



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Inspection of the HSE Child Protection and Welfare Service in Kildare/West Wicklow Local Health Area in the HSE Dublin Mid-Leinster Region

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Name of HSE Region:	Dublin Mid-Leinster
Type of HSE service:	Child protection and welfare service
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Other key National Guidance:	<i>Children First: National Guidance for the Protection and Welfare of Children (2011)</i>
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[†] Data source: HSE Child and Family Services Template completed by HSE Kildare/West Wicklow Local Health Area at the request of inspectors as part of this inspection with amendments following verification by inspectors on site.

About the Authority's monitoring approach

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

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

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

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

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

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

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

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1. Introduction

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

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

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

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

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

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

The inspection findings highlight areas of good practice as well as areas where improvements are required. The inspection report is available to children, parents, service providers and the public, and is published on www.hiqa.ie, in keeping with the Authority's values of openness and transparency.

Acknowledgements

The Authority wishes to thank the children and parents for their cooperation with the inspection process. HIQA inspectors also wish to acknowledge the cooperation of the members of HSE Children and Family Services and senior managers in the area.

2. Profile of HSE Local Health Area Kildare/West Wicklow

At the time of this inspection report the Health Service Executive (HSE) was in a process of structural change. Currently HSE children and family services are delivered at local health area level. The 32 local health areas have been merged into 17 service areas and are managed under area managers.

These functions will transfer into the new Child and Family Agency once established. At present child protection and welfare services area will be inspected by the Authority at LHA level with governance inspected at an area manager level.

Kildare/West Wicklow local health area (the LHA) is in the wider service area of Dublin South West/Kildare/West Wicklow, providing services to the catchment areas of Naas, Celbridge, Newbridge and Athy.

At the time of this inspection, according to the information provided by the HSE, there were 1,676 reports of concerns about children made to the social work service in the previous 12 months. The services provided by the social work department included child protection and welfare, fostering and family support. Forty children were subject to child protection plans and 123 to family support plans.

The LHA child and family service was provided by eight separate teams from four offices in three locations, of which two offices were in Naas. The Area Manager and Child Protection Conference Office was also based in Naas. Two social work teams were based in Athy and they provided a service to the southern area of Kildare/West Wicklow. Two social work teams were based in Celbridge and they provided a service to the northern area of Kildare/West Wicklow.

The service comprised three children in care teams, three children in the community teams, one fostering team and one family support work service team. The children in the community teams provided a child protection and welfare service. The fostering team assessed and supervised foster carers, while children placed in care were the responsibility of the child in care teams. The LHA had a family support work service that was managed by a senior social work practitioner.

The service had an 'intake records' and duty system¹ in place. These were operated by social workers on a rota basis. There was a social worker on duty in Athy, Celbridge and Naas on weekdays. The LHA had access to an out-of-hours social work service.

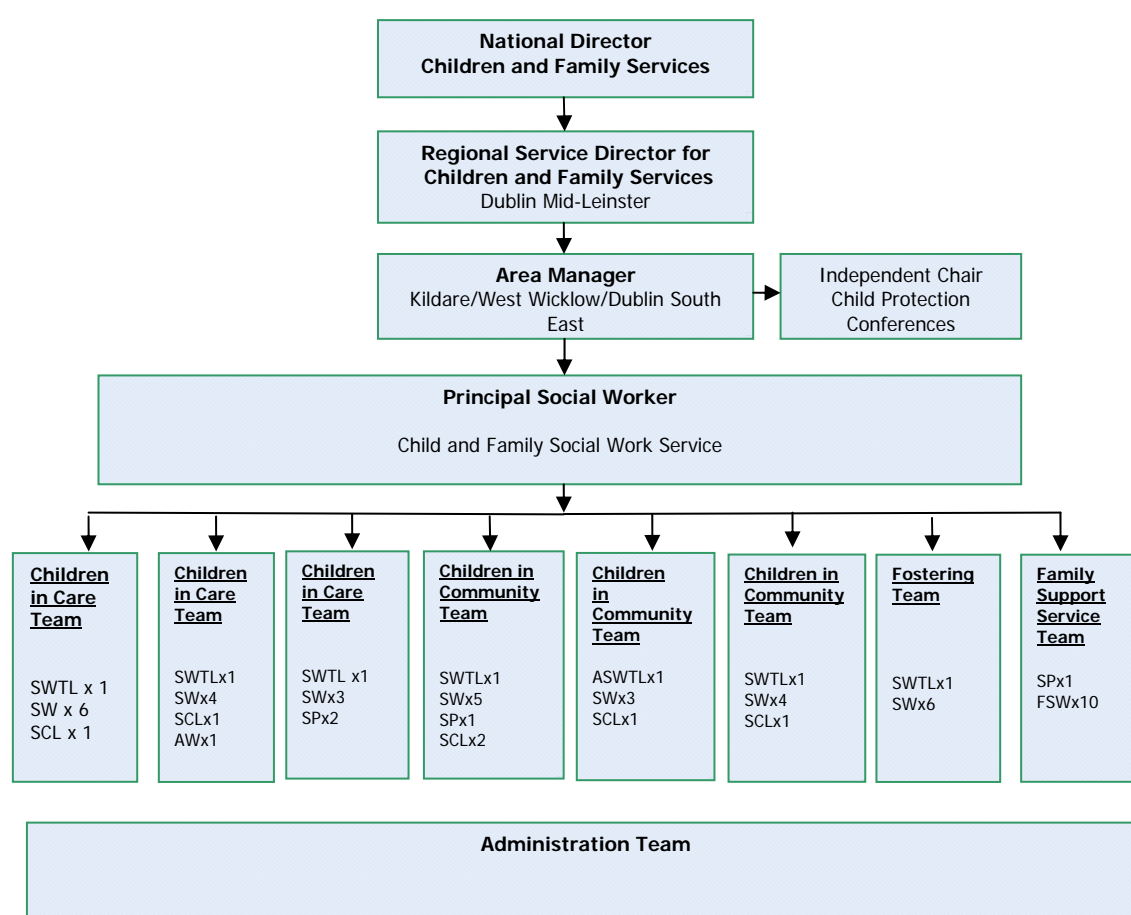
Each social work team was managed by a social work team Leader, one of whom was acting in this position. Social work team leaders were line managed by a

¹ This was a system of allocating a social worker, on a rota basis, to deal with incoming concerns and emergency situations.

principal social worker. This principal social worker and the independent chairperson of child protection conferences reported directly to an area manager who reported to the region's Service Director.

The organisational chart in Figure 1 describes the management and team structure as provided by the LHA.

Figure 1. Organisational structure of the Child Protection and Welfare Service, Kildare/West Wicklow LHA in the HSE Dublin Mid-Leinster Region*



Key:

SWTL = social work team leader

SW = social worker

SCL = social care leader

AW = aftercare worker

SP = senior practitioner

ASWT= acting social work team leader

FSW = foster care social worker

* Source: HSE

3. Summary of findings

The Health Service Executive (HSE) has statutory responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Such 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.

The LHA provided a limited child protection and welfare service within a context of staff shortages, reductions in spending and a significant historical backlog of assessments. Responses and interventions for children at immediate risk were timely, effective and beneficial. However, there were significant delays experienced by other children and high thresholds of harm had to be reached before welfare cases were assessed. Resources were not sufficient to deal with backlogs in assessments that had accrued over time – 721 referrals were awaiting an initial assessment (the majority were welfare cases) and 77 further assessment. These cases presented a significant risk to the safety of the child protection and welfare service.

The LHA had implemented Children First (2011) and fully implemented the HSE standard business processes that supported it to do this. Overall, day-to-day social work practice was found to be respectful, rights based and needs led. There was an obvious drive in the LHA to improve the quality and effectiveness of practice.

The service managers had developed a culture of respect, support, inclusion and approachability. Staff interviewed said this had sustained social work teams through times of change and difficulty. The management team were found to be solution-focussed and this was reflected in the social work team's everyday practice. There was a local commitment to change and service improvement.

The management team faced significant challenges in terms of unassessed cases, use of resources and deficits in infrastructural systems for gathering and analysing information. It was not possible for managers to monitor the effectiveness of their service or to be assured that social work interventions improved children's lives. These risks had been escalated by managers to the National Office.

4. Methodology

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

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

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

The remainder of the fieldwork focuses on all other aspects of the child's journey. The key activities of this inspection involved:

- the interrogation of data
- the examination of local policies and procedures, minutes of various meetings, 13 staff files, audits and service plans
- the examination of 48 children's case files by both tracking and sampling information contained within
- the examination of four alleged retrospective abuse cases
- the examination of 15 complaints
- the examination of nine serious incidents
- consultation with 10 children and young people, and 11 parents
- consultation with the area manager, 19 social workers, eight family support workers, four social work team leaders, one principal social worker, the independent chair of child protection conferences, one family support coordinator and two social care leaders
- consultation with 24 external professionals including mental health, primary care, An Garda Síochána and youth workers
- focus groups
- observing staff in their day-to-day work
- observing practice in three multi-agency meetings, two strategy meetings and two child protection conferences.

5. Overall findings

Theme 1. Child-centred Services

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

Related reference:

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

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

This standard was met.

This inspection found that staff promoted children's rights and respected their diverse needs. Children told inspectors that they were aware of their right to have an opinion and inspectors read case records that showed they were encouraged to express their views in relation to various aspects of their lives. Inspectors heard social workers advocating for and proactively promoting the rights of children at child protection conferences and strategy meetings. The LHA provided literature that showed advocacy services – such as Empowering Children in Care (EPIC) – were accessed by the social work department and there were posters about children's rights under the United Nations Convention on the Rights of the Child (UNCRC) on display. Inspectors found that practice was guided by policies and procedures that reflected these rights. This included a stated anti-discriminatory approach to service delivery and frameworks for assessing needs and vulnerabilities of children that were rights based and culturally sensitive. Inspectors read training records and saw that staff received training in anti-discriminatory practice and the process of carrying out assessments.

