

Child protection and welfare inspection report

Health Information and Quality Authority
Regulation Directorate monitoring inspection report on
child protection and welfare services under the *National
Standards for the Protection and Welfare of Children*, and
Section 8(1) (c) of the Health Act 2007



Name of Service Area:	Dublin South West Kildare West Wicklow
Dates of inspection:	9, 10 and 11 April 2019
Number of fieldwork days:	3
Lead inspector:	Ruadhan Hogan
Support inspector(s):	Jane Mc Carroll Eva Boyle
Type of inspection:	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced <input type="checkbox"/> Full <input checked="" type="checkbox"/> Themed
Monitoring Event No.:	MON-0026430

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public. HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- Setting standards for health and social care services — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- Regulating social care services — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- Regulating health services — Regulating medical exposure to ionising radiation.
- Monitoring services — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- Health technology assessment — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- Health information — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- National Care Experience Programme — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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:

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

1. Inspection methodology

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager and a principal social worker
- interviews with two social work team leaders
- meetings with social workers and social care workers
- interview with a Prevention, Partnership and Family Support senior manager
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of 69 children's case files
- observing duty staff in their day-to-day work
- observation of a meeting

The aim of the inspection was to assess compliance with national standards related to managing referrals to the point of completing a preliminary enquiry. During this inspection inspectors identified if Tusla child protection and welfare services took timely, proportionate and effective actions when responding to referrals about children in need and at risk by evaluating the following:

- timeliness and management of referrals
- effectiveness of risk management processes
- provision of safety planning where required
- effectiveness of inter-agency and multidisciplinary work
- the managing and monitoring of child protection cases in order to improve outcomes for children

Acknowledgements

The Authority wishes to thank the staff and managers of the service for their cooperation with this inspection.

2. Profile of the child protection and welfare service

2.1 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 areas.

2.2 Service Area

Dublin South West Kildare West Wicklow is one of 17 service areas in the Child and Family Agency. Forming part of the Dublin Mid-Leinster region, it encompasses four counties: County Kildare, Wicklow, South Dublin and Dublin South City and is a mixture of urban and rural areas with large rural towns such as Naas and Newbridge and urban areas such as Tallaght and Crumlin.

The total population of the area is 402,436 (according to 2016 Census). 27% of this figure, which is 108,186, are children under the age of 18 years of age. Of the 17 Tusla areas, it had the 3rd highest level of deprivation. In the six months prior to the inspection, the intake service received 2116 referrals of child protection and welfare reports.

The area was under the direction of the service director for the Child and Family Agency Dublin Mid-Leinster Region and was managed by the area manager.

The Dublin South West Kildare West Wicklow intake service is managed by one principal social worker with two intake screening teams based in the Dublin South West area and Kildare West Wicklow area. These teams were managed by two social work team leaders.

The organisation chart in the appendix describes the management and team structure of the child protection and welfare service, as provided by the Service Area (See appendix 1).

3. Summary of inspection findings

The Child and Family Agency has the legal responsibility to promote the welfare of children and protect those who are assessed as being at risk of harm. These children require a proactive service which acts decisively to assess and meet their needs in order to promote their safety and welfare. As much as possible, children and families require a targeted service aimed at supporting families. However, there will always be some children who will need to be protected from the immediate risk of serious harm.

This report reflects the findings of the inspection which are set out in Section 6. The provider is required to address a number of recommendations in an action plan which is attached to this report.

In this inspection, HIQA found that of the four standards assessed:

- All standards were non-compliant major

The decision was made to undertake this inspection in response to risks identified during a previous HIQA inspection of the foster care service in November 2018. At that time, the area identified that staffing deficits compromised the delivery of a safe and effective service.

At the time of this inspection, inspectors found the Tusla service area of Dublin South West Kildare West Wicklow was challenged to ensure a service was consistently delivered. A number of key changes introduced in the area over the previous 12 months, were still not fully implemented at the time of inspection. These included, changes in senior management in the area, the adoption of a national approach to child protection and welfare, the introduction of mandatory reporting, changes to the national standard operating procedures and the roll out of the national child care information system (NCCIS). Additionally, staffing deficits remained high across the entire Tusla service area. All of these issues contributed to the intake service requiring a three month crisis plan from Tusla senior management.

In the majority of cases, five out of six reviewed by inspectors, immediate action was taken where required. However, there were significant systems and practice deficits which impacted on the service that children and families received.

Referrals received were not being entered onto NCCIS in a systematic, consistent and appropriate manner. Inspectors found that individual referrals did not always receive an individual response through a unique preliminary enquiry. This resulted in problems with responding to referrals.

Child protection and welfare referrals were not being completed in line with Tusla standard

business. According to Tusla's business processes, when referrals were received, screening was to be completed within 24 hours in order to determine if the referral met the threshold for a child protection and welfare service and also whether immediate action needed to be taken to ensure children were safe. Inspectors found that although screening did take place, it was often poor quality as threshold levels were not consistently recorded on screening records and timeframes were outside of the 24 hours.

Overall, the quality of preliminary enquiries was poor. Inspectors evaluated the quality of preliminary enquiries by measuring the process against these quality indicators:

- if they were completed within five working days
- if the classification appropriate
- if internal checks carried out
- if details clarified with referrer
- was the priority level appropriate

While the categorisation and prioritisation was largely accurate, the timeliness was poor. Children experienced significant delays in the completion of preliminary enquiries. In addition, basic checks were not consistently completed as part of preliminary enquiries.

Inspectors did find above examples of good social work practice. There were innovative and effective measures in place to divert families to external agencies where a welfare response was more appropriate. However, as children did not receive a service that promoted their welfare and protected them from harm in a responsive manner, this impacted on the timely development and implementation of safety plans.

Safeguarding measures including safety plans and the corresponding supports were not always put in place. Within the intake service, some children had been placed on a waitlist for a child protection and welfare service when the assessment to determine the level of risk and need was of poor quality. Due to staffing deficiencies and capacity issues, social workers did not routinely visit children and families. Preliminary enquiries, including interactions with families, were completed over the phone. In this context, inspectors could not see how meaningful interactions with families to assess and implement safeguarding measures could be put in place.

While inspectors found examples of good co working with An Garda Síochána, the service area was not routinely notifying An Garda Síochána of suspected crimes of willful neglect or physical or sexual abuse against children in a timely manner.

