



**Health  
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An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

# Report of a Thematic Inspection of the Governance of a Foster Care Service

Name of service area:	Carlow/Kilkenny/South Tipperary
Name of provider:	Tusla - Child and Family Agency
Type of inspection:	Foster Care Thematic
Date of inspection:	27-30 June 2022
Fieldwork ID:	MON_0037008

## About this inspection

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency (Tusla) and to report on its findings to the Minister for Children, Equality, Disability, Integration and Youth.

This inspection report, which is part of a thematic inspection programme, is primarily focused on assessing the efficacy of governance arrangements across foster care services and the impact these arrangements have for children in receipt of foster care.

This thematic programme is the third and final phase of a 3-phased schedule of inspection programmes monitoring foster care services.

The previous two inspection programmes were as follows:

- Phase 1 (completed in 2018) - Assessed the efficacy of recruitment procedures, foster carer supervision, and assessment of foster carers.
- Phase 2 (completed in 2020) – Reviewed the arrangements in place for assessing children’s needs, the care planning and review process, preparations for children leaving care, and safeguarding of children.

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 Foster Care* (2003).

## How we inspect

As part of this inspection, inspectors met with the relevant managers and child care professionals and spoke to a small sample of children, parents and foster carers. 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 submitted by the area
- interviews with:
  - the regional chief officer
  - the area manager
  - principal social workers for children in care and fostering
  - the chair of the Foster Care Committee (FCC)
  - the quality, risk and service improvement manager for the region.
- focus groups with:
  - social work team leaders - children in care, fostering, reviewing officer and aftercare manager
  - a total of 16 front-line staff - children in care and fostering social workers, aftercare workers and social care leaders
  - five foster carers
  - nine external stakeholder representatives including four guardians ad litem<sup>1</sup>, and representatives from advocacy organisations.
- observations of:
  - a child-in-care review meeting
  - child-in-care governance meeting
  - meeting with foster carers of siblings group
- the review of:
  - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
  - staff personnel files
  - a sample of 21 children's and 20 foster carer files
- separate phone conversations with:
  - three parents, five children and 16 foster carers.

### **Acknowledgements**

HIQA wishes to thank the parents, children, foster carers and external stakeholders who spoke with inspectors during the course of this inspection in addition to staff and managers of the service for their cooperation.

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<sup>1</sup> Court appointed experienced and qualified persons who act in the best interests of children

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

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

Tusla has responsibility for a range of services, including:

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

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into six regions, each managed by a regional chief officer. The regional chief officer reports to the national director of services and integration, who is a member of Tusla's national management team.

Foster care services provided by Tusla are inspected by HIQA in each of the 17 Tusla service areas. Tusla also places children in privately-run foster care agencies and has specific responsibility for the quality of care these children in privately provided services receive.

### **Service area**

The Carlow, Kilkenny, South Tipperary service area (CKST) is the 10th largest of Tusla's service areas. The 2016 census reported the population of the service area was 244,435 people<sup>2</sup>. This included 65,080 children, representing 26.6% of the area's total population.

The service area is under the direction of the regional chief officer for the South East region, and is managed by an area manager. The area manager has 13 senior managers who directly report to her. For fostering services, this includes two principal social workers for children-in-care and a principal social worker for fostering and aftercare services.

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<sup>2</sup> 2016 Census data

Each locality team is managed by a social work team leader reporting to a principal social worker. Team members include senior practitioners, social workers, social care leaders and social care workers. Aftercare services are led by an aftercare manager. In addition, the service area has two social work team leaders responsible for all reviews of children in care. Two access co-ordinators are responsible for organising family contact for children.

At the time of this inspection, the service area had 302 children in foster care. A total of 212 children were placed in general foster care, and 90 children were placed in relative foster care households. Of these, twelve children were placed outside the service area, and three children were placed in non-statutory foster care settings.

Overall, Carlow, Kilkenny and South Tipperary had a total of 218 foster care households on its foster carer panel. This was made up of 156 general foster care and 62 relative foster care households. A further 10 relative foster carer households had children placed with them while they were undergoing the assessment and approval process. A total of 14 foster care households had higher numbers of unrelated children placed together than foster carers were approved for. The service area did not have any special foster carer households.

**Compliance classifications**

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

Compliant	Substantially Compliant	Moderate Non-Compliant	Major Non-Compliant
A judgment of compliant means that no action is required as the service has fully met or has exceeded the standard.	A judgment of substantially compliant means that some action is needed in order to meet the standard. The action taken will mitigate the non-compliance and ensure the safety, and health and welfare of the children using the service.	A judgment of moderate non-compliant means that substantive action is required by the service to fully meet the standard. <b>Priority action</b> is required by the provider to mitigate the non-compliance and ensure the safety, and health and welfare of children using the service.	A judgment of major non-compliant means that the services has not met the standard and may be putting children in risk of harm. <b>Urgent action</b> is required by the provider to mitigate the non-compliance and ensure the safety, and health and welfare of children using the service.

**This inspection was carried out during the following times:**

Date	Times of inspection	Inspector	Role
27 June	9.00 – 17.00	Sue Talbot	Inspector
27 June	10.00 – 17.00	Sharron Austin	Inspector
27 June	10.00 – 17.00	Hazel Hanrahan	Inspector
27 June	10.00 – 17.00	Lorraine O'Reilly	Remote Inspector
27 June	10.00 – 17.00	Susan Geary	Inspector
28 June	9.00 – 17.00	Sue Talbot	Inspector
28 June	9.00 – 17.00	Sharron Austin	Inspector
28 June	9.00 – 17.00	Hazel Hanrahan	Inspector
28 June	9.00 – 17.00	Lorraine O'Reilly	Remote Inspector
28 June	9.00 – 17.00	Susan Geary	Inspector
29 June	9.00 – 17.00	Sue Talbot	Inspector
29 June	9.00 – 17.00	Sharron Austin	Inspector
29 June	9.00 – 17.00	Hazel Hanrahan	Inspector
29 June	9.00 – 17.00	Lorraine O'Reilly	Remote Inspector
29 June	9.00 – 17.00	Susan Geary	Inspector
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30 June	9.00 – 15.00	Sharron Austin	Inspector
30 June	9.00 – 15.00	Hazel Hanrahan	Inspector
30 June	9.00 – 15.00	Lorraine O'Reilly	Remote Inspector
30 June	9.00 – 15.00	Susan Geary	Inspector