Inspectors saw duty social workers accessing information about agencies that worked directly with different ethnic and cultural groups. The LHA had developed a directory of local services and referenced national guidance on working with members of ethnic minorities such as the Roma community. Inspectors examined specific cases that showed the health and wellbeing of children and families from

different ethnic and cultural backgrounds were met through multi-agency and intra-disciplinary working within the HSE. For instance, a member of staff from another HSE area who spoke a particular language supported a family who did not speak English, while a mobile health unit provided by another HSE area was used by the LHA. External agencies told inspectors that based on feedback from children and families that they worked with, they could confirm efforts made by social workers to overcome cultural and language differences.

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

This standard was met in part.

Inspectors found that the LHA valued the views of children and consulted with them on decisions about their lives. However, improvement could be made in complaints management and supports to communication.

Children said that their views were heard by social workers and that they were encouraged to express how they felt. Inspectors were provided with consultation tools developed and used by social workers. Inspectors observed social workers using age-appropriate language and communication aids. There was evidence that social workers met with children during home visits in order to provide them with opportunities to express their views. Inspectors examined case records that showed some children had access to an independent, court-appointed guardian ad litem to ensure that their voice was heard.

The LHA supported children and families whose first language was not English to communicate effectively. The national practice guidelines 'On Speaking Terms' guided staff when an interpreter was required. The LHA accessed HSE disability services to facilitate communication and consultation, although there was no 'loop' system in place for children and families with hearing difficulties.

Inspectors observed the chair of child protection conferences meeting with children, in advance of conferences to explain the process and answer any questions they had. Professionals who attended child protection conferences and strategy meetings told inspectors that they found them inclusive and that children were listened to and their views were taken on board.

The LHA had a system in place to deal with complaints but it required improvement. Children did complain and this was reflected in records. Complaints examined by inspectors showed that they were dealt with, managed and recorded in accordance with HSE policy. While the complaints log did not record whether children were satisfied with the outcome of a complaint, this was rectified by the principal social worker during the inspection fieldwork.

Overall, inspectors found that the LHA valued and learned from complaints by children. However, not all low level complaints dealt with directly by social workers

were reported to and recorded by the principal social worker for the purpose of oversight and learning. The LHA had a child-friendly complaints information leaflet for children that was developed in consultation with children and the children's advocacy group Empowering Young People in Care. Social workers said they informed children about the complaints process. However, this was not evident from case records or interviews with children. Therefore, it was possible that some children may not know how to make a complaint.

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

This standard was met in part.

This inspection found that social workers communicated effectively with children with whom they worked directly. However, there was also a responsibility on the LHA to raise awareness with children and others in the wider community about their services and about abuse and neglect. Although efforts were made by the LHA in this regard, this required improvement.

Inspectors read case records that showed that direct work with individual children by social workers was effective, timely, sensitive, age appropriate and child centred. Social workers said they gave careful consideration to methods of communicating with children and families with learning or literacy difficulties. Inspectors found that social workers also considered how to communicate when there was multi-agency involvement, so as not to overwhelm children. Children who met with inspectors said they understood the role of the social worker and what was happening in their lives.

Inspectors found that there was a lack of literature about children's services provided by the LHA to the general public and to those accessing their services. Other professionals identified a need for literature to be made available on areas such as children's rights, child protection conferences and information generally about child protection and welfare services. This was acknowledged by the principal social worker and the independent chair of child protection conferences. Development and dissemination of this literature would provide a better public understanding of abuse and LHA services provided to respond to such abuse.

Theme 2: Safe and effective services

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

Related reference:

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

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

This standard was met in part

The LHA protected children and promoted their welfare through consistent implementation of the majority of aspects of *Children First* (2011), and standard business processes supported staff in this endeavour. The area manager and principal social worker provided inspectors with a suite of policies, procedures and protocols which were found to be in accordance with *Children First* (2011). The area manager, principal social worker and social work team leaders utilised communication systems, the supervision process and training opportunities to ensure all staff were informed of new and existing policies and procedures. This was evident from meeting minutes, training and supervision records read by inspectors. Inspectors found evidence that policies and standard business processes were consistently implemented during observation of activities such as child protection conferences, the duty system and strategy meetings. The LHA had identified that incorrect classification of some incoming concerns was a problem. To resolve this issue, the principal social worker and team leaders had arranged additional training and support for social workers and had adequate monitoring systems in place to ensure effective practice. Inspectors examined a sample of social work assessments of concerns about children's circumstances. The sample showed that social work practice reflected the requirements of *Children First* (2011) and social work roles and responsibilities were clear in the assessment of, and dealing with, concerns.

The child protection notification system that recorded the names of all children at ongoing risk of significant harm in the area was not accessible on a 24 hour basis. This was not in accordance with *Children First* (2011), but this is a national problem.

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

This standard was met.

Inspectors found that social workers screened incoming calls and concerns about children effectively and carried out preliminary enquiries. Immediate risks to children were identified by social workers and dealt with promptly and appropriately.

There was a system in place to screen and carry out a preliminary enquiry of all incoming referrals. There were policies, procedures and guidance to support staff to operate this system. This included guidance on determining thresholds of risk and harm to children and evidence-based practice tools. However, social workers did not have a risk framework to support consistent decision making in relation to levels of risk. There was a quality assurance process in place whereby the team leader confirmed the categorisation of referrals as either welfare or child protection referrals. On occasion, the original categorisation of referrals changed as a result of the process, indicating that there was good managerial oversight. Social workers said

that they carried out checks at this stage to identify if children were already known to the service and inspectors read records that showed these checks had been made. Inspectors tracked specific cases with social workers and found an effective use of guidance on thresholds of harm.

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

This standard was met in part.

This inspection found that the LHA took timely and effective action for children who were assessed as being at immediate risk of significant harm, but not for other children referred to this service.

The area manager, principal social worker and social work team leaders were able to show inspectors that there was adequate guidance for social workers in determining thresholds of harm to children and how cases should be prioritised. There was a document in place that provided descriptors of risk and this assisted social workers to categorise them accordingly. Prioritisation forms were completed that captured the identified risks and recorded their prioritisation status as high, medium or low. Inspectors found that these were applied consistently and that they supported the social work department to take immediate actions when required.

The LHA provided data and information to inspectors that showed there were delays in carrying out initial and further assessments for children who were not at immediate risk of significant harm. Backlogs in assessments existed. The LHA provided the Authority with figures that showed there were 721 referrals awaiting an initial assessment and 77 awaiting a further assessment. These figures showed that 287 referrals to the LHA between October and December 2012 had yet to have an initial assessment carried out, and inspectors found an example of a case which had been awaiting an initial assessment since July 2012. The area manager and principal social worker acknowledged that risks remained unidentified for these children. In addition, the social work department had a high threshold in relation to welfare cases. This meant that a welfare concern had to be very serious for it to prompt a response. The combination of delays in all assessments and the high threshold applied to welfare concerns meant that timely actions were not and could not always be taken to adequately meet the needs of some children.

Inspectors found that there were systems in place to try and manage risk in such cases and deal with the existing significant backlogs of assessments. The principal social worker, team leaders and social workers told inspectors that cases awaiting an assessment were reviewed regularly by social work team leaders. This was carried out on an ongoing basis in order to prioritise them for allocation as social work resources became available. The principal social worker and social work team leaders told inspectors that all cases were reviewed regularly within the supervision process. Inspectors read supervision records that provided evidence of these reviews. Social work team leaders had a system that ensured each unallocated case was reviewed thoroughly at a maximum of every six months and inspectors saw evidence of these

on case records. The social work department also made efforts to engage a child or family with a community-based service or professional when they were not in a position to allocate a social worker to the case. When an additional or multiple concern about an existing but unallocated case was reported to the social work department, this prompted the social work team leaders to review the priority status of a case and allocate it if risks had increased. Inspectors saw evidence of this in some cases reviewed, but not all. However, delays in carrying out assessments existed and this meant that children remained at an unknown level of risk.

Children who were allocated a social worker received an effective service. This was the case for children who were deemed to be at high risk in terms of child protection. However, not all cases were allocated. Inspectors examined a sample of these cases which showed timely and effective action was taken on an ongoing basis for these children. Other medium-risk child protection cases and high- or medium-risk welfare cases were not allocated a social worker. The combination of delays in carrying out assessments and allocating these cases to a consistent social worker meant that effective action could not be taken for these children or families.

Inspectors found that staff had a good understanding of when a case had reached the threshold required to pursue a supervision order or instigate care proceedings. The principal social worker, team leaders and social workers said their practice was guided by a combination of legislation, legal advice, recommendations of reports on other cases and professional judgment, exercised within a risk and needs assessment framework. They told inspectors they considered factors such as the level of risk to children, parental engagement with the service and whether social workers had easy access to children they needed to interview. Inspectors found examples of these considerations in case records that they examined.

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

This standard was met in part.

Inspectors found that once assessed, many children and families had access to services that protected children and met their needs. Other children did not have timely access to such services.

This inspection found that despite efforts made by the LHA, some children and families experienced delayed access to child protection and welfare services. Children and families with a medium or high welfare prioritisation were on long waiting lists for social work services and this delayed their access to support services. Information gathered by the LHA showed that there were 221 high priority and 409 medium priority welfare cases awaiting initial assessment.

Inspectors found that there were a number of services available in the community that social workers could access for families. The principal social worker provided inspectors with a copy of a local services directory. The area manager told inspectors

that the LHA was developing a local area pathway model that would assist the social work department to re-direct families to community-based services that could meet their needs. Inspectors found case examples where there was timely access for many children and families to family support and youth services, but delays were also evident. Therefore, there were children and families whose needs were not being met by the required community-based service.

At the time of the inspection inspectors found that social work teams placed a high value on early interventions with families and worked in partnership with other services such as the primary care professionals, through meetings held every two months and liaison with the early years programme. Inspectors found examples of cases where families had received such services when they required them and this was confirmed by some parents, although high thresholds meant that delays did exist generally. The area manager and principal social worker told inspectors about close working relationship between themselves and services for people with a disability. They said this liaison had resulted in the identification of vulnerable groups within that population and promoted early access to appropriate services and supports.