Over the six weeks prior to the inspection, the management of the area identified two significant areas of risk and put a three month crisis management plan in place to address them. They included:

- the backlog in processing and uploading new referrals onto NCCIS and
- the operation of waitlists at the preliminary enquiry stage.

Inspectors found that effective measures had been put in place to reduce the backlog of referrals waiting to be put up on the system. However, there remained significant problems with the operation of waitlists at the preliminary enquiry stage. There were no systems in place to formally review cases on a waitlist for preliminary enquiry. Additionally, cases were closed to the service without the required checks and the rationale for closing either, completed or recorded on NCCIS.

Governance in the area did not promote the development of an intake service that could respond to the required needs. Inadequate service planning contributed to a crisis led approach to delivery of the intake service for a three month period. Staffing deficiencies and staff turnover remained high across all social work and business support teams in the area which also had a significant impact on ensuring a stable and consistent service was delivered. Information technology systems were not being utilised to their potential which could have increased efficiencies in managing referrals.

The oversight of child protection and welfare cases was poor in the area. Formal supervision and quality assurance systems were not effective at providing assurance that the service was being safely delivered. Risk management in the area was not effective at identifying all risks and putting measures in place to mitigate them.

In response to the concerns raised by inspectors following the inspection fieldwork, the Tusla regional service director outlined a number of measures Tusla had put in place to promote service development and learning. These included:

- A national audit/review of notifications made by An Garda Síochána to the service
- An established regional child protection and welfare forum to address promote learning and supporting standardised implementation in key areas, for example, Garda notifications
- A governance and implementation support group for the area was to be established in May 2019 with membership consisting of the area management team, regional human resources manager, regional quality risk and service improvement managers, a representation from Tusla's quality assurance directorate and the regional business support manager.
- Bespoke recruitment initiatives to address the high number of vacancies in the service area
- Scheduling of a service planning day for the intake teams with the focus on developing consistency of practice relating to screening, preliminary enquiries and safety planning
- Ongoing training for principal social workers and social work team leaders in order to support the continual implementation of the new national approach to child protection and welfare

4. Compliance Classifications

We will judge a provider or person in charge to be **compliant, substantially compliant** or **non-compliant** with the regulations and/or standards. These are defined as follows:

Compliant: A judgment of compliant means that no action is required as the provider or person in charge (as appropriate) has fully met the standard and is in full compliance with the relevant regulation.

Substantially compliant: A judgment of substantially compliant means that some action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

Non-Compliant: A judgment of non-compliance means that substantive action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

Actions required

Substantially compliant means that *action within a reasonable timeframe* is required to mitigate the non-compliance and ensure the safety, health and welfare of people using the service.

Non-Compliant means we will assess the impact on the individual(s) who use the service and make a judgment as follows:

- **Major non-compliance:** *Immediate action*¹ is required by the provider or person in charge (as appropriate) to mitigate the non-compliance and ensure the safety, health and welfare of people using the service
- **Moderate non-compliance:** *Priority action* is required by the provider or person in charge (as appropriate) to mitigate the non-compliance and ensure the safety, health and welfare of people using the service

5. Summary of judgments under each standard

<i>National Standards for the Protection and Welfare of Children</i>	
Theme 2: Safe and Effective Services	Judgment
<p>Standard 2:2</p> <p>All concerns in relation to children are screened and directed to the appropriate service.</p>	Non-compliant - Major
<p>Standard 2:3</p> <p>Timely and effective actions are taken to protect children.</p>	Non-compliant - Major
<p>Standard 2:4</p> <p>Children and families have timely access to child protection and welfare services that support the family and protect the child.</p>	Non-compliant - Major
<p>Standard 2:10</p> <p>Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.</p>	Non-compliant - Major

6. Findings

Theme 2: Safe and Effective Services

Services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect children from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the proper support mechanisms are in place to protect children and promote their welfare. Assessment and planning is central to the identification of children's needs, the risks to which they are exposed and the supports which need to be put in place for each individual child to keep them safe and maintain their wellbeing.

Standard 2.2:

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

Tusla Child Protection and Welfare Services receives referrals from various sources including members of the public, professionals, community organisations, voluntary services and An Garda Síochána. This inspection found that referrals were received by Dublin South West Kildare West Wicklow Child Protection and Welfare Service from all of the above sources and these were received in many different ways, including through and electronic portal, verbally, in writing, in person or through a standard referral form which is contained in Children First: National Standards for the Protection and Welfare of Children (2017).

The child protection and welfare service had two social work teams who oversaw screening and preliminary enquiries. One team was based in Tallaght covering the Dublin South West geographical area with the other based in Naas covering the Kildare West Wicklow geographical area. Each team was supervised by a social work team leader who reported to a principal social worker. Members of the public could drop into the Naas office to report concerns about a child, while access to the service was restricted in Tallaght. The area manager told inspectors that premises used by Tusla in Tallaght was not suitable for the safe facilitation of a drop in social work service particularly when waiting areas were shared with other services due to a serious security breach that previously occurred. Members of the public could request a telephone call back from a social worker if they called to the reception of the social work offices. The area manager said that she had made a finalised application to procure alternative social work offices. However, this was taking a considerable amount of time leaving members of the public without the opportunity to make a referral in person.

This Tusla service area had significant problems in responding to referrals and as a result screening and preliminary enquiries were not being completed in line with Tusla standard business processes. Adherence with these business processes were compromised by a number of factors including the service areas capacity to process referrals in a timely manner.

Screening of Referrals

According to Tusla's business processes, when referrals were received, screening was to be completed within 24 hours in order to determine if the referral met the threshold for a child protection and welfare service and also whether immediate action needed to be taken to ensure children were safe. The area had devised a specific tool to record screening. This measure was put in place to document that screenings of all referrals were completed. As part of the screening process, the social work team checked if the children referred were previously known to the service and categorised the type of intervention that they assessed as being required, based on information in the referral.

Inspectors found that the quality of screening in the area was varied and threshold levels were not consistently recorded. The social work team leader completed screening of all referrals and assigned a case to a social worker based on the type of intervention recorded on the screening record. The type of intervention recorded differed in each team, however was categorised in general terms as:

- priority preliminary enquiry to be undertaken due to child protection concerns
- divert to early intervention or meitheal and
- case to be closed.