## Background to this inspection

This thematic programme is the third and final phase of a 3-phased schedule of inspection programmes of monitoring foster care services. The previous two inspection programmes were as follows:

- Phase 1 (completed in this area in June 2017) – Assessed the efficacy of recruitment procedures, foster carer supervision and assessment of foster carers.
- Phase 2 (completed in this area in May 2019) – Reviewed local arrangements for assessing children’s needs, care planning and reviews, preparations for children leaving care and safeguarding children.

### **Summary of the Findings from Phase 1 and 2**

Of the eight standards assessed in Phase 1:

- one standard was judged compliant
- three standards were judged substantially compliant
- four standards were judged major non-compliant.

While systems for the vetting, assessment and preparation of foster carers were effective, and support for children with complex needs was good; there were gaps in the supervision and support of foster carers. Systems for safeguarding children where there were allegations of abuse against foster carers required improvement. Reviews of foster carers were not in line with regulations. Overall, this inspection found leadership, management oversight and governance of foster care services required improvement. This included the management of the Foster Care Committee (FCC).

Of the seven standards assessed in Phase 2:

- one standard was judged compliant
- three standards were judged moderate non-compliant
- three standards were judged major non-compliant.

Staff retention was a significant challenge for the service area leading to high numbers of children in care not having a social worker, or experiencing multiple changes of social worker. Overall, inspectors found significant deficits in governance including in the management of complaints. Responses to significant events and abuse allegations were not always effectively managed. Children did not receive visits from their social worker in line with statutory requirements. The system for care planning and reviews was poorly managed and resulted in children’s needs not being met. Aftercare services were under-resourced. While the service area did not have sufficient numbers of foster carers, the vast majority of children had been placed locally.

A risk-based inspection was undertaken by HIQA in October 2020. This inspection found some improvements in leadership and governance, but the service area was not

compliant with regulations for statutory visits and reviews of children in care. The management of aftercare service provision had been strengthened. Organisational learning was being promoted through increased use of audits, including of the arrangements for children who did not have an allocated social worker. Staff supervision overall was regularly provided, with actions in progress to improve case recording and enhance learning and development of the workforce.

A further follow-up risk-based inspection was undertaken by HIQA in October 2021. This found ongoing improvements in the governance and management of the service, particularly in relation to the quality of care planning and reviews. However, there remained a high number of children who did not have an allocated social worker. Other children experienced frequent changes of front-line practitioners which detracted from the quality of services provided.

### **Self-assessment information and what Tusla said about the service**

Prior to the announcement of the inspection, the service area submitted a self-assessment to HIQA in May 2022. The self-assessment is part of the methodology for this inspection, and required the management team to assess its performance against the eight standards relating to governance and identify where improvements were required.

The service area rated its performance as compliant against three standards and substantially compliant against the remaining five. Of the three standards rated as compliant, inspectors found two were substantially compliant. These included standard 18, Effective policies, and standard 20, Training and qualifications. Inspectors rated standard 19, Management and monitoring of foster care services as non-compliant moderate. Inspectors agreed with the area's judgments of substantially compliant for standard 21, Recruitment and retention of an appropriate range of foster carers, standard 23, The foster care committee, and standard 24, Placement of children through non-statutory agencies. Inspectors found standard 22, Special foster care and standard 25, Representations and complaints were non-compliant moderate.

The reasons for this are detailed within the report and specifically relate to gaps in the capacity of children-in-care teams which had led to increasing numbers of children not having a social worker. There were delays and gaps in the provision of additional support for children with high and complex needs; including their access to relevant specialist support from partner agencies and funding. Arrangements for recognising and recording complaints from children were not effective, and governance arrangements had not adequately informed learning from complaints as a driver for improvement.



Overall, inspectors identified a significant programme of service improvement and management activity in progress to further strengthen local leadership and governance arrangements. However, the ongoing challenges faced by the service area in recruiting and retaining its children-in-care teams meant gaps remained in its capacity to consistently achieve organisational priorities and deliver the standard of services it aspired to. Gaps in its quality assurance capacity meant that learning from allegations and complaints was not sufficiently understood. Overall, the voice and experiences of children required strengthening to promote high standards of child-centred practice.

## Children's experience of the foster care service

Children's experiences of foster care services were sought through speaking with them, their parents, foster carers and external advocates and professionals. The review of their care records, complaints, and management and supervision records provided an overview of the experiences of children.

Inspectors spoke to five children. Of these, three had an allocated social worker and were generally happy with the help they had received:

*'They do their job, and I have no complaints. Anything I ask for, they will do what they can to make it happen'.*

*'They seem to want the best for me. It feels like they are in my corner'.*

These children said they knew about their care plan and that their social worker looked out for them to make sure they were safe. However, one child who did not have a social worker said they did not know what a care plan was.

All children said they liked where they lived and thought that their foster carers were nice people. They had fun things to do and were involved in sports and other activities in their local community. Children said that if they were worried about anything they would go to their foster carers or to a teacher at school for help and support. One child said they had their social worker's phone number. Two children, however, said they were not sure how to make a complaint if they were not happy about something.

Inspectors spoke to three parents. They mostly said they had a good relationship with and contact from their children's caseworkers:

*'My social care worker is very good, very helpful, kind and caring about my child and me'.*

They said they had received a copy of their children's care plans. One parent added that they had valued their social worker going through it with them.

