



Report of an inspection of a Child Protection and Welfare Service

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| Name of service area: | Midlands |
| Name of provider: | Tusla |
| Type of inspection: | Thematic |
| Date of inspection: | 22-26 March 2021 |
| Lead inspector: | Sue Talbot |
| Support inspector(s): | Grace Lynam Leanne Crowe Olivia O'Connell Caroline Browne |

About this inspection

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

This inspection report, which is part of a thematic inspection programme, is primarily focused on defined points along a pathway in child protection and welfare services provided by Tusla: from the point of initial contact or reporting of a concern to Tusla, through to the completion of an initial assessment.

This programme arose out of a commitment made by HIQA in its 2018 *Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs*. This investigation was carried out at the request of the Minister for Children and Youth Affairs under Section 9(2) of the Health Act 2007 (as amended) and looked at the management by Tusla of child sexual abuse allegations, including allegations made by adults who allege they were abused when they were children (these are termed retrospective allegations).

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for the Protection and Welfare of Children* (2012). This thematic programme focuses on those national standards related to key aspects of quality and safety in the management of referrals to Tusla's child protection and welfare service, with the aim of supporting quality improvement in these and other areas of the service.

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans

- speaking by phone to three children and 11 parents/family members
- the review 51 children's case records
- short observation of duty staff
- remote observation of a meeting
- two focus groups of frontline staff and one of team leaders conducted remotely
- interview with two principal social workers
- interview with the area manager.

The aim of the inspection was to assess compliance with national standards related to managing referrals to the point of completing an initial assessment, excluding children on the child protection notification system (CPNS).

Acknowledgements

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

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

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

Service area

The Tusla Midlands service area comprises the counties of Laois, Longford, Offaly and Westmeath. The Midlands has a population of 289,695 people; including 80,196 children and young people aged 0 to 17 years (2016 census data). The rate of child protection and welfare referrals is one of the highest in the country, averaging between 500 and 600 referrals each month.

The Midlands service area is one of four Tusla areas within the Dublin Mid-Leinster region. The region is under the direction of a service director and is managed by an area manager. The management structure of the duty/intake and assessment service comprises a principal social worker (PSW) who reports directly to the area manager and oversees the work of five social work team leaders. Team members include senior practitioners, social workers and social care leaders. The manager of the Partnership, Prevention and Support Services (PPFS) also directly reports to the area manager.

The duty/intake and initial assessment teams each have an identified team leader, with the main hubs for referral located in Portlaoise and Mullingar. An additional team leader has responsibility for the management of the waiting list and standardisation of practice across the four counties. One team leader also has oversight of The Midlands Child Assessment team (MICAT) which provides assessment and support to children who have been sexually abused.

Compliance classifications

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

| Compliant | Substantially compliant | Partially compliant | Non-compliant |
|---|---|---|---|
| The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children. | The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children. | Some of the requirements of the standard have been met while others have not. There is a low risk to children but this has the potential to increase if not addressed in a timely manner. | The service is not meeting the standard and this is placing children at significant risk of actual or potential harm. |

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

| Date | Times of inspection | Inspector | Role |
|---------------|---------------------|------------------|---------------------|
| 22 March 2021 | 09.00-16.00 | Sue Talbot | Inspector (On site) |
| | 10.00-16.00 | Grace Lynam | Inspector (On site) |
| | 10.00-16.00 | Leanne Crowe | Inspector (On site) |
| | 10.00-16.00 | Olivia O’Connell | Inspector (Remote) |
| 23 March 2021 | 09.00-16.00 | Sue Talbot | Inspector (On site) |
| | 12.30-16.00 | Grace Lynam | Inspector (On site) |
| | 10.00-16.00 | Leanne Crowe | Inspector (On site) |
| | 12.00-16.00 | Olivia O’Connell | Inspector (Remote) |
| 24 March 2021 | 09.00-16.00 | Sue Talbot | Inspector (On site) |
| | 10.00-16.00 | Grace Lynam | Inspector (On site) |
| | 10.00-16.00 | Leanne Crowe | Inspector (On site) |
| | 10.00-16.00 | Olivia O’Connell | Inspector (Remote) |
| 25 March 2021 | 09.00-16.00 | Sue Talbot | Inspector (On site) |
| | 10.00-16.00 | Grace Lynam | Inspector (On site) |
| | 10.00-16.00 | Leanne Crowe | Inspector (On site) |
| | 10.00-16.00 | Caroline Browne | Inspector (On site) |
| | 10.00-16.00 | Olivia O’Connell | Inspector (Remote) |

Views of people who use the service

HIQA inspectors spoke with three children over the phone. Two spoke positively about their experience of the child protection service. They were satisfied with the level of contact they had with their social worker and the support they received.