Inspectors were told that all referrals received after January 1st 2019 had screening completed including those that they were awaiting completion of preliminary enquiries. In total, inspectors reviewed a sample of 58 referrals for screening and found the following:

- 32 out of 58 referrals or 55% had screening completed within 24 hours of receipt of referral.
- 21 out of 58 referrals or 36% did not have screening completed within 24 hours of receipt of referral.
- Five out of 58 referrals or 9% had no record of screening completed. All of these screening records related to referrals received after January 1st 2019.

The service area was not consistently and definitively recording thresholds against new referrals. Of the 53 screening records reviewed by inspectors, 43 did not have consistent thresholds recorded, in line with Tusla standard operating procedures. Inspectors found the two social work offices had different categories and significant inconsistencies in the recording of thresholds on screening records. For example, in one of the offices, some screening records were identified as requiring a 'priority' preliminary enquiry with others recorded as 'child protection/high welfare' despite being in the same threshold category. Six

screening records sampled identified two of the three levels of intervention instead of one level, for example, identifying both categories of 'child protection' and 'close'. A social work team leader told inspectors that decisions on thresholds at the screening stage were sometimes suggestions or guidance for social workers prior to them undertaking the preliminary enquiry. This process needed to be consistently applied, as the service area operated a waitlist for referrals requiring preliminary enquiry and the management of the waitlist and associated risk was based on how the correct application of thresholds recorded at the screening stage.

When screening was completed, the social work team leader allocated a case to social workers to complete a preliminary enquiry or placed the referral on a waitlist. Inspectors used the Tusla's standard business process to inform key quality indicators which were used to assess the quality of preliminary enquiries. The quality of preliminary enquiries was determined by measuring the process against the quality indicators. These quality indicators were as follows:

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

The overall quality of preliminary enquiries carried out in the Dublin South West Kildare West Wicklow service area was poor. Inspectors judged 10 out of 41 or 24% preliminary enquiries to be good quality with 31 out of 41 or 76% to be poor quality. Data returned by the area prior to the inspection identified that there were 415 cases awaiting allocation for an initial assessment. A sample of nine of these cases was reviewed where screening and preliminary enquiries had been completed and the case was transferred to the assessing teams to be placed on a waiting list for allocation. Inspectors found that the quality of preliminary enquiries was poor in five cases. Three of these cases were escalated to the area management for assurances that safeguarding measures were in place to ensure children safety.

Inspectors found that individual referrals did not always receive an individual response through a unique preliminary enquiry. For example, inspectors reviewed records where multiple referrals had been received for one child. The content of numerous referrals were recorded under a single preliminary enquiry. This meant that if a subsequent referral relating to the same child was to be reported to a different Tusla service area, the content of the older referrals may not be seen as Tusla personnel in other service areas may not know where to find information on the older referrals. This led to a risk that information on historical referrals would not be considered in any potential future referrals received.

Inspectors found there were significant delays in the completion of preliminary enquiries. Of the 41 referrals sampled by inspectors for completed preliminary enquiries, 14 were

completed within five working days.

Of the remaining 27:

- eight were not signed or dated by a social work team leader,
- nine preliminary enquiries took between three to six months to complete
- six preliminary enquiries took between one and two months
- the remaining four taking between two to three weeks for completion.

The categorisation of referrals following completion of a preliminary enquiry was, for the most part, correct. Of the 41 records of preliminary enquiries reviewed by inspectors, 35 had correct categorisation. Inspectors found the other six preliminary enquiries were of poor quality and had been categorised as emotional or child welfare when the record indicated that they should have been categorised as neglect or physical abuse. This was significant as it impacted on the type of response these children received from the social work department.

The prioritisation of referrals following completion of a preliminary enquiry was also largely accurate. Of the 41 records of preliminary enquiries reviewed by inspectors, 33 had the correct prioritisation recorded. The other eight preliminary enquiries were all of poor quality and did not have enough information to inform a correct prioritisation.

Basic checks were not consistently completed as part of preliminary enquiries. While 95% or 39 out of 41 records of preliminary enquiries reviewed by inspectors, had internal checks completed, 19 out of 41 or 46% did not have details clarified with the referrer prior to completion.

The service area was not routinely notifying An Garda Síochána of suspected crimes of willful neglect or physical or sexual abuse against children in a timely manner. According to data returned to HIQA prior to the inspection, there were 2116 referrals made to the service in the six months prior to the inspection. Of those, only 24 notifications had been made to Gardai which was a very low number relative to the number of referrals made to the service. Of the 77 referrals reviewed by inspectors, none had a notification made to An Garda Síochána by Tusla. Inspectors found eight referrals where a notification to An Garda Síochána may have been required, based on the information on the file. Seven of these eight referrals had completed preliminary enquiries, while the preliminary enquiry relating to the last referral was overdue by four months. All of the cases relating to the eight referrals were escalated to the area management for assurances that notifications were made, where required. Inspectors received a response which outlined that upon review, the social work team intended to consider whether a notification was required as part of an initial assessment upon 'grounding' of the suspicion.

During interviews with inspectors, the Tusla regional service director acknowledged that the number of notifications to An Garda Síochána was low. She said that a notification should be made when there was a suspicion of abuse in line with Children's First 2017; usually at

preliminary enquiry stage and that staff should not await the grounding of the suspicion of abuse. She said that she subsequently issued a memo directing staff in the area that notifications were made in line with this stance.

Non-compliance – Major

Standard 2.3:

Timely and effective action is taken to protect children.

In the majority of cases, five out of six, immediate action was taken to protect children where required. According to data returned to HIQA prior to the inspection, there were 60 cases that required immediate action in the six months prior to the inspection. Staff on the intake teams told inspectors that when a case for immediate action was identified, they ensure it is prioritised. Of the 69 of children's case files reviewed by inspectors, six or 8% were identified as requiring immediate action to protect children. In five of these cases, records showed good quality measures to ensure children's safety. For example, inspectors saw that an immediate visit to the home of a child was conducted, there was excellent quality multi-disciplinary work between the child protection and welfare department and other services such as mental health, hospital, schools and fostering services. Two cases reviewed illustrated excellent inter-agency working between An Garda Siochana and social work staff to ensure safety of children and subsequent work such as placing children in emergency fostering placements had been undertaken in a timely manner. However, a sixth case was escalated to the area management as there had been no response to an allegation of physical abuse of a child. Inspectors received satisfactory responses during the inspection that a home visit to see the child was being undertaken in order to assess the allegations.