One parent reported negatively on their experience of child care reviews that were held over the phone:

*'When I talk, everyone else jumps in'.*

Parents said they valued the care given by their children's foster carers:

*'I know my child is happy. When I speak to them, I know they are safe'.*

Inspectors spoke to foster carers who participated in a focus group, and with 16 foster carers individually over the phone. Foster carers overall reported a mixed picture about the help they received from Tusla. Most said they felt valued and listened to by their fostering link social workers or children's workers. Their comments included:

*'The assessing social worker has been great - responsive to any queries we have'.*

*'Always there, ready to listen and offer advice - delighted to have them; they have been so good in supporting us through change - a rock'.*

*'They are only at the end of the phone. When I need them, there are always there for me - great support. I cannot fault them at all'.*

*'Everyone works together'.*

One foster carer said:

*'The social worker is very good. We have had great support over the years. If we need anything at all, they are on the ball'.*

However, some foster carers said they did not always feel listened to; and had not been adequately involved in decisions about children's needs or placement changes. They raised concerns about the impact for children who did not have an allocated social worker:

*'There is lots of moving around of social workers. It would be nice to have the same social worker, for longer'.*

*'It is very difficult to get help when you need it when the child you are caring for does not have a social worker'.*

One foster carer said their child had three social workers over the past six months and that it was hard re-visiting children's experiences each time someone new started. Others described the process as very frustrating while waiting to get things signed. One person said they felt like a *'middle person with no voice'* and were concerned that the people signing the forms had not previously met the child.

While some foster carers said that they felt able to discuss any aspect of a child's care or protection with Tusla staff, a few said their concerns about children's development had not been listened to. This led to delays in the right support being made available to the child. These foster carers said they were also not clear about how to make a complaint and were unaware of advocacy support available to help them. Others said

they were reluctant to complain. Foster carers reported particularly negative experiences of seeking enhanced payments for children with complex needs: *'It has been a painful experience to secure additional payments, like you are begging'*.

Foster carers said they really valued the help they had received from local fostering support services in helping them to understand and manage the emotional and behavioural needs of the children they were caring for. They also said that the new relative foster carer support group was very helpful. The range of learning and development opportunities available to them, including the two-year therapeutic training course run by a local college, was commended.

External professionals also expressed contrasting views about the quality of foster care services, which largely related to whether children had an allocated social worker: *'X's social worker is excellent'*.

However, they also reported that some children had to wait too long for additional support, and that it was difficult to get the levels of specialist help some children with disabilities needed.

Children's case records showed that the service area prioritised meeting its statutory obligations for statutory visiting and child-in-care reviews. However, there were lengthy gaps in the case records of some children who were unallocated. The ongoing workforce capacity gaps had led to a lack of continuity and co-ordination of visits and care plans for some children.

Foster carer records demonstrated the service area overall had effective assessment and review arrangements in place. Most foster carers benefited from regular support and supervision. Stresses within foster care placements were appropriately identified with additional help provided to help address risks.

Overall, the experience of children, family members and foster carers was mixed, with some examples of a high standard of partnership working and service delivery. The quality of the service provided appeared to be increasingly linked to whether children had a consistent case worker to champion their needs and ensure their care was effectively managed and monitored over time.

## Governance and Management

The Carlow, Kilkenny, South Tipperary (CKST) service area overall had appropriate structures and increasingly effective governance and management systems to oversee the quality and safety of its foster care services. It had a clear strategic direction and plans to support continuous improvement, which demonstrated ongoing learning and review of progress from previous HIQA inspections. There had been further changes of senior managers since the last inspection. These included a new area manager and a principal social worker for children-in-care. Area managers together with the regional chief officer, risk and HR leads, sought to make best use of performance and risk data in regional risk and governance meetings. The new approach aimed to strengthen linkages between local area performance and national targets and service delivery priorities. However, the impact of its service improvement drive continued to be affected by its long-term challenges in recruiting and retaining sufficient social workers for its children-in-care teams. At the time of the inspection, there were three team leader and eight social worker vacancies across two of its three localities. While a recent targeted recruitment drive had been successful in one locality, significant recent social worker turnover was evidenced in another children-in-care team which added to the high numbers of children who could not be adequately supported.

High staff vacancies and turnover had, by necessity, led to tight management of its social work resources, with capacity to respond only to children deemed high priority; and in some cases, the response did not meet the levels of urgency required. This had a significant impact on the quality of relationships practitioners were able to make and maintain with children; and detracted from the provision of an equitable, child-centred service. Front-line managers' capacity was spread too thinly as they were frequently pulled into filling gaps in case management activity. This in turn meant they did not always have sufficient time for their quality assurance or staff support, supervision and development roles. These challenges were recognised and reflected in monthly area manager meetings and in the service area's risk register.

This inspection found that significant improvement was still required to ensure good oversight and effective management and co-ordination of the care needs of all children in foster care. Arrangements for identifying, assessing and funding the additional support for children with high and complex needs were protracted and cumbersome, leading to delays in recognising and securing the right levels of help for some children. The service area's complaints and representation system required further development to improve the awareness and confidence of children and foster carers in its use, and enable it to be an effective system for driving service improvement. These issues had not been adequately considered in the area's self-assessment questionnaire or service improvement plans.

Senior leaders were working to consolidate governance arrangements at a local and regional level, to strengthen capacity to manage risk and ensure lessons were learned from organisational successes and failures. Risk management frameworks were effectively used to alert senior managers to escalating concerns, which in turn were discussed in area management meetings and helped inform regular updating and review of the risk register. Whilst the risk management systems were in place, the impact of contingency plans for managing long-term workforce deficits had only been partially effective to date. Audits were starting to provide a clearer picture of work still required to achieve improved standards of performance, though the frameworks in use would benefit from further review. The biggest risk to the performance of the service area related to its capacity to recruit and retain sufficient social work staff for its children-in-care teams. At the time of this inspection, 129 children (43%) did not have an allocated social worker. A total of 26 children had been on a waiting list for longer than a year, and 47 children were on a waiting list for periods between six months and a year. At the time of the last inspection in October 2021, 71 children (24%) were unallocated. The compliance plan submitted to HIQA following the last inspection, and updated in May 2022, indicated that with effective recruitment; all children could be allocated by the end of 2022.