Some of their comments about their social workers included:

'She listens, and sometimes we compromise when we don't agree on something.'

'My social worker is kind, generous and open-minded.'

One child who did not want any involvement from the child protection service said:

'I just want them to close my file, and go away.'

Children were asked if they had any suggestions as to what social workers could do better. They said they were generally happy and that no improvements were needed.

'Nothing that I can think of. She always tries her best.'

Inspectors talked with 11 parents/family members by telephone. All expressed satisfaction with the service they received. All parents said that there was good communication between them and the social work department. They said that social workers listened to them and their children. Comments included:

'It definitely improved things for me.'

'Very helpful, any questions at all, they answer them.'

'My daughter has a really good relationship with her social worker and social care leader.'

'I feel like they are doing their best for me. They really want to help.'

They said that social workers were quick to respond to referrals. Parents/family members comments included:

'They got things up and running straight away. They are in regular contact to see if I need any other supports.'

'She went out of her way to help me.' *'I have support now and I feel safe.'*

When asked about what could be better, the majority of parents said that they were not sure if social workers needed to improve anything, as they did their jobs very well. One parent said they were not initially happy with the support they received, and had made a complaint. They were allocated a new social worker and reported this had significantly improved their experience of the social work service.

Capacity and capability

The Midlands Tusla service area submitted its self-assessment questionnaire (SAQ) to HIQA in October 2020 as part of the methodology underpinning the child protection and welfare thematic programme. The self-assessment required the area to assess its performance against relevant standards relating to its leadership, governance, management and workforce and to identify areas where improvements were needed. Arising out of the self-assessment, a quality improvement plan was developed by the area prior to the inspection fieldwork.

The service area rated its performance as compliant against all five standards. The SAQ indicated that the service area had strong leadership and management systems; with effective arrangements in place to drive quality improvement. In most areas, senior managers' review of their service performance aligned well with the strengths outlined within this inspection report. This inspection found levels of compliance were not as high as those assessed by the area, and inspectors have therefore rated Standards 3.1 and 3.3 as substantially compliant.

Overall, the leadership, management and governance of the duty/intake and initial assessment service was strong and effective in driving continuous service improvement. The service area benefited from having a stable and experienced management team who knew its communities and their diverse needs well. Senior managers demonstrated a shared vision, strategic direction and drive to continuously improve the safety and quality of its child protection and welfare services. They provided strong support and challenge to frontline teams and partner agencies. The service area had well-developed performance management and monitoring arrangements for managing risk and tracking service delivery. Its systems for recruitment, workforce development, support and supervision of staff were well-established and effective.

The culture of the service area was founded on two key principles; ownership of professional accountabilities and the delivery of high quality, safe and child-centred services. Individual and team accountabilities for service delivery were clear and well-managed at all levels within the organisation. The service area's leadership and organisational culture encouraged team working and innovative practice. Managers valued their workforce and supported their continuous professional development to deliver the best possible service to children and their families. A strong partnership working ethos was evident within and between teams and with wider partner agencies.

The service area's strategic direction and service plans were appropriately aligned with Tusla's national service development and improvement plans. Service plans contained clear actions and targets to strengthen the responsiveness and impact of social work interventions. This was evidenced for example, in the strengthened partnership working between social workers and PPFs services to divert children who did not meet the threshold for social work intervention and strengthen 'step-down' and case closure arrangements. This helped promote a holistic focus on what was working well/areas of practice to strengthen in supporting children and their families.

The quality improvement plan for the service area was comprehensive, contained ambitious timeframes, and clearly identified service development priorities. It included key measures to support learning from internal and external audits to strengthen the management of risk and the quality and safety of its child protection arrangements. High priority actions included further reduction in cases awaiting allocation to prevent delays in handover of high priority cases for initial assessment, and learning from local case reviews to strengthen safety planning and partnership working. Actions to improve timeframes for preliminary enquiries and initial assessments, were rated as medium priority and reflected incremental improvement with revised performance targets set jointly with frontline teams to be achieved by the end of April 2021.