The LHA identified vulnerable groups of children in the community in various ways, which helped determine and provide early interventions and multi-agency responses to needs and risks. The principal social worker provided inspectors with information gathered and analysed by the principal social worker and team leaders on referrals to the service. The principal social worker and team leaders said that this identified, for example, children from ethnic minority groups and adolescents that were particularly vulnerable and had complex needs. Inspectors read cases that showed equitable access to services in the LHA for children and families from different ethnic, cultural and religious backgrounds.

Inspectors examined case records and found that child welfare and family support plans were developed but that there was no standard approach to recording them. The principal social worker and social workers interviewed said that some of these plans took the form of minutes of strategy meetings which were then monitored through the supervision process. Inspectors read a sample of files and found this to be the case. The family support service coordinator provided inspectors with a locally developed family support plan format, as a national template was awaited. Inspectors found examples of comprehensive family support plans that identified the needs of families and actions to be taken by the service to meet these needs. Although there was no standard approach to recording family support plans, case records read by inspectors showed that the relevant social work team leader had oversight of these cases and monitored the implementation of actions to support families effectively.

Standard 2:5 – All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence

This standard was met in part.

Inspectors found that assessments carried out were of a good quality. However, there were delays in the assessment of all child protection and welfare cases which were not in line with Children First (2011).

The LHA had an initial assessment process in place. Inspector examined records that showed that the majority were carried out by a qualified social worker and recorded on a standard template. Inspectors read a sample of initial assessments. They were found to be comprehensive, consultative and of adequate quality. They showed that social workers considered levels of risk, protective factors and strengths within families. Inspectors observed that information used in the assessment process was well recorded and this contributed to transparent and informed decision-making. Other professionals confirmed that they were contacted by social workers when an initial assessment was being carried out.

There was evidence that An Garda Síochána was involved whenever there were concerns about a child as outlined in Children First (2011). Inspectors found that when there were serious and immediate concerns, An Garda Síochána was notified verbally, and this was followed up by a formal written notification from the relevant social work team leader. Routine notifications were made in writing. The area manager and principal social worker said that they were satisfied all concerns that required a notification to An Garda Síochána were prioritised for an initial assessment. Inspectors found evidence of this in case files examined. One social work team leader told inspectors that three cases had been reported to An Garda Síochána verbally prior to an assessment being carried out but that the written notification had been delayed. While there was no adverse effect for the children involved, this was not in line with Children First (2011).

The LHA used strategy meetings at various stages throughout the assessment process and management of cases. Inspectors found that these were effective and decisions about interventions for families, and protective measures to be taken in relation to a child prior to a child protection conference were made. Records showed that attendance by relevant external professionals and agencies varied, but generally, it was sufficient to support sound decision making. Inspectors attended two strategy meetings that were held within 24 hours of the referral being made.

The management team had taken some initiatives to address the waiting list for assessments. The principal social worker, team leaders and social workers explained to inspectors that social work teams carried out a 'blitz' on cases awaiting a variety of responses, including initial assessments, several times a year. Social work team leaders and social workers interviewed told inspectors that it was the decision of a team leader as to what cases would be part of a blitz. The principal social worker provided figures following two blitzes that showed they were effective as an interim

measure for assessing some cases and in closing others. However, this was not a sustainable response to the waiting list and went no way to eliminating it.

Inspectors found examples of welfare cases that had an initial assessment carried out by a social care leader rather than a qualified social worker. The relevant social work team leader had oversight of these cases to ensure they were being worked appropriately. Team leaders confirmed this to inspectors. The principal social worker, family support service coordinator, and family support workers told inspectors that family support workers were often allocated to work welfare cases that were awaiting a social worker. This was to assist in the monitoring of these cases and to inform the social work department if risks escalated. This was found to be an effective strategy, and cases read by inspectors showed that appropriate community based services were provided to some families with the assistance of the family support worker.

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

This standard was met.

This inspection found that child protection conferences were convened in a timely way for children at risk of significant harm, and that child protection plans were developed for these children that promoted their safety and welfare.

LHA practice in relation to child protection conferences and plans was guided by a draft national policy and a local guidance. This was a new process that the LHA had implemented since October 2012 and as such, the LHA should consider a full evaluation of this process. The LHA had an independent chair of child protection conferences. The role of the independent chairperson was clearly defined in an LHA guidance document on child protection conferences but a job description had not been developed nationally for this position. The independent chairperson did not have any formal training for this role but was inducted into the position by the area manager. Inspectors observed practice at child protection conferences that reflected national guidance and the chairperson conducted the conference in an independent manner. There was an established process of referral to a child protection conference and administrative support to the independent chair.

Inspectors read records of a sample of child protection conference minutes. These showed that all relevant professionals were invited to attend and although attendance rates varied, it was sufficient to support the decision-making process as written reports were usually provided. Information provided in reports by other professionals was found to support informed decision making about children at risk. An Garda Síochána personnel and school principals confirmed that they were invited to and attended child protection conferences and submitted either written or verbal reports. Case files showed that children's views were sought prior to the child protection conference and inspectors also found that children and families attended some of these conferences. Inspectors observed one initial child protection

conference and one review child protection conference. They observed that the independent chairperson talked to children and parents prior to the conference and explained the process. Inspectors found that the conferences were well chaired and there was evidence that efforts were made to engage families in the process and encourage them to share their views. Children and parents who attended were heard engaging in discussion and putting their views forward. Inspectors observed one social worker advocating for a child at a review child protection conference. The independent chairperson summarised the risk and protective factors to the child prior to the child protection plan being decided. Inspectors found that risks to the children were the main focus of a child protection conference.

The child protection plans were of good quality. Information provided by the area manager indicated that there were 40 children who were the subject of child protection plans. Inspectors found that this corresponded with the number of children placed on the child protection notification system. Inspectors read a sample of child protection plans and found that they addressed the issues identified at the conference, named the action to be taken and the person(s) responsible. The plans contained timelines for completion of these actions. In this way the plan was focused on improving the life of the child by minimising or eliminating risks to them.

The LHA had an electronic child protection notification system which was in line with national HSE guidance. The area manager told inspectors that she/he was ultimately responsible for this system but that it was managed on his/her behalf by the independent chairperson of child protection case conferences. Inspectors found that this was a new system and although it was found to be well managed, this would be better assessed after a longer period of time. There were protocols in place to access information held on it. The child protection notification system was viewed by inspectors and found to contain all the information required under Children First (2011). It was found to be secure and accessible during office hours. Access to information recorded on the system was confined to named professionals including An Garda Síochána, general practitioners (GPs) and hospital medical staff. Inspectors found that all queries made in relation to it were logged systematically. Although national and local guidance in relation to this system stated that it should be accessible outside of office hours, this was dependent on a national system of recording which had yet to be established.

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

This standard was met in part.

Inspectors found that child protection plans were reviewed in line with Children First (2011). Inspectors read case files that showed cases were reviewed in a timely manner and review dates were set at the initial child protection conference.

Information provided for the inspection indicated that 18 children had their child protection plans reviewed in the 12 months prior to inspection. Inspectors found that updated child protection plans were robust and focused on improving the life of the child. Those sampled identified responsible persons and contained clear time frames for actions to be taken and by whom. Inspectors observed a review child protection conference and found that it focussed on reducing risk to a child. The independent chairperson stated what the outcome of the interventions should be for the child and progress was measured against reports from all professionals involved.

Improvements were acknowledged where appropriate. A range of different professionals working with the children attended the child protection reviews.

The LHA had an effective system for closing cases placed on the child protection notification system. This decision was made at a review child protection conference. Inspectors observed this at one such review. Inspectors found that decisions made were reflected on the child protection notification system.

The social work department had a process for closing all cases but it was not efficient. When a case was allocated to a social worker, the decision to close it was made at supervision between a social work team leader and the allocated social worker. Case records showed that these cases were closed in a timely and efficient way. A standard template was in place that recorded the decision to close a case and where necessary, the social work team leader suggested minor tasks to be undertaken by the social worker before they authorised the case closure. This was confirmed at interview with social workers and inspectors saw evidence of this system on case records. Other professionals said they were informed in writing when a case was closed to the social work department. Inspectors saw examples of these notifications on case files they read. However, the LHA did not always close unallocated cases in a timely way. Social work team leaders told inspectors that there were cases awaiting closure. They said that this backlog was addressed as part of the blitz carried out by separate social work teams and was also one function carried out by the social worker operating the duty system. The inspectors did not find that delayed closures impacted negatively on the children or families involved. However, the delay in closing some cases meant that they were accounted for in the LHA’s open unallocated figures. This was an administrative process that required attention by the LHA.

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

This standard was met in part.

Inspectors found that child protection and welfare interventions improved the lives of many children and young people but not all. Inspectors found that the LHA could not be certain of the effectiveness of social work interventions for some children. Social workers provided inspectors with examples of cases where positive outcomes for those particular children had been limited. Additionally, information provided to the Authority showed that in the year prior to inspection there were 1,676 reported referrals about children and 773 (46%) of these were in relation to children previously known to the social work department. The LHA did not systematically analyse this information to find out whether cases were, for example, being closed too early or there had been a change in the family circumstances. Therefore, the effectiveness of social work intervention for these children and or families was not known to the social work department.

Young people and parents told inspectors that their lives had benefited as a result of receiving child protection and welfare services. Inspectors examined case records that showed there was a reduction in risk to the children in question, and that their health had improved and they experienced safer, better care. Inspectors found that interventions were appropriate to the needs of children and families, and supported children to remain with their families. There was evidence that showed children and families were provided with support networks in the community such as those dealing with domestic violence and mental health. Social workers said they believed their work improved the lives of the families with whom they worked. For example, inspectors observed one session of a LHA-run group for young people which focused on ways of improving positive mental and emotional health. Young people who attended the group said they found it helpful and supportive. Representatives from external agencies confirmed that social work interventions improved the lives of children and families they worked with. A parent told inspectors that she/he was very happy with the service she/he had received and that the social worker had advocated on behalf of the family with other service providers.