Inspectors' review of Tusla's performance data during the first six months of 2022 indicated a steadily deteriorating picture resulting in reducing numbers of children being allocated a qualified social worker. HIQA had previously raised concerns with Tusla's regional and national directors on numerous occasions, and had received compliance plans that provided assurances that these gaps in provision would be addressed. The area manager recently used Tusla's 'Need to Know' <sup>3</sup> risk alert system to advise of further escalating concerns in relation to its impact for children and its capacity to meet its statutory obligations. Although this had been highlighted as 'very high risk' on the area's risk register; to date there has not been an effective strategy or sustainable response to managing the issue. The service area continued to try and mitigate this risk through its ongoing targeted recruitment campaigns and actions to strengthen staff retention.

Area management team meetings ensured ongoing scrutiny of performance data and trends, with management trackers providing regular progress checks of capacity and pressures within teams and service areas. Reporting and oversight of adverse events was appropriately managed, with effective follow-up of incidents where children had been identified as at risk of being harmed.

Service managers demonstrated a strong commitment to ensuring children without an allocated social worker were seen and were safe. At the time of the last inspection, the

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<sup>3</sup> Tusla's internal system for alerting senior managers to areas of significant risk

service area had developed a system of 'safeguarding visits' for social care workers to check the safety and welfare of children. This did not replace the statutory visits that were required to be made by social workers, but was seen as an interim measure of keeping contact with children, identifying where further work was needed, and helping children prepare for the review of their care plan. This practice of safeguarding visits had continued, but over time had become less effective, with increasing delays and gaps in the co-ordination of children's care.

Inspectors reviewed the service area's governance arrangements for children who did not have an allocated social worker, and found that in most cases, consideration was given to ensuring statutory visits and child-in-care reviews took place in line with child care placement regulations. However, inspectors found that the eight-weekly audits did not consistently identify all relevant risks to help inform management decisions about whether a child could be allocated or remained on the waiting list. Where possible, a secondary worker was deployed to support statutory activity for children who remained unallocated. Social care staff, in their role as secondary workers told inspectors that they '*were doing everything else, bar court work*'. Senior managers said they had set clear boundaries for social care staff and for fostering link social workers in relation to their expanded roles to help address growing gaps in local capacity. However, this in turn, had started to impact on their wider accountabilities with examples of delays in direct work with children and fostering development work.

Front-line teams and their managers told inspectors about the ongoing pressures they faced in managing their caseloads and ensuring children's care records were kept up to date. The regional chief officer had approved business cases to strengthen business administration capacity, but there remained a backlog of children's records and supervision case notes to be uploaded onto the National Childcare Information System (NCCIS)<sup>4</sup>. Access arrangements to enable children to have regular contact with their families were also identified as an ongoing challenge in consistently achieving the required service standards.

Following the inspection, HIQA asked the service area to provide an assurance report on how it intended to address these escalating risks and ensure that all children in foster care had an allocated social worker in line with the requirements set out in legislation, statutory regulations and foster care standards. Planned actions were taking place at a number of levels. At a national level, Tusla's new *People Strategy* (2022-2024) sought to make Tusla 'an employer of choice' and explore alternative approaches to recruiting staff with a range of skills and experience to meet the diverse needs of children in care.

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<sup>4</sup> Tusla's national electronic social care record.

The service area had recently appointed three social workers and a social care leader to the locality that had the highest number of unallocated children. These appointments sought to reduce the number of children on the waiting list and help strengthen governance of safeguarding arrangements for children until they could be allocated. The area's recruitment plan also included actions to fill vacant posts in another locality, and appoint two further social care workers to be flexibly deployed across the service area.

The service area also outlined its plans to strengthen its leadership, governance and management of risk. This included strengthening oversight by the Joint Area Alternative Care Governance forum, to help standardise service operations and the promotion of child-centred practice. Gaps in the quality of care delivered to children would be addressed through strengthening audits to include recognition of delays in progressing actions within children's care plans. The service area aimed to also strengthen management oversight of progress within supervision.

The provider assurance report focused largely on seeking new appointments and maintenance of its pattern of safeguarding visits to children who did not have an allocated social worker. It also aimed to strengthen management focus on identifying gaps and delays in implementing children's care plan priorities. However, it did not provide a clear plan with assurances for the allocation of the three children rated high priority, nor did it provide sufficient assurances for the 16 medium priority children in two localities who had remained unallocated for over a year.

Prior to the inspection, the service area had rated its performance as compliant against three standards, and substantially compliant against the other five standards. Inspectors did not agree and queried why judgments of compliance had been made by senior leaders given the high levels of unallocated children, the continuation of care practices that did not adequately meet the standards set out in statutory regulations, and work required to embed learning from audits and from the voice and experiences of children and their families. No standards had been rated non-compliant by the service area. Inspectors did not rate any standards as compliant, and agreed with the area's substantially compliant judgment in three standards. Two standards rated as compliant by the service area were assessed as substantially compliant by inspectors. Another standard rated as compliant by the service area was rated as moderate non-compliant by inspectors.

Overall, senior managers sought to ensure service delivery was underpinned by a range of service improvement plans, operational policies and procedures to promote high quality foster care services. Front-line staff and managers had a good understanding of their roles and professional accountabilities, and wherever possible, ensured children were placed close to their families and communities. However, their

ways of working did not always adequately include children and their families. Inspectors found gaps in their awareness of how to complain. Their involvement in child-in-care reviews required strengthening. Partnership working with health agencies needed further development to ensure children could access the specialist help they needed in a timely way.

The service area had appropriate recruitment arrangements in place to safeguard children, although there were gaps in the employee personnel records that were held nationally at the time of the inspection. The service area had an established programme of workforce learning and development, with a training tracker in place to monitor attendance, including coverage of mandatory training. The area manager had prioritised management development training, and was working to strengthen buddy and coaching arrangements for staff at different points in their careers. There was work required to embed local performance development review arrangements to support organisational capability to continue to meet organisational priorities and enhance staff recruitment.