In recent years, the service area had restructured its duty and intake teams through a separation of screening and preliminary enquiry functions from initial assessment activity. It had reconfigured local resources to provide an additional team leader with a specific remit to manage risk and reduce delays across the system. The service area had reviewed the skill mix of its frontline teams and appointed additional social care leaders to enhance team capacity and responsiveness. They co-worked cases with social workers and team leaders and provided focused support to older children who may be reluctant to engage. The business support infrastructure had also been reviewed to provide enhanced administration capacity to all teams. Pressures on the duty/intake and initial assessment teams remained high given the continued high volume of referrals coupled with vacancies remaining for a senior practitioner, two social workers and a social care leader.

The service area's audit plan combined with strong oversight by the area manager and PSW's helped promote an open and dynamic approach to service improvement. The service area used audits well to target areas for improvement, with re-audit of key areas of activity to provide assurance that high standards of practice were being maintained. For example, the national audit of An Garda Síochána (AGS) notifications in August 2020 had led to the principal social worker sampling 10% of abuse and neglect referrals on a monthly basis from October 2020 to March 2021. This helped ensure timely notifications were made to AGS. There was a clear management rationale for decisions not to notify, with tighter joint arrangements for information-sharing and follow up activity. Similarly, monthly review of supervision helped benchmark progress and evidenced a high standard of support for individuals in line with Tusla guidance.

The area had a strong improvement focus on safety planning to help protect and reduce harms to children. Twenty case records were audited per month throughout 2020, for the quality of immediate safety planning within intake records. Learning from this had led to increased scrutiny and support from team leaders. This provided an important quality assurance check in signing off safety plans and network meeting forms to ensure actions and accountabilities were clear, measurable and jointly owned by children (where appropriate) and their families. Inspectors found such audits were effective in enhancing the quality of safety plans and helped promote a shared understanding of the features of a good safety plan. A sample of 10 records per month at the point of the closure of the intake record were also audited. Audit findings indicated appropriate decisions were made about closure.

Area management meetings were well-structured and took place weekly. Records of meetings indicated strong ongoing management oversight and monitoring of the performance of the service area. Systems for tracking local performance, trends and benchmarking with other areas and nationally were well-established. The duty social work team leaders and principal social workers met regularly with the User Liaison and NCCIS Business Support lead to review local performance and trends, and address any anomalies between local and national reporting.

While monitoring and oversight arrangements enabled prompt identification of drift and delay on individual cases, inspectors found that actions and recommendations arising from this identification were not always effective at increasing the overall timeliness of assessments. Published Tulsa metrics from the previous two years indicated variable performance in achieving target timescales for preliminary enquiries and initial assessments. The service area's reporting indicated local performance overall had remained static over the past year.

Managers, together with frontline teams, had recently agreed targets to achieve a 50% completion rate for preliminary enquiries and 20% of initial assessments in line with standard business processes by the end of April 2021. Actions to fill the remaining team vacancies were in progress to continuously build capacity to improve performance. In addition the quality improvement plan identified a business case proposal to secure an additional social worker post to prevent delays in initial assessments for high priority cases.

Regular management review of unallocated children helped improve scrutiny of the effectiveness of immediate safety planning and ensured priority work was re-allocated in response to escalating concerns or wider team workload management pressures. The service area had recently strengthened its monitoring of children awaiting allocation for an initial assessment for all priority levels. An additional practitioner had been appointed to work alongside the team leader, regularly contacting children and their families to assess for changes in their circumstances or increased risk; with responsibility for keeping their case records up-to-date. This built on a previous arrangement of monthly joint scrutiny by the principal social worker and team leader of high priority cases and provided assurance to senior managers that waitlisted cases were being managed appropriately.

Frontline staff and managers were knowledgeable and made effective use of Tusla's procedures and guidance in managing duty and child protection work spanning screening, preliminary enquiries, initial assessment and safety planning. The area had effectively implemented Tusla's new standard operating procedures which had helped streamline referral management processes at the front door. Decisions about whether concerns or allegations met the threshold for abuse, the nature of abuse and priority level were appropriately recorded and reviewed as further information about past and current harms was sought and assessed by the duty teams.