The LHA promoted the use of evidence-based practice to help children achieve their full potential. Inspectors found that this approach supported staff to make informed decisions about children. Social workers told inspectors they sought advice from specialist services in the community when required. Staff from these services confirmed this and they told inspectors that social workers acted on their advice.

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

This standard was met in part.

This inspection found that significant efforts were made by the LHA to collaborate with other agencies and professionals in a way that promoted the safety and wellbeing of children, but that this required some improvement. The LHA provided inspectors with policies, procedures and protocols to support collaborative working and information sharing about children at risk. This included a national protocol between the HSE and An Garda Síochána and a framework for effective case management and the sharing of information between agencies (April 2013).

Garda Síochána attendance at strategy meetings and child protection conferences was observed by inspectors. Inspectors attended one of the monthly meetings between the area manager, principal social worker, social work team leaders, An Garda Síochána and public health nursing staff. All notifications to and from An Garda Síochána were discussed at these meetings and relevant information was shared for the purpose of protecting children. The area manager called this a 'systems check'. The principal social worker and one garda told inspectors that there was effective and valuable communication between their agencies.

The LHA had a number of initiatives in place to support multi-agency working and information sharing. These included open 'coffee mornings' for professionals in the community to tell them about their service. Following feedback from attendees, these were developed into formal briefing sessions on the service. External agencies and staff interviewed said they found them useful and expressed a wish for them to develop and continue.

The development of the Local Area Pathway had created a need for the LHA to educate other agencies and professionals about their services, roles and responsibilities and this process had begun. External professionals and services told inspectors that information sharing and collaborative working had improved greatly over recent times. The principal social worker and social work team leaders interviewed acknowledged that although the process of educating external professionals about the service and how it operated had begun, more was required by the social work department.

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

This standard was met in part.

Inspectors found that cases worked by the social work department were managed, monitored and planned so as to improve practice and promote best outcomes for children. Social workers told inspectors they were supported in spending the majority of their time doing work that directly benefited children and inspectors read cases that demonstrated effective direct work.

HIQA inspectors found that the LHA had an effective approach to managing caseloads according to their complexity and number. Inspectors were provided with written guidance on this. The LHA was also the pilot site for a new caseload management approach.

All allocated cases were monitored during times of staff absences either through the duty system or by a named social worker. Social workers told inspectors that they could request specific actions such as a monitoring home visit to be carried out during their absence. Social workers said they would tell children and families when they were going on leave to prevent undue stress and explain how cover was being provided. Staff cover for annual leave was a standing item on management meeting minutes read by inspectors. Information provided for the inspection indicated that 13 cases were allocated to, and being worked by, social work team leaders.

Inspectors found that there was good communication between social work teams. Each office held monthly team meetings and the whole social work department, including family support workers and social care leaders, met together on a regular basis to discuss practice issues and share information. Staff told inspectors that there was a 'whole team' approach to service delivery and that if a referral required immediate action it would be responded to by any suitable person from any team. Inspectors found this approach to be part of everyday practice. The LHA made best use of supervision when planning case interventions and there was evidence of learning from case histories. The LHA also used team meetings as an opportunity to make presentations to staff on learning's. These reflective learning sessions were facilitated by the principal social worker.

Although systems were in place to temporarily allocate cases when a social worker was on leave, the social work department was already stretched and consistent cover for all cases was not possible.

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

This standard was met.

Inspectors found that the LHA implemented national policies and procedures in relation to serious incidents. Information provided to inspectors showed that there were nine serious incidents including one death in the LHA in a two-year period prior to inspection. Inspectors observed these with the principal social worker and found they were notified to the National Office for Child and Family Services. This was in line with policy. Cases that reached the required threshold for notification were reviewed by the National Review Panel. The LHA identified and disseminated learning from these events to the social work teams for practice improvement.

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

This standard was met in part.

The LHA was proactive in the identification of indicators of organisational/institutional abuse and this had the potential to protect vulnerable children, but staff competency at identifying early warning signs of such abuse required monitoring by the LHA. The LHA had guidance on dealing with retrospective disclosures, managing information on convicted offenders in the community and assessing alleged perpetrators of abuse living in the local area. Social workers interviewed were aware of these, but early warning signs of organisational abuse were not always recognised.

The LHA had an electronic cross-referencing system in relation to alleged or convicted offenders that was designed to alert them to multiple or subsequent allegations about individuals.

Inspectors attended a strategy meeting held in relation to a possible instance of organisational abuse and found that in this instance, there was a timely response to early indicators of such abuse. There was effective inter-agency working and appropriate information sharing between the LHA and An Garda Síochána in this instance.

The LHA raised awareness about organisational and institutional abuse through networking with other agencies such as groups working with people with a disability and in their everyday interactions with professionals. Inspectors found that there was collaborative working with Children First officers of other organisations when suspected cases arose. Inspectors examined a sample of retrospective cases and found that they were dealt with in accordance with Children First (2011) and in a sensitive manner. The principal social worker told inspectors that sensitive cases were usually allocated to a senior staff member. This was evident in the cases

sampled. However, inspectors did not find evidence that the LHA worked with parents and the public to raise awareness of organisation and or institutional abuse.

However, inspectors were aware of one case where the potential for organisational abuse was not identified as such at point of referral to the LHA. This was acknowledged by the principal social worker. The issue was addressed during the inspection fieldwork and inspectors were satisfied with the LHA response. This prompted the principal social worker to re-circulate all relevant guidelines to the staff team. This is an area of practice that requires close monitoring by the LHA.

The LHA had a policy on institutional and organisational abuse, and staff were aware of this policy. However, this was not supported by a procedure to guide staff on the appropriate steps to take on receipt of a referral that indicated such abuse having due regard for the sensitivities and legalities involved.

Theme 3: Leadership, Governance and Management

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

Related reference:

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

Standard 3:1 – The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare

This standard was met.

Inspectors found that this service performed its functions in accordance with legislation, regulations, national policies and standards. Managers ensured that legislation, policies and regulations were accessible and available to all staff and that their relevance to practice was clearly articulated in staff literature. Inspectors read evidence of this in induction packs, supervision records, staff memorandums, guidance notes and meeting minutes they read. Staff who were interviewed were familiar with national standards and policies and showed confidence and competence in applying them to their work. Inspectors found clear indicators that legislation, regulations and standards were embedded in everyday practice. Social work practice was found to be clearly based on legal limitations when intervening in family life, and there was high regard for the rights of children.

The LHA had improved the system for screening and carrying out preliminary enquiries following the implementation of recommendations arising from investigations. Inspectors read presentations that showed investigation findings were clearly communicated to staff and those interviewed confirmed this. Inspectors found that the area manager and principal social worker were proactive in the

implementation of recommendations from regulatory bodies. For example, inspectors read meeting minutes that showed recommendations made by the Authority in other reports on other regions were being considered by the management team for implementation locally.

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

This standard was met in part.

Inspectors found evidence of strong local leadership and managerial oversight across the service. This was provided by the area manager, principal social worker and social work team leaders within a positive, respectful and inclusive working environment. The culture in the service was positive, open and accountable and focused on improvements. There were some systems in place to make staff accountable for practice.

There was a clear management structure which created effective lines of authority and accountability and this was supported by defined roles and responsibilities. The reporting relationships between social workers and team leaders were clear. Social workers and team leaders knew what their responsibilities were and these were set out in their job descriptions. The principal social worker and area manager were also clear about their roles and responsibilities.

The LHA provided inspectors with the statement of purpose and function which set out the service's aims and objectives, and the services provided including how and where they were provided. This corresponded with individual managers' descriptions and understanding of the service and their roles and responsibilities within it. Staff said that they were supported, supervised and guided by managers in a way that empowered them to carry out their duties to the best of their ability. Supervision records confirmed this.

The service managers showed a good understanding of the shortfalls within the service and had identified these prior to the inspection. The area manager met with the principal social worker on a weekly basis, or as necessary, to keep him/her informed about the day-to-day delivery of social work services. They told inspectors that this provided an early warning system in relation to any difficulties experienced.

The LHA had a local action plan stating how it would meet the national strategic plan, and it was focused on improving, for example, the number of cases assessed. The plan acknowledged the complexity of the population and the service it required. It also identified the central role of cost containment and the delivery of core service priorities for the coming year. Minutes of various meetings for all grades of staff within the service showed that there was a clear connection between the national, regional and local managers' vision for the service, in the goals set by them, and their expectations of their staff when carrying out their everyday duties.

The HSE's *Framework for measuring, managing and reporting social work intake, assessment and allocation activity* was fully implemented by the LHA. This was a mechanism to identify and report pressures on the service. The LHA provided several of these reports to inspectors who found that these pressures were reported in accordance with national requirements. The area manager told inspectors that key performance indicators informed the local operational plan and annual adequacy reports. However, inspectors found that although service deficiencies were reported using this mechanism, it brought about little change to service delivery. For example, repeated reports to the HSE's National Office for Child and Family Services on delays in carrying out assessments due to limited social work resources did not ensure the required resources were provided to improve service delivery. This continued to have a negative effect on the capacity of the service to meet its responsibilities.

Progress was measured to some extent through collection and comparison of quarterly key performance indicators. The area manager provided quarterly figures to inspectors that showed incremental improvements in service delivery, such as a reduction in the number of referrals without an initial assessment. Overall, the service was found to be gathering information but it required sustainable methods of analysing key information in order to fully evaluate and monitor the service on an ongoing basis.

Some audits of social work practice were taking place. The independent chairperson of child protection conferences audited case files of children referred for a child protection conference to ensure safe and effective practice. There was a system in place to audit 10% of all case files per quarter. Inspectors were provided with reports and recommendations on this activity and this information was also shared at staff meetings.

While the inspectors found that the process of evaluating the quality and safety of child protection and welfare services was at an early stage of development within the LHA, the management team faced significant challenges in terms of unassessed cases, use of resources and deficits in infrastructural systems for gathering and analysing information. The management team had escalated these risks to the National Office.