The service area benefited from a stable and experienced fostering workforce. Recruitment and ongoing support for foster carers ensured high priority was given to addressing their learning and development needs. Gaps in the availability of suitable foster carers to meet the diversity of children's needs were recognised, with work planned to strengthen the recruitment of foster carers from other cultural backgrounds. The FCC together with the area's Placement Committee ensured service delivery was secured by a structured assessment and matching process, though the area experienced ongoing capacity challenges in the availability of emergency and long-term placements to meet current levels of demand. All foster carers exiting the service in the last 12 months were offered an exit interview, and four out of the 20 who left had been completed within this period. The service area recognised the need to encourage wider feedback of foster carers' experiences to inform the continuous development of the service.

Work was required by Tusla's national office to provide clear guidance about alternative models of foster care, including special foster care. The service area did not have any special foster care arrangements, although it had some effective bespoke arrangements for children with complex needs that reflected the levels of intensive care or supervision that they needed. Inspectors were told by front-line staff and foster carers about growing dissatisfaction with the area's enhanced payments arrangements, which they reported as slow and cumbersome in relation to the approval of additional costs. Children with complex needs or disabilities who did not have an allocated social worker experienced a disjointed approach to the co-ordination of their care and multidisciplinary working.



The service area experienced gaps in the membership and leadership of its FCC over the past year that it was working to address at the time of the inspection. Its decision-making focused on promoting the best interests of children and ensuring foster carers felt valued and supported in their role. Members of the FCC discharged their responsibilities in line with Tusla's policies, procedures and guidance, but its oversight of serious concerns, allegations and appeals by foster carers required strengthening. The business of the committee was effectively managed by the committee co-ordinator who provided good support in monitoring organisational performance in line with regulations. A draft copy of the FCC annual report (2021) was available at the time of the inspection, but did not provide sufficient analysis of data and trends to inform wider service improvement activity.

The service area had relatively low usage of non-statutory foster carers. It had appropriate arrangements in place to ensure children benefited from the same protections set out in regulations. Managers had oversight of providers' adherence to contracts and the service level agreements in place with their wider organisations. Non-statutory foster care providers had been unable to respond to the majority of referrals made by the service area over the past year, and further consideration needed to be given to this sector's contribution within the area's future fostering strategies.

The service area had relevant policies and procedures to ensure that children, their families, foster carer and others could raise complaints and give feedback about their experience of foster care services. However, there had been no complaints logged by the service area over the past year from children. This required further management review. Staff had received training in managing representations and complaints and were working to resolve issues informally and in a timely manner, but children's records provided limited evidence of how informal complaints were being managed or the lessons learned from them. The small sample of formal complaints reviewed by inspectors indicated delays in reaching an outcome from complaints. The service area's governance arrangements did not support sufficiently strong tracking and reporting. Learning from compliments and complaints had not been effectively integrated into its wider service improvement plans.

The next sections of this report provide further detail on the area's leadership and governance against each standard, and the effectiveness of its systems to continuously drive improvements in the quality of its services.

## Standard 18 : Effective Policies

Health boards have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.

The service area judged themselves to be compliant with this standard. Inspectors did not agree with this judgment and assessed this standard as substantially compliant.

The CKST service area had an annual service plan, service improvement plan and fostering strategy that provided a clear strategic direction and performance framework for the delivery of its organisational priorities. The service area's policies, standard operational procedures and guidance complied with the requirements set out in legislation, regulations and standards, and were in line with Tusla's national approach. Most had been reviewed and updated within the expected timeframes, with good attention paid to ensuring staff were aware of practice requirements. Training had been provided to help them prepare for the implementation of new policies or standard operating procedures.

Fostering teams informed foster carers about key policies through their assessment, approval and review activity. Information-sharing events and support and supervision visits helped foster carers explore their role and responsibilities. Some policies had been adapted for children to help them know their rights and prepare for their reviews. Safeguarding and statutory visit records sometimes included details that information leaflets had been provided and discussed with children. Audits of care practice provided a structured approach for checking compliance with policies and procedures. Managers were working to promote a consistent standard of practice in the management of supervision visits, waiting lists and case notes on children's records. The service area's leadership team set a clear expectation that children understood how to make a complaint, however, the lack of any formal complaints from children over the past year required further review.

Fostering teams sought to continuously build their knowledge and skills in delivering improvements in their approach to supporting foster carers. Team meetings included discussion of the area's achievements and challenges in meeting the *National Standards for Foster Care* (2003). A specific standard was discussed at each of their monthly meetings. This was good practice and made effective use of each other's skills, knowledge and experience.

The membership of the foster carer panel was subject to regular review. The status of foster carers and any specific changes to their approval status, suitability or capacity were clearly recorded and monitored. Arrangements for foster carers transferring into the service area were adequately managed.

The service area's standard operating procedure for the transfer of children between child protection and welfare and children-in-care teams was due for review. The timeliness of transfer between teams had been highlighted as a growing concern due to increasing pressures in both teams and had been added to the area's risk register. Decision-making about handover timeframes was overseen by team leaders and principal social workers. A duty rota was in place to address urgent concerns while awaiting handover to children-in-care teams.

The service area had relatively few children placed out of area, mostly with relative foster carers. Review of one foster carer's record indicated good levels of contact, visiting and oversight by CKST's link social worker while foster carers were being assessed. There were arrangements to present the foster carers for approval to the relevant other service area's FCC. However, the children were unallocated and transfer arrangements had not yet taken place.

Appropriate use had been made of public health guidance in the management of visits and meetings during periods of COVID-19 restrictions. However, almost all children-in-care reviews, continued to take place by teleconference. Foster carers told inspectors they had not been offered an alternative. These arrangements would benefit from further review to help strengthen relationships with children and their parents, and enhance their participation in meetings about them.