There were innovative and effective measures in place to divert families to external agencies where a welfare response was more appropriate. Cases which had been appropriately screened as being a lower priority were allocated to a social care worker who completed the preliminary enquiry under the supervision of a social work team leader. If the outcome of that the referral did not meet the threshold for a child protection response yet the family benefit from a welfare intervention, an effective process to divert families into external agencies was in place. Inspectors interviewed the social care worker and observed a specialist meeting, that was held regularly, to decide interventions to be offered to families. The meeting was attended by representative's from external agencies to whom Tusla could refer and a decision was reached during the meeting as to the appropriateness of the referral and capacity of the agency to undertake any potential work.

However, despite the above examples of good social work practice, as previously stated, there were significant problems in responding to referrals and as a result screening and preliminary enquiries were not being completed in a timely and comprehensive manner. This impacted on some children referred to the service who did not receive a timely visit from a social worker. Consequently, safeguarding measures including safety plans and the corresponding supports were not always put in place.

Safety plans were not being drawn up in a timely and consistent manner. The delay in undertaking preliminary enquiries impacted on the timely development and implementation of safety plans. Hiqa would not expect to see a safety plan on every case reviewed, but

given the delays the area had in completing preliminary enquiries, it was vital that strong safeguarding measures were in place while children were awaiting a service. Of the 69 children's case files reviewed by inspectors, 50 related to children open to the child protection and welfare service. 20 out of these 50 or 40% of cases open to the service and reviewed by inspectors, did not have a preliminary enquiry completed and consequently had not been assessed to find out if a safety plan was required. The remaining 30 of these cases had a preliminary enquiry completed yet only three had reference to safety planning. Inspectors found that the safety planning measures agreed with families were often done so verbally. Two cases had verbal safety plans put in place with a third having a formal safety plan drawn up two weeks after a verbal safety plan was agreed the family. Inspectors found that of the 30 cases where preliminary enquiries were completed, 11 or 36% required safety planning. In total, HIQA escalated three cases to the area management for appropriate safeguarding measures to be put in place in response to the significant risk identified.

While the area did take initiatives to embed safety planning in practice, it was not implemented by the time of the inspection. Staff told inspectors that they had completed a four day intensive workshop on the new national approach to child protection with a focus on safety planning. They also said that due to staffing deficiencies and capacity issues, they did not routinely visit child and families, instead completing preliminary enquiries, including interactions with families, over the phone. In this context, inspectors could not see how meaningful interactions with families to assess and implement safeguarding measures could be put in place.

Non-compliant – Major

Standard 2.4:

Children and families have timely access to child protection and welfare services that support the family and protect the child.

As stated, there were significant issues in responding to referrals. Inspectors found that child protection and welfare reports were not responded to in a timely or comprehensive manner resulting in children experiencing long delays prior to receiving a response from the service. Over the six weeks prior to the inspection the management of the area identified two significant areas of risk and a three month crisis management plan was put in place to address them. They included:

- the backlog in processing and uploading new referrals onto NCCIS and
- the operation of waitlists at the preliminary enquiry stage.

The area management team identified the significant issues and escalated them to the regional service director and the Tusla chief operation officer, in February 2019 prior to inspection. Inspectors found that the crisis management plan was effective at eliminating the backlog of referrals to be entered onto the system. However, there remained significant problems with the operation of waitlists at the preliminary enquiry stage.

There were no systems in place to formally review cases on a waitlist for preliminary enquiry. According to data submitted to HIQA prior to the inspection, there were 168 cases on a waitlist for a preliminary enquiry and 415 cases on a waitlist for initial assessment. For the purpose of this inspection, inspectors did not review the management of cases on a waitlist for initial assessment, instead focusing on the waitlist for preliminary enquiry. The crisis management plan indicated that the primary means of managing these 168 cases on a waitlist for preliminary enquiry was completion of a screening record in order to prioritise cases for immediate action. There was no evidence that cases remaining on a waitlist for preliminary enquiry were subject to ongoing review other than when a new referral was received which related to the same child. Inspectors reviewed 21 cases awaiting completion of a preliminary enquiry. Fourteen had been referred to the social work department in over five working days and inspectors could not see evidence that these cases were subject to continual review and prioritisation. Inspectors escalated one of these cases to the area manager who subsequently provided a satisfactory response to the issue identified by inspectors. Inspectors found inconsistent recording practices such as the recording of more than one referral on a single preliminary enquiry. This led to a potential risk that newer referrals were not considered appropriately.

Some cases were closed to the service without the required checks and the rationale for closing either, completed or recorded on NCCIS. Of the 69 children's case files reviewed by inspectors, 19 related to closed cases. Of these 19 cases, records showed that eight were

closed appropriately after details had been clarified with the referrer and checks including phone contact or visits to the parents, child and network professionals where appropriate. Three cases had very poor recording yet the information on the referral did not meet the threshold for a service. The remaining eight cases were escalated to the area management for assurances that basic checks were carried out and that the social work department had assured itself that children were not at risk. A satisfactory response was subsequently received which acknowledged that the rationale for closure of cases was not routinely recorded.

Non-compliant – Major

Standard 2.10:

Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.

Over the 12 months prior to the inspection, Tusla had implemented significant changes in how referrals were assessed and recorded nationally. A new national approach to child protection and welfare had been adopted and was in the process of being fully implemented within this service area. This involved a significant amount of training, workshops and fundamental changes in how social workers interacted with families to ensure children's safety. Mandatory reporting had been introduced. There had also been changes to the national standard operating procedures which saw the extension of timelines for preliminary enquiries change from 24 hours to five days. Additionally, a new information technology system, the national child care information system (NCCIS) had been rolled out nationally. Again, this required re training of staff and a change to basic recording practices on which social work interventions and decisions were evidenced. These changes required stability within the social work teams in order for a consistent service delivery. Staff told inspectors that they were aware of the difficulties with staffing in the area, the impact this had on the intake service and the plans in place to address this issue.