Standard 3.3 – The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery

This standard was met in part

There were systems in place to review and assess the effectiveness of the child protection and welfare service but they required improvement.

Since January 2013, monthly meetings between managers were held for the purpose of assessing and ensuring compliance with Standards. Inspectors were provided with an action plan that resulted from these meetings. This plan clearly identified individuals who had been given responsibility for specific tasks, such as ensuring information on staff supervision files was satisfactory, that adequate literature about the service was developed and that local and national policies were collected, updated and where necessary, staff training was provided. The requirement to meet National Standards was a key priority of the LHA action plan for 2013.

The LHA had a risk management system in place to identify, assess and manage risk but inspectors found that roles and responsibilities in relation to risk management needed to be clearer. Information and data on risk was not fully utilised for the purpose of learning and service improvement. The principal social worker provided inspectors with copies of all relevant policies related to risk. The area manager and principal social worker had developed a risk management plan to address risks. They highlighted issues such as low staffing levels and cases awaiting an assessment. This plan identified the main deficits in service delivery and the resources required to address them which were dependent on the provision of additional social work staff. Strategies were in place to mitigate risk, and the waiting list for assessment had reduced by 8% but the overall risk persisted. A contingency plan had also been developed by the area manager in the event of additional resources not being allocated to the service. A proposal based on the risk management plan had been submitted to the National Office for Children and Family Services by the service director. Inspectors read meeting minutes that showed organisational risks were a standing item on the agenda for all team and management meetings, and mitigating factors were discussed to try and reduce the risks.

Staff interviewed had a minimum understanding of these policies or their roles and responsibilities in relation to reporting and identifying risk at an organisational level. They told inspectors that they had not had specific training in this context. Training would provide staff with a better understanding of their roles and responsibilities and ensure all risks were reported appropriately.

The LHA had a health and safety log and a near-misses book in each office. Social workers interviewed were aware of these and their purpose. Inspectors found that social workers identified near misses such as unauthorised access to social work offices by a member of the public. However, the service did not benefit from an

analysis of the information in these logs. This was acknowledged to inspectors by the principal social worker.

This inspection found that the process of evaluating child protection and welfare services provided by this LHA was at an early stage of development. The family support service had been evaluated and the principal social worker monitored complaints about the service and had collated findings for the two-year period prior to inspection. The use of this information for service improvements was at an early stage and although it had brought about improvements in service delivery, such as a better approach to receiving incoming referrals, the management team were not using the information effectively. This was acknowledged by the principal social worker.

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

This standard was met in part.

The LHA had arrangements in place with agencies that provided services on its behalf. Inspectors found that service level agreements contained sufficient monitoring and governance arrangements although they had not been signed for 2012. Inspectors were provided with meeting minutes between the area manager and these agencies. They showed a satisfactory level of accountability in relation to the services provided. This included compliance in relation to HSE policies and their full integration into these services. It also included meeting National Standards. There was evidence of monitoring of reports by the principal social worker, who received periodic samples of files to audit. The area manager told inspectors that she/he visited these agencies and met children and families on an ongoing basis. The area manager said that although some improvements were required she/he was satisfied that services delivered were in line with service level agreements. However, there was no evidence that these monitoring arrangements were sufficiently robust for the LHA to be assured that external providers were providing a safe and quality service.

Theme 4: Use of Resources

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

Related reference:

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

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

This standard was not met.

There was some information available to support service planning, but the LHA had not carried out a comprehensive needs analysis of their service. Therefore it was not in a position to ensure resources were deployed to achieve best achievable outcomes for children and families.

Although resources available to the LHA were well managed and deployed, deficiencies in staffing created an unsustainable situation and did not allow the LHA to deliver a consistently safe and effective service. The main focus of the LHA at the time of the inspection was to deliver the best service possible within current constraints, and there was a whole-service approach taken to achieve this.

The deficiencies in staffing determined the allocation of resources. Inevitably managers prioritised high risk cases which led to increased thresholds for welfare referrals. Overall, deficiencies in staff resources undermined the service's efforts and commitment to meet the needs of and manage risks to all children. There were vacancies in the service at the time of the inspection. The HSE's *Framework for measuring, managing and reporting social work intake, assessment and allocation activity* figures provided by the LHA showed that the service was functioning at a staffing level of 77%. This was expected to decrease to 70% by August 2013 due to extended staff leave. This was below the recommended HSE national figure of 80%. The area manager told inspectors that there was no current mechanism in place to address this deficiency and that if it was not forthcoming, service delivery would be adversely affected. Inspectors read reports and meeting minutes that showed staffing concerns were reported by the area manager and service director, along with a proposal to address service requirements, to the HSE's National Office for Children and Family Services. An answer was awaited at the time of the inspection.

There was some information available to the area manager and principal social worker such as the profile of the area and population prepared by the Kildare Children's Services Committee. Managers used this information to assist their service

planning. The profile identified, for example, the need for supports for parents of young children in the local area. Staff told inspectors that team planning days provided them with an opportunity to contribute to service delivery. Information gathered by the LHA, for example, in relation to findings of the evaluation of the family support service, and information on referrals and referrers, supported the teams to plan their service.

Agencies that provided a service on behalf of the LHA, or received grant aid, submitted reports to the area manager on needs of their service users. These identified, for example, a need for services for adolescents and families who had experienced domestic violence and this service was put in place. Inspectors found that there was a constant flow of information from other agencies such as the Garda Síochána to the service in relation to local needs, and inspectors observed this in meetings they attended.

The HSE had arrangements in place to monitor and evaluate the financial performance of the service. Inspectors were provided with a sample of monthly financial reports by the area manager. These were submitted to the regional accountant and regular teleconferences and meetings monitored expenditure and revised cost containment plans.

Theme 5: Workforce

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

Related reference:

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

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

This standard was met.

All staff were safely recruited through the National Recruitment Board in line with national policy and legislation. Inspectors read a sample of individual personnel files. They showed that the most recently recruited staff were vetted appropriately and had the required qualifications. Personnel files were well structured and organised and were securely stored. However, some files were not complete and did not always contain sufficient evidence of staff qualifications or the required references. The area manager said that some personnel records that were missing from the files read by inspectors were held in other HSE offices.

There was a comprehensive induction process in place. The area manager provided inspectors with copies of the induction policy and process. The induction pack included information on prioritisation of cases, thresholds of harm, principles underlying service delivery, practice guidance for dealing with domestic, sexual and gender-based violence and the complaints process. Most of the managers confirmed receiving induction and orientation into their new roles. More recently recruited social workers interviewed said they received an induction pack and had undergone a thorough induction process. They confirmed that they felt sufficiently informed and supported to undertake their role. There was a probationary period in place for each new social worker.

Social workers confirmed that they were given protected caseloads to allow them to settle in to their posts, as well as a period of shadowing and reading time.

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

This standard was met in part.

Inspectors found that staff were committed, skilled, experienced and competent but that staffing levels were insufficient. Information provided by the LHA showed that there was a good skill mix of experienced and more recently qualified social workers on the teams, as well as social care and child care leaders and family support workers. Inspectors met with and observed a team meeting with family support workers and found that they worked in partnership with the social workers in the best interest of children and their families. Inspectors also observed the work of the administration teams and found them to be competent, professional and efficient. Some social workers told inspectors that they had worked on different social work teams. They said that they were able to share their experience with other colleagues. The area manager said that staff retention was high and this was reflected in the dataset returned by the LHA. This dataset showed that the majority of staff had worked in the area between three and 12 years.

Inspectors found that managers had varying degrees of experience and training in managing the service. The area manager had appropriate qualifications and experience and told inspectors that she/he had participated in specific training provided nationally for managers. The principal social worker had management training and reported that she/he had received close mentoring for her role from the area manager. Team leaders had received training in supervision and had a number of years of professional experience.

The social work team leaders made good efforts to ensure continuity of service to children who were assigned a social worker, but this was difficult in the context of staff vacancies. This was evident from case records and in a document on social work roles provided by the principal social worker. The principal social worker told inspectors that although efforts were made to plan for staff leave, current resources did not support managers to do so effectively.

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

This standard was met in part.

This inspection found that staff were adequately supported and supervised. The social work team placed a high value on supervision and practice was underpinned by a written local policy. The National Office for Children and Families had developed a national supervision policy. The LHA was in the process of implementing this within the required time frames. Inspectors read a sample of supervision records, while social workers said that they were regularly supervised. This was recorded clearly in case files reviewed and inspectors found that it provided accountability and guidance

in relation to practice and professional development. The LHA was also awaiting the roll out of a national performance management system. The principal social worker told inspectors that managers had recently received a copy of the national performance management policy and had received training on the new system.

Inspectors found that safe practice was promoted through adequate policies and procedures. Staff interviewed were familiar with policies such as lone working and protected disclosures.

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

This standard was met in part.

This inspection found that staff training was provided by the LHA but an improved system of identifying training needs and recording training provided was required.

There was a training programme in place for social workers but it was not based on a needs analysis which would support the service to meet its objectives. Training records held by the principal social worker indicated that all staff were trained in Children First (2011). Social workers said that they also attended other training including the national business processes, Marte Meo (attachment theory), suicide and drug prevention, court work, data protection and report writing. Social workers said they were encouraged and supported to upskill constantly. Social workers and team leaders said that best use was made of various team meetings to have discussions on practice areas and external speakers were brought in from time to time. Inspectors saw evidence of this in team meeting minutes.

The principal social worker had carried out an audit of staff training in May 2013 which recommended the development of a centralised recording system for training and that time was set aside at team meetings for training purposes. The principal social worker acknowledged that the system for recording staff training could be improved upon. There was no formal training programme in place for 2013.

Some inter-agency and multidisciplinary training was delivered by the LHA but not on a regular basis. This meant that there were some limited opportunities for LHA staff to share experience and expertise in the context of training and to strengthen working relationships. Social workers told inspectors that they had received Children First (2011) training with other professionals. They said they found this both beneficial and challenging. Inspectors attended a briefing session for primary care teams on the Child and Family Agency. At this meeting, public health nurses confirmed that they were regularly invited to attend training related to child protection and welfare. However, other professionals said that further training in conjunction with the social work department would be beneficial to improve inter-agency and multidisciplinary working.