Systems to support learning from peer review were well-established and proactively supported continuous improvement in the quality of practice and management of risk. Priority was given to equipping frontline staff and managers with the knowledge and skills to make best use of NCCIS. Overall, inspectors found information about individual children was well-managed and kept up-to-date on electronic case records. No areas of risk to the safety of children were escalated by inspectors from review of the sample of children's records.

Inspectors found strong messaging about professional accountabilities, the quality of practice and services provided in a range of individual and team guidance and senior management communications. Regular file audits were undertaken by social workers, social work team leaders and principal social workers to ensure data and records about activities were accurate and up-to-date. Frontline workers were encouraged to

self-audit their own work to enhance their reflection on whether the required standards of practice had been achieved, and what could have been done better or differently.

The service area actively sought to use compliments and complaints to support organisational learning and quality improvement, using positive feedback from children and their families to reflect on what worked well. Complaints were a feature of all management team agendas and discussed in one to one supervision

The service area had appropriate arrangements in place for the identification, management and review of organisational risk. Tusla's *'Need to Know'* process was effectively used to alert the service director to significant notifiable events in relation to specific children or to emerging areas of systemic risk. The risk register provided a clear overview of organisational risks, including analysis of root causes; and was reviewed quarterly by the senior management team to assess the effectiveness of existing controls. The risk register succinctly captured the areas of major risk in relation to COVID-19 on service delivery; improvements needed in the timeliness of preliminary enquiries and initial assessments; historical under-funding of its family support and preventative services and ongoing social work vacancies. Risks escalated to the service director had been actioned, with supportive measures in place such as CPW practice development, workforce planning/development and data review forums.

Frontline staff and their managers had adapted well to the impact of COVID-19 pandemic challenges on service delivery. The service area complied with Tusla's national policies and procedures in the management of risk and ensured children and their families understood the restrictions whilst encouraging their continued engagement in line with public health guidance. Risk assessments were completed for home visits or other face-to-face meetings with children and their families as their circumstances required. Locality offices remained open; and staff were vigilant to risks to children, including domestic abuse which had been identified as a growing area of concern within the children and young people's local area plans. Frontline staff said their managers supported them well through the difficult periods of national and local lockdown; equipping them for home working and helping them to adapt their practice to a changing work environment.

Senior managers actively supported organisational learning from reviews, inquiries or inspections. Team meetings helped reinforce awareness of individual and shared accountabilities, recognition of good practice and of areas where further improvement was needed. Learning from research was encouraged, including from other jurisdictions, to promote shared knowledge and use of evidence-based practice. Managers had started to analyse re-referrals to help provide better understanding of the sources of referral and issues within specific localities to help strengthen

preventative capacity. They had recognised the majority of referrals related to child welfare concerns; many of which were rated as medium or low priority.

Senior managers provided good leadership in a range of partnership forums. Meetings with AGS through the Senior Management Liaison Forums helped ensure good joint oversight of complex cases; with priority given to ensuring timely strategy discussions/joint actions. The area had used learning from local and national audits to further tighten its management systems and joint working relationships.

The area manager, together with a strengthened PPFS management team, had been working to address historical under-funding of preventative services compared to other areas nationally. A significant programme of work was in progress to strengthen commissioning and joint working; with evidence of positive impact including equity of access and an increased range of local community-based services. All commissioned services received at least a formal annual review. Pathways for referral to PPFS services had been reviewed. There was evidence of regular service updates, with ongoing review of agency capacity and waiting times.

An inspector's observation of the fortnightly review, evaluate and divert (RED) team meetings demonstrated effective implementation of the Midlands standard operating procedures for referral, information-sharing and feedback. Case discussions provided a shared focus on areas of unmet need, priorities and current risks to children. Decisions were recorded on 'outcome sheets' that were then uploaded onto children's individual records. PPFS managers kept the social work team leader informed of any significant case developments on a 'case update form' that was completed on a monthly basis. These measures helped ensure ongoing monitoring of progress, risk and capacity.