Aftercare planning for young people overall was good, with most assessments and care plans developed in line with the timeframes set out in aftercare policies and procedures. The service area had two Aftercare Steering Committees with relevant membership from partner agencies. Members were working to agreed shared priorities to strengthen access to services to support young people's transition to adulthood. Deficits in the availability of supported housing had been identified, and there were plans in progress to strengthen local capacity.

The service area was working to improve partnership working with the Health Service Executive (HSE). A new structure of locality meetings had been recently established. The quality of joint working, however, had been impacted by lengthy waiting lists for assessment and treatment in local health services. There remained delays and gaps in access to a range of therapies and the co-ordination of specialist care. Front-line staff told inspectors about their concerns for children not being able to access the right service at the right time. In some cases, the only help available was some distance outside the service area, which led to additional pressures on children and their foster carers. Tusla was in the process of establishing a therapeutic team for the region to help address some of these deficits.

The service area had appropriate liaison arrangements with An Garda Síochána that ensured regular information sharing and strengthening of joint approaches for protecting children. Service managers had identified the need to improve joint working for when children were taken into care in an emergency, and had expanded its senior liaison meeting membership to include a child-in-care principal social worker.

Overall, the service area had appropriate plans and policies for meeting regulations and best practice standards. However, it needed to strengthen its approaches to the participation of children and improve their access to specialist supports.

**Judgment: Substantially Compliant**

## Standard 19 : Management and monitoring of foster care services

Health boards have effective structures in place for the management and monitoring of foster care services.

The area judged themselves to be compliant with this standard. Inspectors did not agree with this judgment and assessed this standard as moderate non-compliant.

The service area had clearly defined governance and management structures in place to oversee the quality of its foster care services, but these required development to achieve the required impact in all areas and secure the future sustainability of services. The area manager had identified the need for greater oversight of children-in-care and had recently established a new governance group to help strengthen organisational learning.

Senior manager accountabilities were clear; with an effective reporting system to the area manager and regional chief officer. Two children-in-care principal social workers and a fostering social worker directly reported to the area manager. They, in turn, supervised the work of locality team leaders, reviewing officers and an aftercare manager. Other principal social workers provided additional support in areas that would benefit from an independent view. This included chairing of placement disruption meetings, the management of complaints and oversight of audits.

The membership of front-line teams included social workers and other child care staff with different qualifications and experience. The service area had appointed social care leaders and social care workers, as secondary workers to help address gaps in its statutory arrangements for children who did not have an allocated social worker.

The service area's arrangements for prioritisation of unallocated children in care remained its area of highest risk. Some children had remained unallocated for considerable periods of time. Compliance with statutory regulations had not been effectively addressed. Not all risk factors had been considered when prioritising some cases. For example, inspectors brought the circumstances of three children to the attention of principal social workers whose priority level had not been appropriately assessed or responded to in line with the urgency required. This included children who had been placed with unassessed, unapproved foster carers. In reviewing these cases, inspectors found the levels of management oversight had been poor. In one case, where a social care worker had been assigned to provide support to a child, there had been a two year delay in statutory visits taking place. Manager review had not identified either the length of time the child was overdue a statutory visit or the drift in the implementation of child-in-care review decisions. In a further case the child had a history of placement moves, including a placement breakdown, with evidence of ongoing difficulties in the current placement, yet they were unallocated.

The records of another child, later confirmed with the case holder, indicated that they had been unallocated for over three years. Other children on the area's waiting list had not had a social worker for over a year. Two children remained unallocated despite Court Directions that they should not be unallocated for longer than four weeks. Increasingly, social work intervention was time-limited as over-stretched frontline practitioners tried to address gaps. One child's record indicated they had been allocated and re-allocated to four different secondary care workers over a period of eight months. Another child had experienced 13 different social workers over a period of five years. The impact of children not having a social worker for a significant period of time was also being raised in child-in-care and foster carer reviews. Team leaders were also increasingly pulled into directly managing complex cases. This in turn impacted on their capacity to develop and support their frontline teams and provide assurances of the quality of practice.

Senior managers provided strong leadership during what had been an extremely challenging period for the service area since the last inspection. They had focused their attention on delivering critical organisational priorities and were working to steadily build workforce capacity and capability, with mixed results to date. The regional chief officer had good oversight of the performance of the service area through quarterly regional risk management meetings and their supervision of the area manager. Service leaders were seeking to achieve better value from local resources through partnership working and sharing of expertise. Inspectors found some examples of well-established relationships with community and voluntary sector organisations that promoted innovative practice. Locality arrangements with the HSE were being strengthened, however, there was work required to ensure local provision

and access to specialist resources was sufficient to meet the diverse and complex needs of children in foster care.

Service area managers were working to implement ongoing service and practice improvements to address inequities in children's experiences, delays and gaps in service provision. Operational priorities included recruitment and retention of its social work teams, compliance with statutory regulations, addressing gaps in foster carer capacity, and strengthening its learning and development programmes. The service area had expanded its programme of audits, and had a range of systems in place for monitoring its performance. Management trackers were being actively used to improve identification of organisational pressures and risks. They were effectively used to help drive improvements in the area's compliance with regulations, the timeliness of aftercare assessments and plans, and for foster carer assessments and reviews.

Performance and risk-management arrangements were being continuously reviewed and strengthened. The service area's risk register was well-managed at a local and regional level, with good analysis of risks and their impact for children and the wider organisation. Contingency plans included clear actions to mitigate risks. The children-in-care register was routinely updated and reviewed by managers, with evidence of a recent action to strengthen recording of children's specific additional needs.

The NCCIS service lead provided good support to managers in their work to monitor compliance with statutory regulations. Monthly and quarterly data reports helped promote managers' oversight of organisational risks and trends. The service area reported it was 90% compliant with its child-in-care reviews. Some children who were unallocated experienced delays in their review taking place as they were reliant on secondary workers to undertake the planning and co-ordination. The process was also reliant on the availability of managers to oversee the process, including sign-off of care plans. Delays were being tracked through weekly checks at the time of the inspection.