Theme 6: Use of Information

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

Related reference:

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

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

This standard was met in part.

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

The LHA had a good awareness of information governance. Computers were password protected as was direct access to the social work information system which held sensitive information. The child protection notification system was accessible only to agreed personnel. Information about children and their families was found to be treated respectfully, used ethically and in a way that protected the rights of individuals. This was crucial, considering the vulnerability of some of the children and families accessing this service. There were policies, protocols and guidelines in place for sharing information between agencies and across the HSE service. One good example of this was a local inter-agency framework for sharing information when there was multi-agency involvement.

The system in place to manage information to support the delivery of services was not robust and there was a risk that services being provided to children may not have been effectively planned and/or delivered based on accurate information. The LHA child protection and welfare service had several systems, manual and electronic, in place to collect and gather information.

Inspectors found that standardised information was gathered by the LHA. The data and information collected included the number of and type of referrals to the service per month; the number of referrals awaiting assessment; number of cases allocated

a social worker; and the number of cases awaiting allocation. The principal social worker gathered and reviewed information and data on case lists, the child protection notification system, complaints register, referrers and types of referrals. Inspectors also found that some information could only be gathered manually and this was a draw on resources that were already stretched. However, there was no clear system of managing this information to support the delivery of effective child protection and welfare services due to the deficits in the infrastructural information systems.

Inspectors found that incoming calls to the social work office were not always recorded. Inspectors observed social workers taking incoming calls that resulted in advice only being provided to the caller. Inspectors found that the majority of these were recorded on a standard template but others were recorded in individual social worker notebooks that were then destroyed. This meant that some social work activity was not acknowledged in service figures and it could not inform service planning.

The LHA had carried out a data protection audit and findings of this audit were being addressed by the principal social worker. Social workers interviewed said that their induction had included training on data protection and freedom of information legislation. The induction pack provided to inspectors showed this information was provided to social workers in writing.

The LHA had policies and procedures in place to ensure children and families had appropriate access to information held on them. One young person accessed their file during the course of the inspection fieldwork. The principal social worker and social workers interviewed had a good understanding of these policies and procedures and inspectors heard social workers giving advice to families on accessing information and also what they could access under relevant legislation.

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

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

This standard was met in part.

Inspectors found that the service had a dual information system that supported the management of child protection and welfare concerns and this was an area of practice that required some improvement. There was an electronic information system in place, Social Work Information System (SWIS), that recorded and provided information on children at risk, numbers and types of referrals, social work activities and reports that were generated by the social work department. Access to this system was restricted and password protected. However, this system was not

compatible with national information systems and therefore there was a significant amount of information gathered manually by social work team leaders, the principal social worker and the area manager, with the support of an administration team. Observation of various systems showed that although they were labour intensive and impacted on resources at times, they provided the information required by the LHA. A national system was awaited by the LHA.

Inspectors examined the electronic child protection notification system and found it was up to date, secure and recorded all information required. This included all enquiries made about children placed on it.

Computers in use by all staff were backed up on a national server. However, a fully integrated system was not in place. For example, a social work team leader in Athy could not share information in a common place on their computer with administrative staff working in Naas. This was particularly problematic when changes needed to be made to key information collected for monthly returns. This was confirmed by one social work team leader and it had an impact on time and resources spent on maintaining up-to-date case lists and allocations.

The colour coding system used to classify level of risk experienced for children was not clearly understood. Social workers interviewed did not have a common understanding of this classification system. There was the possibility that children known to the service could be confused with children at risk of ongoing harm.

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

This standard was met in part.

The service had a record-keeping and file management system that required some improvement. Inspectors found that record keeping in the service was in accordance with policies and procedures. These policies and procedures were found to be in line with relevant legislation and national policy. Inspectors read documents that showed files were audited in line with national requirements. This was confirmed by the area manager, principal social worker and independent chair of child protection conferences. Inspectors read service records that showed that recommendations from these audits were implemented by the LHA.

Records of child protection and welfare concerns were held on both the SWIS and paper files. Paper files were considered to be the master file. Inspectors read a sample of files and found them to be accessible, legible, well structured and contained all relevant information. However, the LHA did not consistently have a chronology of significant events representing the HSE's Child and Family Services involvement with a child/family, milestones reached, and any known significant events, positive or negative, that would impact on the safety, care and wellbeing of the child.

There was a safe system for archiving files belonging to closed cases. Paper files in relation to open cases were held in social work offices by the allocated social worker. Those belonging to open, but unallocated, cases were held by the relevant social work team leader. Files were also held by the area manager in relation to notifications to An Garda Síochána. Inspectors saw that all files were stored safely in locked cabinets. However, the principal social worker and administration staff interviewed confirmed that there was no dependable system in place to track a file to its exact location once it had left the administration office. Records of meetings from one social work office showed that some files had gone missing for a period of time.

Closing the fieldwork and next steps

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

6. Summary of judgments under each standard

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

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

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

Theme	National Standards for the Protection and Welfare of Children	Standard Met, Met in Part and Not met
Theme 6: Use of Information	Standard 6:2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	Met in part
	Standard 6.3 Secure record-keeping and file-management systems are in place to manage child protection and welfare concerns.	Met in part

7. Glossary of Terms

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

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

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

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

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

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

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

Child protection conference (CPC): a child protection conference (CPC) is an inter-agency and inter-professional meeting, convened by the designated person in the HSE. The purpose of a child protection conference is to facilitate the sharing and evaluation of information between professionals and parents/carers, to consider the

evidence as to whether a child has suffered or is likely to suffer significant harm, to decide whether a child should have a formal child protection plan and if so to formulate such a plan.

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

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

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

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

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

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

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

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

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

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

Staff: the people who work in, for or with the service provider. This includes individuals that are employed, self-employed, temporary, volunteers, contracted or anyone who is responsible or accountable to the organisation when providing a service to children and families.

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

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

8. Action Plan

Health Information and Quality Authority Regulation Directorate



HSE response to report²

HSE Area	Dublin South West / Kildare / West Wicklow
Service ID as provided by the Authority:	628
Date of inspection: DAY/MONTH/YEAR	14 May 2013 – 29 May 2013
Date of completed Action Plan: DAY/MONTH/YEAR	

Recommendations

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

Theme 1: Child-centred Services

The LHA was not compliant with the standard in the following respects:

The LHA complaints system did not ensure all complaints were reported and recorded appropriately and in a way that would provide managerial oversight and learning.

The LHA did not have a system to record when children were informed of the complaints process.

1. Action required:

The LHA should put in place a system of reporting and recording all complaints that provides managerial oversight and facilitates learning.

2. Action required:

The LHA should put in place a system of recording when children are informed about the LHA complaints process.

² The Authority reserves the right to edit responses received for reasons including clarity, completeness, and compliance with legal norms.

Related reference: Standard 1:2	
<p>Children are listened to and their concerns and complaints are responded to openly and effectively.</p>	
Please state the actions you have taken or are planning to take with timescales:	
Timescale and post-holder responsible:	
HSE response:	
Refresher training on Complaints procedure to be provided to all staff.	Jan 2014 PSW 1
Team Leaders to keep a database of all complaints dealt with at team level which is similar to the database already held by PSW.	Jan 2014 – when training has been provided (PSW 1 responsible)
Complaints leaflet for children accessing the service will be provided and explained by staff and this will be recorded on his/her file.	Completed 01/09/2013
The complaints leaflet for children will be explained and provided to every Child in Care as part of the Care Planning Review process. This will be recorded in the minutes of each child in care review.	PSW 1: 1/09/2013 Completed.
The Area Database as been adjusted to record outcomes of complaints and service user satisfaction.	Completed
A Complaints Officer (at PSW Grade) has been appointed to oversee all complaints for the area.	Completed
The Complaints Officer will provide a report to the Area Management Team on a six-monthly basis for analysis and to review trends. The analysis will be part of the data used to inform the service planning process for the area.	Complaints Officer first quarter of 2014.

Theme 1: Child-centred Services	
<p>The LHA was not compliant with the standard in the following respects: The LHA did not have effective communication systems with children, families and the general public about the service.</p>	
<p>3. Action required:</p> <p>The LHA should put in place systems that ensure children, families and the general public are provided with information about the service.</p>	
<p>Related reference: Standard 1:3 Children are communicated with effectively and are provided with information in an accessible format.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>An information leaflet and poster on the Child Protection and Welfare Service will be designed.</p> <p>This information leaflet and poster will be circulated in health centres, GP surgeries and other community services across the area i.e. Citizen Advice Offices, Libraries.</p> <p>An information leaflet is available for families in relation to the Family Support Work Service. This has been circulated to HSE and Community Services in the area.</p> <p>The annual presentations that the Social Work Department have provided since 2008, with other services working with children and families, will continue. These presentations have been provided in each of the 3 geographical patches and all GPs, Schools, HSE services and voluntary agencies in the area are invited. The information leaflet on the service will also be provided at these presentations.</p> <p>An evaluation will take place on these presentations, which will include seeking feedback from those in attendance) to changes format and content of these presentations as required.</p> <p>A list of the Designated Liaison Person (Children First) for local community/sports/volunteer groups will be obtained from the Children First Training Office. An annual workshop will be provided to these community groups on the HSE Children and Family Service.</p>	<p>PSW 1: End of November 2013</p> <p>December 2013</p> <p>Completed</p> <p>Presentations planned for December 2013.</p> <p>SWTLs and PSW1 –February 2014</p> <p>Area Manager and PSW 1 March 2014.</p>

Theme 2: Safe and Effective Services	
The LHA was not compliant with the standard in the following respect:	
The LHA did not consistently implement all aspects of Children First (2011) in order to protect children and promote their welfare.	
4. Action required:	
The LHA should ensure that children are protected and their welfare is promoted through the consistent implementation of all aspects of Children First (2011).	
Related reference:	
Standard 2:1	
Children are protected and their welfare is promoted through the consistent implementation of Children First.	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
HSE response: The CPNS System will be accessible on a 24-hour basis when the National System is in place.	End of 2013 Project Lead CPNS