The Dublin Mid-Leinster region had a detailed recruitment plan and tracking system which provided good analysis of workforce requirements in the Midlands service area. Priorities were clear and well-monitored within shared work to continue to build the capacity and capabilities of the local service and address the remaining service vacancies. The service area welcomed and effectively supported social work students on placement. A strong 'grow our own' approach underpinned local recruitment. This led to the successful appointment of newly qualified staff which helped address some of previous challenges in attracting and appointing social work staff. At the time of the inspection, the child protection and welfare service had 16 social workers with less than two years' service. A further three new appointments had been made in the early months of 2021. Exit interviews were routinely offered to people leaving the service. This helped identify areas to strengthen in relation to career development or where additional training and support would be beneficial.

Frontline staff reported positively about their induction and the changes that had been made to deliver a comprehensive 'virtual' programme. Newer team members said they had good access to advice and support from work colleagues and had been allocated a mentor. New workers were well-supported, had their development needs identified and were allocated manageable caseloads.

Prior to the inspection fieldwork, the service director for the Dublin Mid-Leinster region reviewed a sample of 10 staff records selected by the lead inspector to ensure safe recruitment standards were met. Feedback provided assurances that all employment records contained up-to-date documentation including Garda vetting, with relevant details of the post holder's experience, qualifications and references. The feedback received also indicated that the professional registration of all social workers was up-to-date; with a clear system in place to ensure annual review.

Overall, the service area demonstrated a well-structured and managed approach to supervision and support of its workforce. All social work team leaders had accessed training in supervising others. Supervision was undertaken in line with Tusla guidance, including frequency. It was appropriately tailored, taking account of individual levels of performance, experience and seniority within the organisation. Supervision was undertaken as a collaborative approach, with expectations and standards clearly set out within supervision contracts which were reviewed annually. Case studies were also effectively used in group supervision and learning groups to continuously build the confidence, knowledge and expertise of team members.

Supervision records reviewed by inspectors evidenced a clear focus on the quality of child protection practice. Decisions and actions regarding next steps in the management of complex cases were clearly recorded. Frontline staff spoke positively about managers having an open door policy and benefiting from a supportive organisational learning culture. A suite of practice tools had been developed by managers to support practitioners in gathering a consistent standard of information and analysis of risk.

Supervision records included recognition of positive practice and individual achievements. Frontline line staff and managers were effectively supported and held to account for progress against service improvement priorities. Each supervision session took account of the caseload size and complexity of the work using the national caseload weighting tool. Appropriate consideration was given to the need for protected time. Inspectors saw that team leaders took appropriate action to re-allocate cases to another worker when this was necessary. Management records indicated that there had been no frontline team member with an unmanageable caseload since April 2020. Staff safety and wellbeing was sensitively considered within

supervision discussions. The area had a wellbeing tool that could be used to provide additional personal support.

The Midlands' training needs analysis and workforce development plan was aligned to national and local service development priorities. Its performance development review (PDR) process enabled access to relevant additional training for individuals. Staff were encouraged to engage with Tusla's '*Empowering Practitioners in Practice*' (EPPI) initiative to build on their practice interests. The approach to annual appraisal of staff knowledge and competences was well-established, with six monthly reviews in place. Given the challenges of COVID-19 which prevented face-to-face learning, the majority of mandatory training was undertaken by virtual means through e-learning and group reflective practice. Children First, Health and safety and the management of personal and confidential information was provided to all staff. Priority was also given to updating staff about Tusla's revised standard business processes and building their competences in embedding the national safeguarding children approach.

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| <p>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.</p> | <p>Judgment Substantially Compliant</p> |
| <p>The service area's leadership and management supported the delivery of a good service overall to children and their families. Service delivery was aligned to relevant legislation, regulations, policies and standards to protect children and promote their welfare. Frontline and senior managers maintained strong oversight of practice including decision-making about the management of risk and prioritisation of casework from initial referral through to case closure. Although the service area had taken action to address delays for children awaiting an initial assessment, some capacity challenges remained in ensuring a prompt handover of children between the duty and initial assessment teams. Timeframes for preliminary enquiries and initial assessments were an area for improvement.</p> | |
| <p>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.</p> | <p>Judgment Substantially Compliant</p> |

Governance of the service area's child protection and welfare services overall was strong. Audits were effectively used to promote challenge, learning and continuous improvement in the quality, safety and impact of social work interventions. A shared culture and ownership of individual and team accountabilities to deliver high quality and child-centred services was evident within individual supervision, team meetings and learning activities. Risks were appropriately identified, well-managed and effectively aligned to support continuous improvement in the area's performance. However, while monitoring arrangements identified where there was drift and delay in individual cases, actions and recommendations arising was not always effective at reducing the lack of timeliness in the application of standard business processes.