The inspection history of the service area dating back to 2017, indicated a lengthy period of non-compliance with inspection standards. Tusla's Practice Assurance and Service Monitoring (PASM) team had undertaken one audit over this time. This was in relation to the area's support and supervision arrangements for foster carers which took place in 2020. Senior leaders advised that the capacity of this team had been stretched, with its programme of activity largely focused on child protection and welfare issues. This meant that the area's fostering services had limited opportunity to benefit from Tusla's wider monitoring and quality assurance systems, and relied heavily on its internal quality assurance arrangements.

The area manager had identified the need to strengthen the area's service development and quality assurance capacity. A new additional principal social worker post had been approved to enhance organisational capacity to deliver its service improvement plans. A suitable candidate had been appointed, but had not yet started work. The service area's annual programme of audits was informed by feedback from frontline teams and managers about their priorities for improvement. Findings and action plans were collated by relevant operational managers. A programme of repeat audits was in place where service performance indicated further improvement was required to ensure that progress was being sustained over time.

Inspectors reviewed the area's audit arrangements and found that they required further development to improve the focus on the quality of practice and provide assurance that relevant actions had been addressed in a timely manner. A recent audit of children in voluntary care identified that parental consent for 10 out of 85 children subject to these arrangements, required updating. However, the audit did not take account of the length of time voluntary care orders had been in place, or whether they continued to be in the 'best interests' of children. Inspectors also identified there was potential to combine audits to provide a more holistic picture of quality and risk.

The service area carried out a recent audit of safeguarding visits undertaken by secondary workers to establish their frequency, whether the approved recording template had been used, and whether relevant information was recorded on NCCIS. This audit indicated a continued lack of standardisation of practice. These findings were discussed at the children-in-care governance meeting and were attributed to inconsistencies in practitioners' use of the naming convention, rather than gaps in the required levels of activity. Inspectors found that the quality of safeguarding records where the practice template had been used was generally good, and provided a clear picture of children's views, observations of their presentation and quality of their relationships.

Managers recognised the risks associated with delays in recording and uploading key documents onto children's records. They had given agreement for practitioner 'shutdown' days to allow for uninterrupted time for children's plans and case notes to be kept up to date. Inspectors found in their review of children's case records that case management discussions were not always available or uploaded onto NCCIS. A recent management audit found that out of a random sample of 100 children's records checked, the majority did not contain case notes of all contacts with children or issues discussed in supervision in line with the expected standards of practice. Senior managers advised there remained a backlog of records still to be uploaded onto NCCIS.

Inspectors reviewed a total of 15 staff supervision records and found an acceptable standard of practice overall in the frequency of supervision for managers and qualified social workers. The supervision records of managers included discussion of audit findings and service performance, including waitlists, capacity pressures and team achievements. Children with complex needs and allegations or serious concerns against foster carers were also regularly discussed. However, records of supervision did not consistently adhere to the approved recording template which led to differences in the quality of records, including discussion of caseloads, professional accountabilities and actions. While there was evidence of supervision audits on some staff files, records did not provide sufficient analysis or challenge of the quality of supervision practice. Inspectors identified that caseload management tools had not been reliably used, with examples of the tool being copied and pasted over time, with no clear management actions noted or evidence of ongoing review of the impact of unmanageable caseloads.

The sample of supervision records included a social care worker's record. This record indicated that formal supervision had only occurred on a six monthly basis, although a log of brief additional records of informal case discussion with their team leader was also included in the supervision record. Given that social care workers were regularly carrying out key tasks for children who did not have an allocated social worker, this was not sufficient and did not comply with their supervision contract which indicated that supervision should occur a minimum of every eight weeks.

Inspectors reviewed a sample of five of the nine allegations and serious concerns about foster carers. Gaps and delays in processes from the point of notification, investigation, outcomes-reporting and feedback were evident in almost all cases. Senior managers and the FCC were working to strengthen their oversight of the end-to-end process. A tracker for appeals had been put in place to prevent future delays in the management of allegations.

The performance of the service area in the management of child-in-care reviews had continued to improve since the last inspection. Processes to reduce the incidence of cancellations and ensure the timely submission of draft care plans to the review chairperson had been strengthened. Children's records generally indicated that they had been supported to complete their 'Me and My Meeting' booklet. However, levels of attendance by children and young people at their reviews remained low. This meant that opportunities to help children speak up for themselves, a key skill in building their personal independence and resilience, were not being maximised.

An inspector observed a child-in-care review held via tele-conference. The child was not present and neither were their parents. The reasons for this were discussed at the meeting. Positively, the foster carer and school were actively involved in



identifying the additional support the young person required. Suggested changes to the child's care plan had clear and measurable actions.

Children's case records indicated 'placement at risk meetings' were overall managed well, and provided open and constructive discussion of escalating concerns about children's care needs and the capacity of their foster carers. In some cases, it was clear that the interventions had been effective, and had sustained relationships or prevented placement breakdown. The service area reported it had a total of nine placement disruptions in the last 12 months. Placement disruption meetings were effectively chaired by a principal social worker independent of the process. The involvement of and feedback from foster carers was an essential part of the review process. Placement disruption records had a strong focus on lessons learned, including review of the impact for the child. Some children had remained for increasingly lengthy periods of time in emergency care placements given the lack of long-term placements, and the service area had on occasion used foster carers that were not designated as emergency carers. The risks associated with these gaps in capacity were recognised by managers and were informing foster carer recruitment plans.

Inspectors found good levels of support and supervision provided to most foster carers, with effective use made of the approved recording template. Monthly audits of records of foster carers provided a clear picture of the quality of practice and of areas for further improvement. Inspectors found one foster carer record that showed a nine month gap in visiting where the children placed were unallocated and the foster carer review was overdue by five months. This had been viewed as a stable long-term placement, and capacity risks had not been adequately recorded in supervision with the fostering social worker. Inspectors found, as did local audits of foster carer records, that the quality of record-keeping on foster carer records was at times impacted by difficult to read handwritten records or cumbersome filing.