Inadequate service planning contributed to a crisis led approach to delivery of the intake service for a three month period. There was a defined management structure with clear lines of accountability and responsibility. However, in the six months prior to the inspection, there had been changes to the management structure and personal throughout the service area. One principal social worker transferred to another Tusla service area and changes to the intake service management had been made. A principal social worker transferred from long term child protection and welfare service to oversee the all intake service in January 2019 while continuing to hold some responsibility for their previous role at the time of the inspection. As a result, the principal social worker could not give a full focus to the development of the intake service. During interviews with inspectors, she outlined how she thought the intake service should be delivered in line with new national approach to child protection and welfare and new standard operating procedures (SOPs). For example, expansion of the intake teams to enable high quality preliminary enquiries to be undertaken that would pre-empt the need for initial assessments. However, she acknowledged that there had been no in-depth analysis of what was needed to be done, such as, an analysis of the current capacity of intake teams and if it was sufficient to meet the need for service requirements in line with the new approaches and SOPs. Additionally, there were no corresponding service plans drawn up. She told inspectors that service planning would begin once crisis planning had concluded. The Tusla service director told inspectors that a national child protection strategy was in place and the service had strong and experienced managers who would implement this strategy. She also said that in the context of the

changes underway in the intake service, staff needed support so they did not become overwhelmed with the level of change.

Staffing deficiencies and staff turnover remained high across all social work and business support functions in the area which also had a significant impact on ensuring a stable and consistent service was delivered. At the time of the inspection, the area manager told inspectors that there were 26 vacancies across social work, social care, family support practitioners and business support staff. In relation to the intake service, social work vacancies remained unfilled for long periods prior to the inspection. The area manager told inspectors that a significant amount of her time was spent ensuring critical vacancies across the entire service were filled. Recruitment of staff was not timely and the area manager said that while social work posts had been approved, due to a national shortage of social workers, they had not been filled.

Inspectors found there had been some positive innovations put in place to mitigate against the high number of job openings in the area. Social care professionals were employed to undertake preliminary enquiries under the supervision of social work team leader. Staff members were assigned specific responsibility for areas such as domestic violence. These measures were somewhat effective at creating efficiencies within the intake teams. However, while these measures were proactive, they did not result in a significant reduction of the cases on a waitlist for preliminary enquiries nor the consistent completion of good quality and timely preliminary enquiries.

Effective measures had been put in place to reduce the backlog of referrals waiting to be recorded and put up on the system. A backlog of referrals to be entered onto the Tusla information technology system- the national child care information system (NCCIS) had built up over a number of months and reached as high as 572 in February 2019. The area manager told inspectors that the service area did not have any tolerance for such waitlist. HIQA was of the view that the use of a waitlist for referrals to be entered onto the system, so that preliminary enquiries could take place, was unacceptable. Following an escalation of this risk by the area manager to the service director in February 2019, a three month crisis plan from Tusla senior management was put in place. This plan involved meeting with the relevant Tusla service director who approved overtime of business support staff so that the backlog of referrals could be entered onto the system. Inspectors found this waitlist had reduced to zero and new referrals were being entered onto the system as they were received.

However, despite the above progress, information technology systems had not been sufficiently implemented to support the social work teams. The national child care information system (NCCIS) was introduced into the area in June 2018. It was intended that electronic files of children case records would take the place of paper files. However, by the time of the inspection, the area was using both systems which was a duplication of work. The transition to the primary use of electronic files through NCCIS had been delayed as the

recruitment of a key NCCIS support personnel in the area did not occur until January 2018, six months after the system was introduced. The area manager told inspectors that the delay in appointing the NCCIS support person was due to difficulties in approving internal transfers across the service area. A significant amount of data relating to children from an older information technology system, required validating before it could be transferred into NCCIS. This was a task for the NCCIS support person and hence this validation of data was delayed by six months. The impact of these delays was that dual recording systems remained in place and the area did not implement sufficient standardised approaches to the electronic recording of screening and preliminary enquiries.

Referrals received were not being entered onto NCCIS in a systematic, consistent and appropriate manner. While hard copies of referrals were held on paper files, the business support teams did not have the necessary equipment to scan referrals received and upload them against the child's record onto NCCIS. In addition, screening records were held on paper files only and were also not uploaded on NCCIS. To get around this issue, the service area adopted recording practices that were not consistent with the national recording practices and were a risk to service delivery nationally. These inconsistent recording practices could not be standardised without the NCCIS support person. The overall impact of this was that the area was not able to maintain adequate oversight of children's case files.

Risk management in the area was not effective at identifying all risks and putting measures in place to mitigate them. Inspectors reviewed the risk register and found that some of the significant risks identified on this inspection had been identified by the area and plans were put in place to mitigate them. For example, as stated earlier in this report, risk escalations had been made to the service director in relation to the backlog in processing and uploading new referrals onto NCCIS and an effective plan had been put in place. Risk escalations had also been made relating to staffing deficiencies. However, other risks such as poor quality screening and preliminary enquiries or the low number of Garda notification were not sufficiently identified and therefore could not be managed.

Case reviews undertaken following significant events were of good quality and learning was disseminated. Inspectors were assured that there was a knowledge of a high standard in social work practice and this insight was shared.

The oversight of child protection and welfare cases was poor in the area. At the time of the inspection, NCCIS could not be relied upon to provide assurance to the senior management team that child protection and welfare reports were being assessed and responded to in line with the requirements of the service. The area was still reliant on the staff to record individual referrals on lists in order to provide data for the Tusla national metrics. Formal supervision and quality assurance systems were also not effective at providing assurance that the service was being safely delivered. Inspectors saw little evidence of formal auditing of cases on a waitlist for allocation. In addition, there was no ongoing system of auditing, in

order for the area management to assure themselves on the quality of work undertaken.

The monitoring of cases through formal supervision also did not provide adequate oversight. Of the 11 staff supervision files reviewed, six staff members had regular supervision, where individual cases were discussed along with the staff member's professional training needs. For the remaining five, the frequency of supervision was not in line with their supervision contracts. While the area manager said there was close working relationships and frequent informal discussions between her and principal social workers, supervision records for the area manager and principal social worker were infrequent and brief. Inspectors could not see how this would be an effective method of providing adequate oversight of the service. The area manager informed inspectors that a caseload management approach for social workers within the intake service was under review. Therefore, it was not clear how managers formally tracked staff member's capacity to take on additional work. Staff and social work team leaders told inspectors that due to the nature of the work, there were high levels of daily informal support.

The area manager told inspectors that staff in the area worked incredibly hard in difficult circumstances and she primarily attributed concerns with the service to the deficiencies in staffing and the slow development of NCCIS. She told inspectors that: she had concerns with the quality and integrity of data on NCCIS, she was not assured that thresholds were consistently applied and she was not assured that An Garda Síochána were notified of suspected crimes relating to willful neglect or physical or sexual abuse against children. She said that the area was focused on the management of screening and the elimination of the backlog of referrals in the intake service.

