrangements were put in place to ensure children's safety and that children were seen.

The frequency and quality of social work visits was improved. Of the 16 cases reviewed by inspectors, all but one had regular social work visits where children were seen in their home environments and spoken with where appropriate. Inspectors received satisfactory assurances from the social work team leader that social work monitoring of the child was appropriate and they were safe in the care of a relative. Unannounced visits by social workers were evident on case records particularly where an assessment of the parental capacity to safeguard children was required. In addition, the social work department utilised alternative methods of monitoring in particular cases such as member so safety networks who were assessed as being protective.

There was an improvement in the use of child protection safety planning meetings to monitor child protection safety plans between CPCs. According to the Tusla guidelines for CPCs and the CPNS, regular safety planning meetings were to be convened following the CPC, to create a more detailed child protection safety plan, review the safety for the child and monitor the progress in the case. At the time of the last inspection, regular safety planning meetings were evident in only one out of 18 cases reviewed and was not in line with the Tusla national guidelines for CPCs and the CPNS. During this inspection, safety planning meetings were a regular feature in 14 out of 16 cases.

Despite the more consistent use of safety planning meetings, further improvement were required. Of the nine cases reviewed where ICPCs were held following the last inspection, all had initial safety planning meetings held. These meetings usually took place two months after the ICPC, which was a delay. Of the other seven cases reviewed by inspectors, safety planning meetings were held on five with a lack of parental engagement on the remaining two preventing the scheduling of safety planning meetings. The frequency of these meetings was not always consistent and was not always in line with actions outlined in supervision by the social work team leader.

In July 2020, Tusla issued a new standard business process for child protection safety planning process. Documentation was also implemented so that these meetings could be recorded in a consistent format. Principal social workers and social work team leaders told inspectors that it was a significant challenge to implement these new standard business process within a short timeframe, i.e., between July and November 2020. They maintained that as a result, the practice of using safety planning meetings to monitor child protection safety plans was not consistently implemented since the last inspection in January 2020. A review of children's NCCIS case files showed that chairing of these meetings were more consistent after July 2020, which was in line with changes to business processes.

Overall, safety planning for children on the CPNS was improved. At the time of the last inspection, safety planning in two out of 15 cases were judged by inspectors to be adequate. At the time of this inspection 14 out of 16 cases had adequate safety planning in place. There was evidence of detailed arrangements to ensure children's safety and parental capacity assessments undertaken social workers. Of the two cases where inspectors found that safety planning was not adequate, the social work department sought supervision orders from the Court and an escalation of monitoring was underway to address the identified risks.

Review CPCs were used effectively to monitor the progress of child protection safety plans. Inspectors found that review CPC records had review of actions from the previous conference which informed the decision as to whether a child was to remain on the CPNS or not. In line with the findings from the last inspection, CPC chairs identified drift in cases and communicated their concerns to the relevant principal social worker.

Improvements in how the social work service was delivered had positive impacts for children on the CPNS. Inspectors found that no children were subject to drift. Of the 89 children on the CPNS, 11 were placed for longer than 18 months. Inspectors found that these cases were being appropriately worked. All had been referred to the complex case forum and had case trajectory approved by senior management. Where legal orders, such as supervision orders, were required to progress cases, there was evidence they were sought. At the time of this inspection, four children on the CPNS had met the threshold for an admission to care. A review of these cases showed that while remaining at home was not safe for them in the long term, their immediate safety was not at risk and searches for appropriate care placements were underway. Inspectors were informed by the area manager and principal social workers that finding suitable placements for children who should be in care or who are in care, and required a more suitable placement was one of the most significant challenges that Tusla faced.

At the time of the last inspection, HIQA found that critical decisions taken at CPCs were not able to be implemented due to poor quality interagency arrangements between Tusla and the HSE, particularly in circumstances where children had a disability or where children had mental health issues. None of the cases reviewed during this inspection required significant interagency arrangements. Hence, inspectors were unable to evidence any improvements to this process. Nonetheless, records did show that CPCs and some safety planning meetings used external professionals to assist with the monitoring of children's safety and to report on the progress of cases.