Theme 2: Safe and Effective Services	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA was not able to assess the level of risk to some children and therefore their need for protection had not been determined.</p> <p>The LHA was not able to take timely and effective action to protect some children because of high numbers on waiting lists for assessments.</p>	
<p>5. Action required:</p> <p>The LHA should put in place systems to allow for timely protective action to be taken for all children requiring the service and that children are not left at risk while awaiting assessments.</p>	
<p>Related reference: Standard 2:3 Timely and effective action is taken to protect children.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>A Designated Intake Social Worker is appointed to carry out screening and preliminary enquiries on all child protection and welfare referrals. This will ensure more consistent standardisation and implementation.</p> <p>The additional capacity created within teams by not providing Intake cover will be used to increase the number of Initial assessments allocated.</p> <p>One additional SW has been allocated to Initial assessments.</p> <p>SWTL escalate cases of serious concern that cannot be allocated within teams to PSW (who reviews allocation capacity on all teams to arrange allocation).</p> <p>Differential Response Model process to take on 10 welfare referrals per month initially and to increase incrementally in 2014.</p> <p>The Area Management Team will review on a bi-monthly basis the waiting times for families awaiting assessment and intervention and update the action plan in respect of same.</p>	<p>PSW 1 - implemented</p> <p>PSW 1 & 2: Nov 2014</p> <p>PSW 1; implemented.</p> <p>Implemented</p> <p>PSW 1: Jan 2014</p> <p>AM and PSW 1&2: November 2014.</p>

Theme 2: Safe and Effective Services	
The LHA was not compliant with the standard in the following respect:	
The LHA did not ensure early intervention services were provided to all children and families with welfare needs.	
6. Action required:	
The LHA should ensure that early intervention services are provided to support children and families where welfare concerns have been identified.	
Related reference: Standard 2.4	
Children and families have timely access to child protection and welfare services that support the family and protect the child.	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
HSE response:	
A PSW is being appointed to implement the Local Area Pathway across the area. These Local Area Pathways are part of the National Service Delivery Model for Children and Families. The purpose of this model is to provide support to children at an earlier point and as such prevent, if possible, the concern escalating to a child protection concern.	PSW 1 – 11/10/2013
Work has already commenced with the Local Youth Service to provide a Differential Response to medium/low welfare referrals. Draft protocols and a training plan are in place for the implementation of model. This model will provide more timely access for children in relation to both the assessment of a welfare concern and also to supports if deemed required in the assessment.	Area Manager and PSW1 Jan 2014
The Interface with Primary Care /C&F Forum was established in January 2013 and is continuing. This interface included workshops taking place between Primary Care teams and Children and Family Services regarding child protection and welfare work.	Area Manager C&F and Primary Care Manager; Performance and Development
From the evaluation of the workshops held; the CP&W Teams will engage with Primary Teams on a quarterly basis to review all welfare referrals common to the service. This will promote the provision of services to children who	31/11/2013

<p>have been referred to the Social Work Service but where it has not been possible to allocate a social worker to the family.</p> <p>Evidence-based Programmes such as Incredible Years and Strengthening Families will continue to be used as models to provide support services for families referred to the Department for a welfare concern – 1 Social Care Leader post supports the implementation of these programmes across the areas.</p>	Implemented.
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Theme 2: Safe and Effective Services

The LHA was not compliant with the standard in the following respects:

The LHA did not have adequate or sustainable systems in place to eliminate waiting lists for assessments.

The LHA did not always make written notifications about cases to An Garda Síochána in a timely manner.

7. Action required:

The LHA should put robust and sustainable systems in place to eliminate waiting lists for assessments.

8. Action required:

The LHA should ensure written notifications are made to An Garda Síochána in line with Children First 2011.

Related reference:

Standard 2:5

All reports of child protection concerns are assessed in line with Children First and best available evidence.

Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>An Action Plan was submitted to HIQA in May 2013 and is in the process of implementation. This action plan includes:</p> <ul style="list-style-type: none"> - the appointment of a designated Intake worker to improve level of consistency and standardisation for new referrals - additional capacity generated within teams not providing Intake cover will be used to increase the number of Initial Assessments allocated. This will provide a 	<p>May 2013</p> <p>Completed Sept 2013</p> <p>PSW 1 & 2 January 2014</p>

<p>sustainable system of reducing initial assessments for welfare cases.</p> <ul style="list-style-type: none"> - 1 additional SW allocated to Initial assessments only. - each Children in Community team will redeploy one social worker to do Initial Assessments only - SWTL escalate cases of serious concern that cannot be allocated within teams to PSW (who reviews allocation capacity on all teams to arrange allocation). - DRM process to take on 10 welfare referrals per month initially and to increase incrementally in 2014. 	<p>Completed</p> <p>Jan14 – PSW1 and SWTLs</p> <p>Completed</p> <p>Area Manger and PSW 1</p>
<p>The Area Management Team will review on a bi-monthly basis the waiting times for families awaiting assessment and intervention and update the action plan in respect of same.</p>	<p>Area Manager and PSWs 31/10/213</p>
<p>The waiting lists have been updated on the Area's Risk Register and will be reviewed by the Area Management Team quarterly. This review will review progress being made and to consider whether a risk still remains to service users. These risks will be escalated to Service Director if required.</p>	<p>Area Manager and PSWs</p>
<p>Requests to fill all staff vacancies within social work teams have been resubmitted to the National Office.</p>	<p>Implemented Sept 13. Area Manager – Completed</p>
<p>In conjunction with the Service Director, the Area will carry out needs analysis to ascertain what level of resource is required to address the needs of children and families in the area.</p>	<p>May 2014 – Area Manager Service Director</p>
<p>Action 8</p>	
<p>The Social Work Management Team will provide refresher training to ensure that all notifications to An Garda Síochána are made in writing in a timely manner.</p>	<p>PSW1 & 2: 5/11/2013</p>
<p>The current file audit system will be expanded to include duty and Intake files. The file audit process will include the requirement to notify An Garda Síochána of suspected abuse.</p>	<p>PSW1,2 and CPC Chair: 30/09/2013</p>
<p>Reports on these audits are sent to the Area Manager on a quarterly basis.</p>	<p>Completed</p>

Theme 2: Safe and Effective Services	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA did not have an efficient system in place to close cases not allocated to a social worker.</p>	
<p>9. Action required:</p> <p>The LHA should put in place an efficient system to close cases not allocated to a social worker.</p>	
<p>Related reference: Standard 2:7</p> <p>Children's protection plans and interventions are reviewed in line with requirements in Children First.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>Action 9 HSE response:</p> <p>The Area's closure policy will be reviewed and updated.</p> <p>Team Leaders will identify to the PSWs on a quarterly basis unallocated cases awaiting closure. The PSW will also get a report on the number of cases closure approved within the Department each quarter (from SWIS). This will create a focus within the Social Work Management Team on this area of work and as such promote the development of a more efficient system for closing cases that are unallocated.</p>	<p>PSW1: 30/11/2013</p> <p>March 2014</p>

Theme 2: Safe and Effective Services	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA did not have adequate systems in place to determine the effectiveness of social work interventions for some children and families.</p>	
<p>10. Action required:</p> <p>The LHA should put in place systems to determine the effectiveness of social work</p>	

interventions for children and families.

Related reference:

Standard 2:8

Child protection and welfare interventions achieve the best outcomes for the child.

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

Timescale and post-holder responsible:

Action 10:
HSE response:

An audit of the 46% of cases re-referred in the previous 12 months will be undertaken and analysed to see if cases have been closed too early, if there had been a change in family circumstances and/or if families are returning to the Social Work Department due to a having a previous positive experience.

PSW 1 30/11/2013

The current process in place for seeking feedback from children ("Listening to Children" worksheet) and families who have accessed the Family Support Service will be expanded to include all families referred to the Social Work Service. Families will be asked to complete this form at the point of closure of a case and/or at specific junctures in their contact with the service. The use of these feedback forms will help inform service planning and evaluation.

PSW 2 February
2014

All of the above will become a standard part of the data review process i.e. analysis of complaints logs; feedback forms; analysis of re-referrals will provide a system that assesses the effectiveness of the services and promotes positive outcomes for children.

Area Manager

The LHA was not compliant with the standard in the following respects:

The LHA did not have adequate systems in place to educate other professionals about the service.

11. Action required:

The LHA should improve systems to inform other professionals about the service.

Related reference:

Standard 2:9

Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.

Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>Action 11 HSE response:</p> <p>The annual presentations that the Social Work Department has provided since 2008, with other services working with children and families, will continue.</p> <p>These presentations have been provided in each of the 3 geographical patches and all GPs, Schools, HSE services and voluntary agencies in the area are invited. The information leaflet on the service will also be provided at these presentations.</p> <p>A formal evaluation will take place on these presentations, which will include seeking feedback those in attendance) to changes format and content of these presentations as required.</p> <p>The Primary Care interface meetings will continue and liaison meetings between Child Protection and Welfare Teams and Primary Care Networks to be established. This will promote greater interagency and inter-professional working and also provide a forum for learning.</p>	<p>Completed</p> <p>December 2013 – SWTLs & PSW1</p> <p>February 2014 – PSW 1 PSW 1: 30/11/2013</p> <p>PSW 2: end of November 2013</p>

Theme 2: Safe and Effective Services	
The LHA was not compliant with the standard in the following respects:	
The LHA did not have adequate systems in place to manage and monitor cases not allocated to a social worker or during times of staff absences.	
12. Action required:	
The LHA should put robust and sustainable systems in place to manage and monitor cases unallocated to a social worker including during times of staff absences.	
Related reference: Standard 2:10	
Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:

<p>Action 12 HSE response:</p> <p>Waiting lists will be subject to a full review on a quarterly basis. Social Work Team Leaders will provide a report to the PSW on all unallocated cases quarterly.</p> <p>PSW will review and sample a number of cases on waiting lists for the SWTL review to ensure that systems in place are adequate to manage a case when there is no social worker allocated.</p> <p>Systems are in place to ensure cover is provided to cases during times of staff absences. The duty social work service provides a response to such cases. In addition to this Social work Team Leaders assign specific named staff to carry out certain duties required i.e. home visit, access visit, while the allocated social worker is absent.</p>	<p>PSW1 and CP&W Team Leaders 31/10/2013</p> <p>PSW 1&2 31/10/2013</p> <p>Completed.</p>
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Theme 2: Safe and Effective Services

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

The LHA did not always identify early warning signs in cases of potential or actual organisational and or institutional abuse.