Standard 5.1

Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.

Judgment

Compliant

The service area had made good progress in recruiting and developing its workforce, recognised where additional capacity was still needed, and had plans to address this. Employment records indicated appropriate checks had been made to ensure staff records contained Garda vetting, relevant qualifications, experience and references, and that their professional social work registration was up-to-date.

Standard 5.2

Staff have the required skills and experience to manage and deliver effective services to children.

Judgment

Compliant

Senior managers paid good attention to equipping frontline staff and team leaders with relevant knowledge and skills to effectively identify and manage risks to children's safety and welfare. There was a range of formal and informal opportunities for reflecting on the quality of social work practice underpinned by a well-established staff development and review process.

Standard 5.3

All staff are supported and receive supervision in their work to protect children and promote their welfare.

Judgment

Compliant

Supervision of staff was regular, well-managed and effectively recorded. It provided clear direction and review of the quality of case management and the performance of staff. Caseloads were manageable and staff were actively supported and encouraged in their continuous professional development.

Quality and safety

Overall the service area's child protection practice strongly promoted the quality and safety of interventions with children and their families; with evidence of a high standard of social work practice in line with the Tusla's nationally adopted safeguarding approach on most case records seen. There were no children awaiting allocation at the point of referral or at handover from the initial assessment to the child protection teams. However, some residual gaps in organisational workforce capacity combined with continued high referral and re-referral rates were preventing a timely, consistently responsive service to children and their families following the point of screening through to completion of initial assessments. In particular, work was needed to improve the timeliness of preliminary enquiries and initial assessments and to prevent delays in handover between the duty/intake teams to the initial assessment teams for children where risks to their safety were ongoing.

The Midlands rated its performance as substantially compliant in relation to the theme of child-centred services (Standard 1.3). Its self-assessment highlighted further improvements were required to fully embed a child-centred approach in all aspects of the service. Inspectors considered that the area's performance had become compliant in its delivery of child-centred services in the time period since it submitted its self-assessment questionnaire in October 2020. Inspectors found a strong child-centred ethos underpinned organisational culture, service improvement priorities and social work practice.

Inspectors reviewed 15 records for child-centred practice and found a high standard of casework and vigilance to risks to children's welfare and safety. Social workers and social care leaders paid good attention to building relationships with children and ensuring their voice, presentation and experience was woven into assessments and safety planning. Management audits helped promote the use of 'plain language' in specifying essential safety goals and the changes parents needed to make to provide a safe and nurturing environment for their children.

Children's records demonstrated good exploration and recording of children's daily lives. There was explicit reference to the rights of children on some case records which provided effective challenge and recognition of the risks to and vulnerability of children. Children were generally seen/spoken to alone and this was an area of practice that was regularly discussed in case discussions and supervision. Care was taken to ensure children had someone they trusted who they could go to for help.

The service area had a good range of information available to children and their families about what to expect from the child protection and welfare service. New initiatives to strengthen child-centred practice had been recently implemented. The area's youth participation group had been involved in the development of a short animation film '*Our Voice, One Goal*' to help explain the role of the social worker to children. The film used feedback from children to raise awareness of what worked best in engaging and listening to them. Social workers were provided with age-appropriate scripts to help them explain to children why they were involved and how they would be working with them and their families. This built on earlier joint work undertaken alongside '*The Mighty Midlands*' who pre-COVID 19 had been an important local resource in helping shape learning from the experiences of children. The participation of children, young people and their parents remained a central focus within the service area's development plans.

The service area rated its performance as substantially compliant in relation to the theme of safe and effective services (Standard 2.1). The area's SAQ identified that there were a number of children awaiting completion of an initial assessment; and that its actions to address risks in this area had been strengthened through enhanced management oversight leading to a steady reduction in the numbers of children 'unallocated' awaiting initial assessment. The SAQ however, did not comment on the area's performance in meeting standard business process timescales which demonstrated ongoing challenges in sustaining and further improving performance over the past year, and remained an area of ongoing risk for the service area. For these reasons, inspectors considered that overall performance in this area was partially compliant.