<p><b>Standard 2.6</b> Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.</p>	<p><b>Judgment</b> <b>Substantially compliant</b></p>
<p>Further improvements in social work service delivery were required to ensure full implementation and monitoring of child protection safety plans.</p>	
<p><b>Standard 2.7</b> Children’s protection plans and interventions are reviewed in line with requirements in Children First.</p>	<p><b>Judgment</b> <b>Compliant</b></p>
<p>Review CPCs were used effectively to monitor the progress of child protection safety plans.</p>	
<p><b>Standard 2.9</b> Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.</p>	<p><b>Judgment</b> <b>Compliant</b></p>
<p>A review of records showed that external professionals assisted Tusla with the monitoring of children on the CPNS.</p>	

# Compliance Plan

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

<b>Provider's response to Inspection Report No:</b>	<b>MON-0030926</b>
<b>Name of Service Area:</b>	Cork
<b>Date of inspection:</b>	24, 25, 26 November 2020
<b>Date of response:</b>	Friday, 29 <sup>th</sup> January 2021.

These requirements set out the actions that should be taken to meet the *National Standards*

<b>Theme 2: Safe and Effective Services</b>	
<b>Standard 2.6</b>	
<b>Substantially Compliant</b>	
<b>The provider is failing to meet the National Standards in the following respect:</b>	
Further improvements in social work service delivery were required to ensure full implementation and monitoring of child protection safety plans.	
<b>Action required:</b>	
Under <b>Standard 2.6</b> you are required to ensure that: Children who are at risk of harm or neglect have protection plans in place to protect and promote their welfare	
<b>Please state the actions you have taken or are planning to take:</b>	
The implementation and monitoring of Child Protection Safety plans, including the frequency and consistency of Safety Planning meetings, will form part of the supervision between the Social Worker and the Team Leader to ensure adherence to the Child Protection Conference safety plan. Any issues in convening safety planning meetings in accordance with the agreed frequency will be addressed in Supervision and new actions will be agreed, depending on the needs of the children subject to these plans.	
<b>Proposed timescale: Immediate</b>	<b>Person responsible: Team leaders and PSW's</b>

## **Standard 3.1**

### **Substantially Compliant**

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

The monitoring and trending of initial CPC timeliness by CPC chairs had not yet been implemented.

Individual case supervision practices as outlined in the last compliance plan were not consistently implemented.

#### **Action required:**

Under **Standard 3.1** you are required to ensure that:

The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

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

1. In the absence of appropriate permissions on NCCIS for the Child Protection Conference chairs to review timelines, an Area interim measure has been devised provide such timelines. Training will be provided for the Administration team, on advanced finds on NCCSS on the 25<sup>th</sup> January 2021. This will show the number of approved Child Protection Conference requests and the number of Child Protection Conferences held. Combining the results of these two advanced finds will enable the identification of timelines.
  - A data quality officer will be available to support staff with this exercise during Q1
  - This information will be made available to the Area Manager and the teams on a quarterly basis at the Area Forum meetings.
  - An end of year report will be provided annually which will reflect stats, timelines and categories of cases listed, this will include a team and an area analysis.
2. The Principal Social Worker, in conjunction with the team leaders will review the standardised supervision Pro-forma as per the Supervision policy which includes: discussion decisions, actions and review of previous actions and the Principal Social Worker will review a sample of Supervision records to ensure compliance. Any issues in relation to compliance will be addressed in the Team Leader supervision with the Principal Social Worker.

<b>Proposed timescale:</b>	<b>Person responsible:</b>
1. Q1 2021	CPC chairpersons
2. Q1 2021	Team leaders and PSW's

**Standard 3.3**  
**Substantially Compliant**

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

Learning from serious reviews had not been shared in a timely manner.

**Action required:**

Under **Standard 3.3** you are required to ensure that:

The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery.

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

1. The child protection Principal Social Work (PSW) group will take the learning from the audits relating to the frequency and quality of supervision and devise a learning Action Plan within the teams based on the findings of same. This will include a briefing to all team leaders by the PSW's.
2. Consultation with the Working Group on Dissemination of Learning will ensure an integrated approach to implementation of all learning action plans. Some progress has been made in relation to piloting a Rapid Review process, and also templates have been developed nationally to assist in the dissemination of the learning. Briefings will be held with staff to disseminate this learning in Q2 2021. A record of attendance will ensure all relevant grades attend these briefings as part of continual professional development.
3. The effectiveness and safety of Child Protection & Welfare service delivery will be a standing item on the PSW Group Supervision Agenda and that of the Complex case forum meetings.

<b>Proposed timescale:</b>	<b>Person responsible:</b>
1. Q3 2021	PSW's
2. Q2 2021	PSW's & Area
3. Immediate	Manager