The LHA did not have adequate procedures in place to ensure suspected cases of organisational and or institutional abuse were dealt with appropriately and in a sensitive manner.

13. Action required:

The LHA should put systems in place to ensure early warning signs in cases of potential or actual organisational and or institutional abuse are identified.

14. Action required:

The LHA should put procedures in place to ensure potential or actual cases of organisational and or institutional abuse are dealt with appropriately and in a sensitive manner.

Related reference:

Standard 2:12

The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

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

Timescale and post-holder responsible:

<p>HSE response:</p> <p>The Local Guidance will be re-circulated to all staff and will be included in the new Induction Guidance for Staff. Refresher training will be provided to staff. This training will be both the local guidance document and also on the sensitivities of this area of work and the early warning signs.</p> <p>The Designated Intake Social Worker will be requested to alert the PSW of any referrals where organisational/institutional abuse may be a possibility.</p> <p>As part of this guidance document, the Principal Social Worker will have oversight of such cases and as a result ensure that staff involved in such assessments has the required experience. This is required due to the complexities of this work.</p> <p>This topic will be included in future briefings with all external organisations and meet and greet coffee mornings.</p>	<p>PSW 1: 05/11/2013</p> <p>Completed</p> <p>Completed</p> <p>December 2013</p>
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Theme 3: Leadership, Governance and Management	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA did not have adequate systems in place to monitor, evaluate and improve the provision of child protection and welfare services to children in a systematic way in order to achieve better outcomes for children.</p>	
<p>15. Action required:</p> <p>The LHA should put systems in place to monitor, evaluate and improve the provision of child protection and welfare services to children in a systematic way in order to achieve better outcomes for children.</p>	
<p>Related reference: Standard 3:2</p> <p>Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>A system to analyse all data in respect of the service will be developed to include: all waiting times; re-referrals in the past 12 months; complaints; incident reports and feedback from service users and external agencies.</p>	<p>Area Management Team 30/11/2013</p>

The learning from this analysis will be used to inform the Annual Service Plan and the Area Service Improvement Plan at Area and Sub-team levels.	
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Theme 3: Leadership, Governance and Management	
The LHA was not compliant with the standard in the following respects:	
The LHA did not have adequate systems in place to review and assess the effectiveness and safety of child protection services.	
16. Action required:	
The LHA should put in place systems to review and assess the effectiveness of child protection services.	
Related reference: Standard 3.3	
The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
HSE response: A monitoring system to review compliance with Child Protection and Welfare Standards will be developed. This will include the review and analysis of data collected; file audits and service-user and external agency feedback. This will be included in the Area Service Improvement Plan. Feedback on the review of services will be included in the presentations provided to external agencies. The Risk Management System will be updated to include: roles and responsibilities; analysis of all incidents and near-misses. This will be included in the Induction Guidance for all staff. The Need to Know Notification System has been expanded to ensure that the PSW is alerted to all CP&W and service issues on Teams. These will be escalated as appropriate by PSW. Training on the Risk Management System will be provided to all staff. A Regional Risk Register will be established	Area Management Team 31/01/2014 Area Management Team 31/01/2014 Service Director: January 2014

Theme 3: Leadership, Governance and Management	
<p>The LHA was not compliant with the standard in the following respect:</p> <p>The LHA did not monitor the external providers on a consistent basis to be assured that the commissioned services were providing services to children and families that were compliant with legislation, regulations, Standards and national policy.</p>	
<p>17. Action required:</p> <p>The LHA should further develop an effective system to monitor external providers' compliance with legislation, regulations, Standards and national policy</p>	
<p>Related reference: Standard 3:4</p> <p>Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy and standards.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>A PSW with responsibility for Prevention Partnership and Family Support has been appointed to monitor the compliance of external organisations with legislation, regulation and child protection and welfare standards.</p> <p>The monitoring meetings already in place will continue.</p>	<p>PSW1 1/10/2013</p> <p>Implemented</p>

Theme 4: Use of Resources	
<p>The LHA was not compliant with the standard in the following respect:</p> <p>The LHA had not undertaken a needs analysis to effectively plan, deploy and manage resources to protect children and promote their welfare.</p>	
<p>18. Action required:</p> <p>The LHA should undertake a needs analysis periodically to effectively plan, deploy and manage all resources to protect children and promote their welfare.</p>	
<p>Related reference: Standard 4:1</p> <p>Resources are effectively planned, deployed and managed to protect children and promote their welfare.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>We will agree with the National Office a strategic framework to undertake a needs analysis.</p> <p>In conjunction with the Service Director, the Area will carry out needs analysis to ascertain what level of resource is required to address the needs of children and families in the area.</p>	<p>January 2014 – Area Manager and Service Director</p> <p>May 2014 – Area Management Team</p>

Theme 5: Workforce	
The LHA was not compliant with the standard in the following respects:	
The LHA did not have sufficient staff resources to meet the needs of children using the service.	
19. Action required:	
The LHA should undertake a workforce analysis to determine the correct staffing levels to meet the needs of children using the service.	
Related reference:	
Standard 5:2	
Staff have the required skills and experience to manage and deliver effective services to children.	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
HSE response: We will agree with the National Office a strategic framework to undertake a workforce analysis.	January 2014
In conjunction with the Service Director, the Area will carry out a workforce analysis when the framework for same is agreed. The purpose of this will be to ascertain the agreed staffing levels to meet the needs of children using the service.	May 2014
Agency have been appointed to the area in the interim.	Completed

Theme 5: Workforce	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA did not have an adequate process in place to formally appraise each staff member's performance to ensure their professional responsibility for the quality and safety of the service.</p>	
<p>20. Action required:</p> <p>The LHA should establish and implement a performance appraisal system.</p>	
<p>Related reference: Standard 5:3</p> <p>All staff are supported and receive supervision in their work to protect children and promote their welfare.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>Feedback on performance will be incorporated in supervision sessions.</p> <p>A National Performance Management System will be implemented.</p>	<p>Area Manager, PSW and SWTLs Jan 14</p> <p>Head of Corporate Affairs Nat Office – 2014</p>

Theme 5: Workforce	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA had not undertaken a training needs analysis to inform its staff training requirements.</p> <p>The LHA did not have a planned staff training programme in place.</p> <p>The LHA did not provide adequate multidisciplinary training.</p>	
<p>21. Action required:</p> <p>The LHA should undertake a training needs analysis, informed by the child protection and welfare needs of the children and families accessing the service and the developmental needs of the staff.</p>	
<p>22. Action required:</p> <p>The LHA should develop a training programme based on a training needs analysis.</p>	
<p>Related reference: Standard 5:4 Child protection and welfare training is provided to staff working in the service to improve outcomes for children.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>A Training Needs Analysis will be carried out by the Area in conjunction with Workforce Development. This will be used to develop a staff training plan.</p> <p>Continued Professional Development will continue to be a fixed item on the agenda for all supervision sessions. The focus of this is to discuss learning needs of staff.</p> <p>A centralised log of training undertaken will be kept. This information will be used to inform future training plans and analyse training needs.</p>	<p>PSW 2, Area Manager and Workforce Development March 2014</p> <p>Completed</p> <p>March 2014</p>

Theme 6: Use of Information	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA did not utilise all information collected and gathered to plan and deliver child protection and welfare services.</p>	
<p>23. Action required:</p> <p>The LHA should ensure that all relevant information is used to plan and deliver effective child protection and welfare services.</p>	
<p>Related reference: Standard 6:1</p> <p>All relevant information is used to plan and deliver effective child protection and welfare services.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>The recording of information and advice calls has been logged as an implementation issue and will be integrated into the NCCIS.</p> <p>As an interim measure, a system has been developed using Casenote section in SWIS to log information and advice calls.</p> <p>The LHA will review all performance data quarterly at the Area Management Team Meetings.</p> <p>A PSW to manage the complaints system has been appointed. Part of that role will be to analyse the data in respect of complaints for the Area Management Team.</p>	<p>National Lead NCCIS 1/09/2013 Area Manager and PSWs – completed PSW 1 and Designated Intake Social Worker</p> <p>31/10/2013</p> <p>PSW 3: completed</p>

Theme 6: Use of Information	
<p>The LHA was not compliant with the standard in the following respects:</p> <p>The LHA did not have a secure integrated information system that supported the management of child protection and welfare concerns.</p>	
<p>24. Action required:</p> <p>The LHA should request a secure, integrated information system to support its work.</p>	
<p>Related reference: Standard 6:2</p> <p>The service has a robust and secure information system to record and manage child protection and welfare concerns.</p>	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
<p>HSE response:</p> <p>The Social Work Information System (SWIS) is in place within the area and is fully implemented. This is a secure information system.</p> <p>The National Child Care Information System is currently being tested with a planned roll out across the 17 LHAs. The LHA will fully cooperate with this roll out. SWIS will remain in place until the National system is implemented.</p>	<p>Completed</p> <p>Responsible: Project Team for NCCIS Phase 1 in 2014; Phase 2 ongoing in 2015.</p>

Theme 6: Use of Information	
The LHA was not compliant with the standard in the following respects:	
The LHA did not have a file tracing system in place.	
25. Action required:	
The LHA should put in place a system for tracing files.	
Related reference: Standard 6.3 The service has a robust and secure record-keeping and file-management system to manage child protection and welfare concerns.	
Please state the actions you have taken or are planning to take with timescales:	Timescale and post-holder responsible:
HSE response: A manual file tracing system for files will be developed and implemented	PSW 2 and Grade V: 31/12/2013

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