Child protection and welfare referrals were made to Tusla's duty hubs in writing, over the phone or through the Tusla portal. Duty and assessment teams promptly screened all referrals within 24 hours and acknowledged their receipt in a timely manner. A pre-intake review form was completed by the team leader and provided clear management direction about the level of urgency and next steps in allocating work to the duty team. All previous referrals, types of abuse and priority levels were clearly mapped within intake records; with appropriate consideration given to the recency of previous referrals and trends in line with Tusla's cumulative harm guidance. Parental consent for network checks was appropriately managed. Inspectors found that a child's priority status was reviewed following the gathering of further information.

Frontline staff and their managers demonstrated good awareness of Tusla's relevant policies, procedures and guidance. They were clear about their professional accountabilities to act in the 'best interests' of children. Inspectors observed the work of the duty team in one locality. Staff appeared knowledgeable and skilled in undertaking assessments through the use of telephone and video calls. Despite not being able to visit homes as frequently as previously due to the COVID-19 pandemic, many records provided a holistic picture of the needs and risks to children and outlined next steps that were proportionate to risk and informed the need for ongoing work or case closure.

Inspectors' review of children's records that required immediate action were appropriately and promptly managed; with evidence of good joint working, for example, with An Garda Síochána, health services and homelessness accommodation providers. This helped ensure the safety of children at high risk of abuse or neglect was urgently responded to in line with safeguarding procedures. Where risks to children were deemed to be high, they were visited at home and encouraged to visit the locality social work office.

Referrals were appropriately closed when children and their families were assessed as not requiring, or no longer requiring a social work service. Children and young people were appropriately diverted to community or family support services through fortnightly RED (review, evaluate, direct) meetings. Priority was given to children and their families who needed an urgent family support response. Ongoing social work intervention was proportionate to the level of risk identified and the need for additional assessment/joint work with parents, their children and alongside other professionals.

There was evidence of good joint working with local hospitals concerning the safe discharge home of babies or young children. There was also appropriate recognition of children's emotional and mental wellbeing from being exposed to poor parental care or attachment. In cases of child sexual abuse, appropriate arrangements were in place to safeguard children whilst adults of concern were being investigated. This included timely information-sharing between duty teams, the Midlands Child Assessment team (MICAT) and with AGS for children who required specialist interview, assessment and support.

Duty workers undertaking preliminary enquiries sought to build a holistic picture of risks to children and their individual needs at an early point following referral. Intake records were generally well-completed; with evidence of consultation with children (appropriate to their age and understanding) and their parents/relevant others within the family network. Chronologies were effectively used within some intake records of children to inform shared understanding of children's experience, of parental capacity and risks to their safety. However, practice was variable in the extent to which the five-day target timescale from referral to completion of preliminary enquiries was met.

Recent data submitted in advance of the inspection for the period September 2020 to March 2021 indicated 35.4% of preliminary enquiries had been completed within the five day timescale. Performance was slightly lower overall to the average of published Tusla returns for the first three quarters of 2020 (38.41%). Inspectors sampled 38 children's records for the quality of screening and preliminary enquiries. Ten records (26%) were completed within five working days as set out within national targets. A further 12 were completed within a month, and nine within one to two months. The longest timescale from referral to sign off by a team leader was four and a half months on records seen. Inspectors identified a few instances where the intake record had not been launched in a timely manner by the duty worker to progress the process of preliminary enquiry following screening. This added to casework delay.

Initial assessment data for the period September 2020 to March 2021 indicated 15.6% met the 40 day referral to completion of the initial assessment timeframe. This was significantly lower than the average of published Tusla returns for the first three quarters of 2020 (26.86%). The initial assessment teams did not have sufficient capacity to accept timely handover of all children who required a detailed assessment; which led to extended delays from the point of referral.

Inspectors reviewed 21 reviews of initial assessments, 16 were completed and five were ongoing. Of those completed, seven (44%) meet the target 40 day timeframe from referral to completion of the initial assessment. Inspectors found initial assessments were undertaken and completed in a timely manner for all children who were at significant risk of harm; with appropriate escalation to child protection conference or admission to care. Of those completed that did not meet the 40 day timeframe, inspectors found examples of variable performance, with some children experiencing a lengthy delay. Timescales ranged from just outside the 40 day target, to six and eight month delays; with the initial assessments for three children taking 10 months from point of referral to completion and sign off by the team manager. The initial assessment teams' capacity to allocate the work contributed to some extended timeframes; and in other cases, there were process issues in that the initial assessment was launched and completed the same day once all direct work had been undertaken.