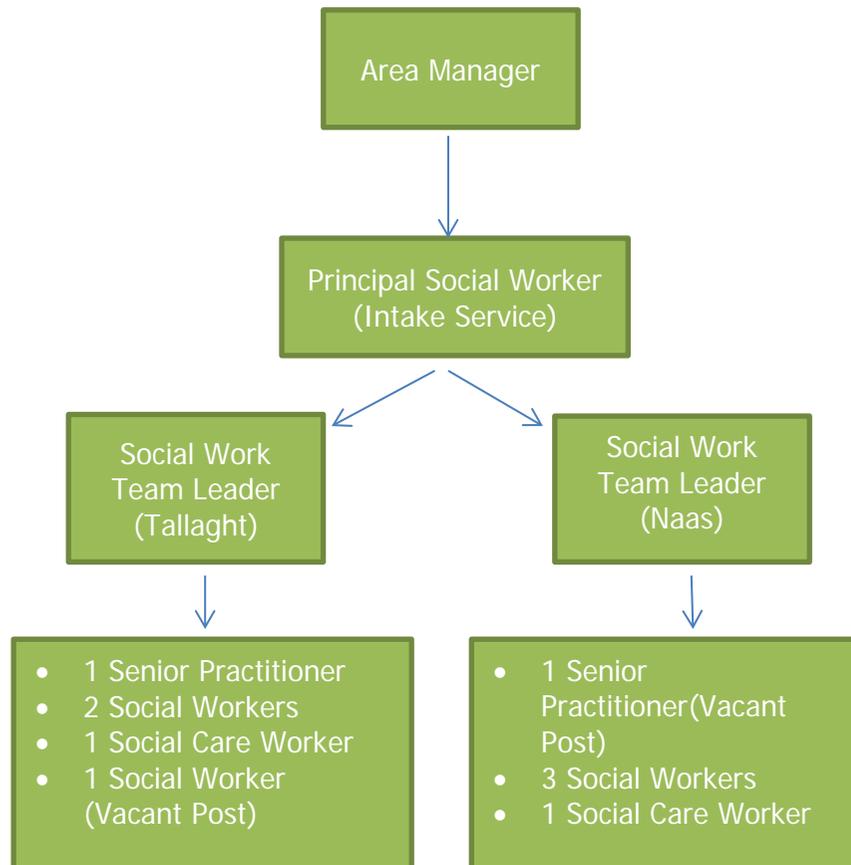
In response to the concerns raised by inspectors following the inspection fieldwork, the Tusla regional service director outlined measures Tusla had put in place to promote service development and learning. These included:

- A national audit/review of notifications by An Garda Síochána
- An established regional child protection and welfare forum to address promote learning and supporting standardised implementation in key areas, for example, Garda notifications
- A governance and implementation support group for the area was to established in May 2019 with the membership consisting of the area management team, regional human resources manager, regional quality risk and service improvement managers, a representation from Tusla's quality assurance directorate and the regional business support manager
- Bespoke recruitment initiatives to address the high number of vacancies in the service area
- Scheduling of a service planning day for the intake teams with the focus on developing

- consistency of practice relating to screening, preliminary enquiries and safety planning
- Ongoing training for principal social workers and social work team leaders in order to support the continual implementation of the new national approach to child protection and welfare

Non-compliant – Major

Appendix 1 – Organisation Chart



**Tusla Source*

Action Plan

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

Provider's response to Inspection Report No:	MON-0026430
Name of Service Area:	Dublin South West Kildare West Wicklow
Date of inspection:	8, 9, 10 April 2019
Date of response:	1 st July 2019

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

Theme 2: Safe and Effective Services

Standard 2.2

Non-Compliant Major

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

Public access to the child protection service, via a drop in service, was restricted in the Tallaght office.

Individual referrals did not always receive an individual response through a unique preliminary enquiry.

The quality of screening in the area was varied and threshold levels were not consistently recorded.

The overall quality of preliminary enquiries carried out in the Dublin South West Kildare West Wicklow service area was poor.

The service area was not routinely notifying An Garda Siochana of suspected crimes of wilful neglect or physical or sexual abuse against children in a timely manner.

Action required:

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

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

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

2.2.1: As referenced in the inspection report, a business case has been submitted for new accommodation for the Tallaght Social Work Service. This will provide more suitable public access space that is also in line with health and safety requirements. This will be pursued on an ongoing basis and requires approval by the Tusla board.

2.2.2: In the interim, there will be public access to the Child Protection and Welfare Service in Tallaght. In the event that a member of the public presents to the Tallaght Social Work Office, a member of the social work service will have face to face contact regarding reason for visit to office, subject to risk assessment of each situation (given previous health and safety issues). Any child or young person who presents at the office in Chamber House is and will always be met by a Social Worker;

2.2.3: All individual children who are referred will have an individual intake record completed as required on every referral. This action has commenced. From July 2019, a monthly audit will take place by the Intake Principal Social Worker on a random sample of referrals and preliminary enquiries to ensure that this is taking place;

2.2.4: A briefing workshop will take place on 4th July 2019 with all intake staff with regard to screening and preliminary enquiries as per Tusla's Interim

Practice Guide re Referral and Assessment Process (February 2018). A further date has also been scheduled in July to focus on using the Signs of Safety national practice approach with regard to questioning at Preliminary Enquiry and in line with the Standard Business Process;

2.2.5 From July 2019, the Principal Social Worker for Intake will carry out a monthly audit on a sample of referrals and completed preliminary enquiries to ensure that the quality of screening and preliminary enquiries improves. Any learning identified through this audit will be shared and a plan for implementation agreed at the Intake and Child Protection and Welfare Team meetings;

2.2.6 In the event that specific learning gaps or performance issues are identified through this process, these will be addressed through individual supervision sessions and personal development plans (as appropriate);

2.2.7 Since the inspection the screening sheet used by the Team Leaders has been amended to clearly reflect the threshold level indicated at the point of reviewing the referral information;

2.2.8 The Quality Team Leader Post is currently in the process of being filled within the Area and part of the workplan at Intake will include a focus on routine auditing and feedback to Intake teams regarding consistency in recording of threshold levels;

2.2.9: A practice guide has issued from the Chair of the Regional Child Protection and Welfare Forum to all staff in the region, including DSW KWW to direct that a Garda Notification needs to be completed at the point when there is a suspicion that child abuse may have occurred which includes at screening and preliminary enquiry stage. This was implemented with immediate event in KWW/DSW;

2.2.10: To ensure oversight of implementation of the above action, the Principal Social Worker for Child Protection Conferences will audit on a monthly basis a sample of intake and child protection & welfare cases from July 2019. In addition to this, on an ongoing basis, the Principal Social Worker for Child Protection Conferences will have an oversight role in highlighting and reporting issues relating to the quality of intake records and initial assessments submitted for Child Protection Case Conferences. This will include ensuring Garda Notifications are completed in a timely way.

Proposed timescale	Person responsible:
2.2.1 March 2020	Area Manager/ Business Support Manager
2.2.2 Immediate	Principal Social worker for Intake, Social Work Team Leader for Intake & Business Support Manager
2.2.3 With immediate effect and audited monthly from 1/07/2019	Principal Social Worker for Intake, Social Work Team Leader for Intake
2.2.4 By 31/07/2019	Principal Social Worker for Intake
2.2.5 Monthly from 1/07/2019	Principal Social Worker for Intake
2.2.6 Immediate	Principal Social Worker Intake, Social Work Team Leader for Intake
2.2.7 Immediate	Social Work Team Leaders for Intake
2.2.8 October 2019	Quality Team Leader (pending appointment)
2.2.9 Immediate	Area Manager and Principal Social Worker for Intake
2.2.10 By 30/09/2019	Principal Social Worker for Child Protection Conferences

Standard 2.3

Non-Compliant Major

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

Safety plans were not being drawn up in a timely and consistent manner.

Plans to embed safety planning in practice were not implemented.

Action required:

Under Standard 2.3 you are required to ensure that: Timely and effective actions are taken to protect children.

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

2.3.1: Guidance on immediate safety planning will be issued from Tusla's Policy and Transformation Directorate in the coming weeks and following the sitting of the National Policy Oversight Committee (NPOC) on 11th July 2019. This guidance will provide greater guidance and consistency relating to the standard required for safety planning;

2.3.2: The Signs of Safety Learning and Development Practice Leads that are assigned to DML will provide a training workshop with all staff in the Area with regard to the new guidance that will be issued. An initial meeting has been scheduled for 4th July and with a further date to be scheduled for the end of July also;

2.3.3: For all referrals, where there is an identified immediate safety concern for a child, this will be forwarded to the Social Work Team Leader for the Child Protection and Welfare Team that covers the geographical patch where the child resides. It will be responsibility of this Social Work Team Leader to ensure an immediate response and to ensure a safety plan is in place and reviewed as required. Where a threshold for an Initial Assessment is met, but where there is no identified immediate risk, this will also go to the Social Work Team Leader for the Child Protection and Welfare team where the child resides with the Safety Plan that has been put in place at Preliminary Enquiry;

2.3.4: A visit will be undertaken to children and families by the Intake Social Work Teams for referrals where it is not possible from the preliminary enquiries to determine that there is sufficient safety for the child to allow the referral to be closed, but where it is not meeting a clear threshold for initial assessment. The purpose of a visit in these cases is to ensure that there is sufficient safety and supports for the child to close or divert the referral to family support services. If there is not sufficient safety identified, then a case will be forwarded to a social worker for initial assessment as per the national standard business process;

2.3.5: As part of Tusla's Child Protection and Welfare Strategy, two social work team leaders from within the area have been selected to be practice

leads with regard to implementation of the Signs of Safety national approach to practice. These practice leads will attend a one-day regional learning event (June 2019) and a workshop in the region led by National Practice leads (Sept 2019). The area practice leads will then deliver two workshops in KWW/DSW (Dec 2019) and also support the delivery of one workshop in a neighbouring area (Dec 2019). The focus will be on using the Signs of Safety national approach to practice for safety planning with child protection cases and child welfare cases open to social work departments. This will include the process for safety planning for children who had not yet had a child protection case conference and who are awaiting allocation to a social worker. Both the Signs of Safety system for the prioritisation of cases and the Signs of Safety Planning process have been developed, tested and amended using the Intensive Workshop format.

Proposed timescale:	Person responsible:
2.3.1. 31/07/2019	Director of Policy and Transformation
2.3.2. 31/07/2019	Signs of Safety Learning & Development Practice Lead
2.3.3 Immediate	Intake Principal Social Worker, Social Work Team Leader for Intake
2.3.4 Immediate	Intake Principal Social Worker, Social Work Team Leaders for Intake and Intake Teams
2.3.5 From 1/06/2019	Nominated Signs of Safety Practice Leads (Social Work Team Leaders)

Standard 2.4

Non-Compliant Major

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

Children did not have timely access to a child protection and welfare service.

The service had waitlists at the preliminary enquiry stage.

There were no systems in place to formally review cases on a waitlist for preliminary enquiry.

Some cases were closed to the service without the required checks and the rationale for closing either, completed or recorded on information technology systems.

Action required:

Under **Standard 2.4** you are required to ensure that:

Children and families have timely access to child protection and welfare services that support the family and protect the child.

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

2.4.1: In order to ensure timely access to the Child Protection and Welfare Service a review of capacity to respond to referrals within timeframes will be conducted by the Service Director and Area Manager. This review will be completed by September 2019 and support from a Lean Specialist from National Office will also be requested to inform this process;

2.4.2: Since the time of the fieldwork inspection in April 2019, social work vacancies within the intake service have been filled. There remains 1 senior social work practitioner post vacant and there is currently a regional recruitment campaign in place for senior practitioner posts. It is anticipated that these posts will be filled by Quarter 3 2019;

2.4.3 A business case has also been submitted by the Senior Management Team with regard to increasing the staffing levels at Intake and to include 1 additional Social Work Senior Practitioner, 1 additional Social Care Worker and 1 additional Social Worker on each Intake team (total of 6 additional staff);

2.4.4: As a safeguarding measure, from 1st June 2019, Intake Team Leaders have revised the screening proforma at Intake to include an audit of outstanding Preliminary Enquiries. This audit will be completed by Intake Team Leaders on a monthly basis. The Principal Social Worker will review a sample of these on a monthly basis as part of her audit. Through the Regional Child Protection Forum, standard audit sheets will be devised for Preliminary Enquiries and the measure above will be used in the interim until there is an agreed national approach. The Intake Team Leader will review the cases awaiting on a monthly basis in order to reprioritize cases as required and this will be a standing item on supervision between the Team Leader and the Principal Social Worker. Also a report to the Area Manager on waiting times for children for Preliminary Enquiry will be provided on a monthly basis;

2.4.5: The User Liaison Social Work Team Leader for the National Child Care Information System continues to do one to one sessions with all Intake and Child Protection and Welfare teams to ensure good quality records and clear recording of decision making on case closures. A monthly feedback report will be provided to the Principal Social Worker for Intake for the purpose of identifying areas of good practice and also areas that require improvement.