The standard of initial assessments overall was good with effective use made of tools to engage and hear the voice of children, explore risk and parental protective factors. Interventions were appropriately tailored to children's ages and stages of development. The use of children's own words was captured well, and used within their records to ensure the impact for children was kept at the centre of discussions within assessments of family dynamics and risks. Inspectors found thoughtful consideration of the impact on children's emotional and behavioural development from exposure to domestic abuse or child sexual abuse.

Recognition of culture, language and ethnicity was appropriately detailed within assessment processes. Managers had prioritised this as an area of practice to strengthen; with evidence of social work practitioners becoming more confident and knowledgeable in exploring different cultures and family norms. Service managers had a good understanding of the increasing diversity of their local communities and ensured translation/interpreting support was provided to children and their families as needed.

At the time of the inspection, 51 children who were awaiting allocation for an initial assessment. A total of 10 children were rated as high priority, and 41 as medium priority. The service area had made steady progress over the past year in reducing the number and waiting times for children who required assessment or support. In January 2020, the service area had 137 unallocated cases, 25 were assessed as high, 107 were medium and five low priority. As highlighted in the earlier section of this report, there was in place a dedicated resource to regularly 'check-in' with these children and their families until the initial assessment work could commence. This strengthened management oversight, combined with activity such as auditing of the quality of immediate safety plans by the PSW had led to the escalation of cases that required an urgent response. This approach helped in maintaining contact and oversight of risk; with appropriate follow up of the effectiveness of the immediate safety plan put in place following closure of the intake record with decision for an initial assessment to provide a more detailed analysis of risks and of parental protective factors.

The service area routinely kept children and their families informed about delays in progressing initial assessments. Senior managers reported they had not received any complaints from children and their families about the process of handover, being allocated a new social worker or delays in re-allocation.

Safety planning was embedded within preliminary enquiries and initial assessment processes and promoted the development and review of individual safety plans in line with changes in risks to children or in their family circumstances. There was appropriate identification, challenge and review when parental engagement was not sustained or there was limited evidence that outcomes for children were improving. Inspectors sampled 19 records for safety planning. They found effective safety planning practice in 17 of these (89%).

Inspectors found that AGS notifications had been appropriately made, were generally timely, and were signed off and tracked in line with Tusla's guidance. Joint working with AGS was well-managed and undertaken in line with the Joint Protocol. Notifications were appropriately made and signed off by the principal social worker with effective sharing of information about the impact for children and tracking of the progress of investigations. Strategy/joint action meetings were held at relevant stages of the investigation process. Joint training covering Tusla's national approach to safeguarding children was delivered to AGS in one locality. This was well-received and helped promote increased understanding of joint agency accountabilities for protecting children. Senior managers intended to expand the training offer to the rest of the local AGS force as soon as public health measures allowed.

The closure of child protection casework with children and their families was generally well-managed. Inspectors reviewed nine records for case closure and found a good standard of practice in eight of these. In one case record, it was not clear if the child, who was of an appropriate age and understanding, had been spoken to about case closure. This was recognised as an area of practice to strengthen. Parents routinely received letters advising them that there was no longer a role for the Tusla social work service. Decisions about closure were effectively managed within case discussions and supervision, with next steps clearly outlined. Records of closure summaries indicated reduction of risks to children and detailed any ongoing need for lower level support. Information was appropriately shared with other service areas or jurisdictions when children and their families moved out of area.

Standard 1.3

Children are communicated with effectively and are provided with information in an accessible format.

Judgment

Compliant

The service area demonstrated a high standard of child-centred practice. Children were seen and spoken to alone; and their voice and experience actively informed the assessment process.

Standard 2.1

Children are protected and their welfare is promoted through the consistent implementation of *Children First*.

Judgment

Partially Compliant

The service area had effectively worked with its frontline teams to embed Tusla's national safeguarding approach. The quality of direct work with children and their families overall was good. However, the timeliness of key assessment activity and handover between frontline duty and assessment teams was constrained by gaps in the capacity of the service. This meant that there were ongoing delays for some children and their families receiving the help they needed.