Proposed timescale:	Person responsible:
2.4.1 End of Quarter 3 2019	National HR/Recruitment
2.4.2 30/09/2019	Regional Director DML & Area Manager DSW/KWW
2.4.3 Immediate	Area Manager
2.4.4 From 1/06/2019	Principal Social Worker Intake, Social Work Team Leader for Intake and Intake Teams
2.4.5. Ongoing	User Liaison Social Work Team Leader, NCCIS and Principal Social Worker Intake

Standard 2.10

Non-Compliant Major

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

Service planning was inadequate.

Information technology systems had not been sufficiently implemented to support the social work teams.

Referrals received were not being entered onto information technology systems in a systematic, consistent and appropriate manner.

Risk management in the area was not effective at identifying all risks and putting measures in place to mitigate them.

The oversight of child protection and welfare cases was poor in the area.

The monitoring of cases through formal supervision did not provide adequate oversight.

Action required:

Under **Standard 2.10** you are required to ensure that:

Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.

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

2.10.1: As part of Tusla's Child Protection and Welfare Strategy, each Tusla area, including DSW KWW, has an implementation plan in place with regard to Signs of Safety as the national approach to practice. This area implementation plan has key deliverables and milestones identified and also has a risk escalation process integrated into the area and regional reporting system. Updates on area implementation plans are reviewed at the national core project meetings which track progress on implementation and respond to risks identified. Project management support is provided to the area in tracking and reporting progress on this implementation plan.

2.10.2: A Service Plan for the Intake Service KWW/DSW was drawn up on 27th May 2019. A review of this Intake Service Plan is scheduled for 6th November 2019. A wider Area Service Planning Day is scheduled for the 3rd July 2019 and the objective is to develop a service plan for the Area in line with Tusla's National Business Plan and incorporating actions and targets set from this action plan;

2.10.3: The Service Director and Area Manager will complete a review of the organisational structure in the Area with a view to increasing capacity for the intake service. This will be completed by September 2019 and will influence future service planning and delivery;

2.10.4: The area User Liaison Social Work Team Leader for NCCIS was appointed in January 2019. This post holder will continue to provide intensive

support to Principal Social Workers, Social Work Team Leaders and Social Workers on the use of the system and to increase knowledge of how this IT system can be used to provide greater oversight and governance of the service provided;

2.10.5: The Area User Liaison Social Work Team Leader provides monthly reports to the Area Manager and Principal Social Worker with regard to usage by staff of the National Child Care Information System. These reports are and will continue to be used to monitor usage by social workers across teams, including intake. The work plan of the User Liaison Social Work Team Leader will use this information to inform her work plan with regard to staff who need additional support;

2.10.6: There are no backlogs in the area with regard to referrals being put on the National Child Care Information System. Business support staff are now assigned to put referral records on the system and the Business Support Manager has been tasked with ensuring consistency with regard to this. Scanners are now available to the intake service across the Area. The issue of a backlog of referrals going onto National Child Care Information system is now fully addressed and there are no concerns in this regard any longer;

2.10.7 The NCCIS User Social Work Team Leader, in conjunction with the Social Work Team Leaders for Child Protection and Welfare is continuing to work towards cleansing the data on NCCIS so that the spreadsheets used will no longer be required. This will eliminate the duplication of work and improve the integrity of the data and as such the capacity of management to have oversight and governance of the service;

2.10.8: The Regional Quality, Risk and Service Improvement Manager will provide briefings across all teams in the area on Tusla's risk management policy for the purpose of ensuring that service risks are appropriately identified and responded to;

2.10.9 An audit schedule will be developed for the area by September 2019 for the purpose of reviewing the service and to identify areas of positive practice and also areas of significant risk. Risk Registers will be updated accordingly;

2.10.10: A governance and implementation support group will be established with the first meeting planned being held in May 2019. This group will be chaired by the Regional Service Director and will be attended by the Area Manager, the Area Management Team, monitoring officers from the Quality Assurance Directorate and the Regional HR manager. The purpose of this group is to oversee actions from this inspection, to support implementation and also to identify and respond to key risks within the service;

2.10.11: All managers within the service, including the Regional Service Director, Area Manager and Principal Social Workers will be provided with additional training on the use of the National Child Care Information System to ensure its optimum usage in supporting oversight and governance of the child protection and welfare service. This training will be completed by October 2019.

2.10.12: An audit of supervision across the Area will be completed by the Principal Social Worker for Child Protection Conferences by September 2019. Areas for improvement will be identified from this audit and a plan put in place to address this. In the interim, each Principal Social Worker will be required to provide a standardized report to the Area Manager in advance of 1:1 meetings

to ensure all key areas of work are discussed and recorded.

2.10.13 Every 2nd month the two intake teams will have a joint team meeting which will focus on practice development and to ensure a consistent practice approach at Intake across the Area.

Proposed timescale:	Person responsible:
2.10.1 From 1/05/2019 and 6 monthly thereafter	Area Manager/Principal Social Worker for Intake & Child Protection & Welfare
2.10.2 From 1/05/2019 and further dates schedules July and November 2019	Principal Social Workers for Intakes and Child protection and Welfare and Area Manager DSW/KWW
2.10.3. 30/09/2019	Regional Director DML & Area Manager DSW/KWW
2.10.4. 7/01/2019	User Liaison Social Work Team Leader, NCCIS
2.10.5 Monthly	User Liaison Social Work Team Leader, NCCIS
2.10.6 Ongoing	Business Support Manager
2.10.7 Ongoing	User Liaison Social Work Team Leader, NCCIS
2.10.8. 31/10/2019	Regional Quality, Risk & Service Improvement Manager
2.10.9. 30/09/2019	Principal Social Worker Intake & Area Manager
2.10.10. 31/07/2019	Regional Director DML
2.10.11 31/10/2019	User Liaison Social Work Team Leader, NCCIS
2.10.12. 30/09/2019	Principal Social Worker for Child Protection Conferences/ Area Manager DSW/KWW
2.10.13 Bimonthly from 01/07/2019	Principal Social Worker Intake and Intake Social Work Team Leaders