Service managers encouraged creativity and innovation in services, and had effective arrangements for partnership working with foster carers to help improve outcomes for children. The Brothers and Sisters Separated in Care Support (BASSICS) programme, provided good support to foster carers in their work to support children from large families placed in different foster care households. The programme offered a range of opportunities for bringing together siblings, and helped safeguard children's identity and culture. Inspectors observed one such meeting and considered that it provided an effective forum for celebrating the achievements of children and strengthening foster carer peer working.

Overall, the service area had clear service improvement priorities and a shared strategic direction for the management and monitoring of its foster care services. It

leadership and governance arrangements were being continuously strengthened, with examples of innovative practice. However, the ongoing gaps in its children-in-care workforce capacity adversely impacted on service continuity and the quality of care provided to children who remained on waiting lists for allocation to a social worker. Management oversight of the process for allocation and de-allocation of children required development and relied on children's records being kept up to date and that secondary workers benefited from regular supervision.

**Judgment: Moderate Non-Compliant**

## Standard 20 : Training and qualification

Health boards ensure that the staff employed to work with children and young people, their families and foster carers are professionally qualified and suitably trained.

The area judged themselves to be compliant with this standard. Inspectors did not agree with this judgment and assessed this standard as substantially compliant.

The gaps in the sufficiency of the area's workforce to effectively meet the needs of children in care are detailed in the previous standard. Local managers were well-supported by the regional chief officer and Tusla's HR team through approval of business cases for new or additional posts where its capacity was inadequate. Notwithstanding this, the area did not have sufficient staff at the time of inspection.

The service area had appropriate systems for An Garda Síochána (police) vetting and annual review of social workers' professional registration. However, checks made by HIQA with the National Personnel Record Office indicated there were gaps in employee records. This included CORU registration certificates for eight employees. Garda vetting was out of date for two staff, two records did not contain employee contracts and professional qualifications were missing on two records. These gaps were brought to the attention of the area manager at the time of the inspection who provided assurances in writing that gaps in centrally held records would be addressed.

The service area had an established programme of work to strengthen staff recruitment, retention and morale. Induction and the continuous professional development of staff was prioritised within its training and service improvement plans. The service area had undertaken a training needs analysis for 2022 and

maintained a management tracker of all training undertaken by its workforce. The area was working to deliver joint training with the HSE to help build relationships and a shared approach to the delivery of care for children with complex needs.

Managers prioritised staff care and wellbeing. The service area had an established 'Celebrating Kindness, Service and Teamwork' initiative that encouraged a caring work culture through promotion of positive behaviours and best practice. Wellbeing meetings sought to encourage new approaches to enhancing staff support and wellbeing. A team development wellbeing day had been recently held for children-in-care staff. Monthly reflective practice was offered to all fostering link social workers and children-in-care social workers, and was being extended to include the fostering assessment team. This was facilitated by a consultant who was involved in delivering the Therapeutic Foster Care programme.

The service area's management of performance and development reviews (PDRs) was not yet fully embedded. Inspectors found that the majority of supervision records reviewed did not contain up-to-date personal development plans. The service area had identified gaps in management training for nine frontline and three senior managers. The new area manager had prioritised the provision of coaching and significant programme of management development was being planned in partnership with Tusla's national office tailored to the specific individual and organisational needs of the service area.

The service area had a training strategy for the development of its foster carers, which recognised the value of programmes of joint training. It had recently piloted the 'Rupture and Repair' programme as an on-line training course involving both foster carers and social workers. This had been evaluated and was recognised as a positive development in enabling shared reflection on the challenges foster carers experience while caring for children. It helped inform strengthening of approaches for the management of unplanned placement endings. The engagement of foster carers was found to have worked well, but the engagement of social workers was recognised as an area for further review.

Overall, service managers recognised their responsibilities to promote safe recruitment and the ongoing learning and development of its workforce. Gaps in its performance development review arrangements and management development programmes were areas that required further work.

**Judgment: Substantially Compliant**

## Standard 21: Recruitment and retention of an appropriate range of foster carers

Health boards are actively involved in recruiting and retaining an appropriate range of foster carers to meet the diverse needs of the children and young people in their care.

The area judged themselves to be substantially compliant with this standard. Inspectors agreed with this judgment.

The service area had a clear vision and direction to support the recruitment and retention of foster carers. It focused on strengthening partnership working, ensuring foster families had a positive experience of caring for a child, and that relevant supports were in place for them and the children placed in their care.

The service area had a strong track record in placing the vast majority of children locally. Planning for placements ensured priority consideration was given to the identification of relatives as potential foster carers. This approach recognised the importance of children's relationships and identity. It also promoted continuity of school attendance and engagement in their local communities. Most foster carers commended the levels of contact and support they had received from fostering teams. At the time of this inspection, all foster carers (that had children placed with them) had an allocated fostering social worker.

Fostering teams recognised gaps in the diversity of its foster carer resources and were working to encourage greater interest and involvement from members of minority ethnic communities, including travellers. Other gaps in meeting children's needs included provision for babies and for children with complex emotional needs and behaviours or disabilities. The monthly review of the foster carer panel alongside placement committee discussions provided ongoing feedback about gaps in provision and foster carers' capacity and skills to support the best possible matching.

The service area had a comprehensive foster carer recruitment programme. The level and range of foster care recruitment activity undertaken by the service area was notable, and benefited from the involvement of foster carers and a care-experienced adult. Over 60 such recruitment activities had taken place in the past 12 months. Overall out of the 85 enquiries made, eight general and 20 relative foster carers had progressed to the application and assessment stage. The effectiveness and outcomes of recruitment activity was routinely evaluated and used to inform future campaigns. The service area had implemented trackers for the management of foster carer enquiries through to their approval by the FCC. This provided a clear picture of workflow from initial enquiry, through the provision of information, Garda vetting and other suitability checks. This also ensured effective monitoring of timescales for the

commencement and completion of assessments and for fostering foundations training.

At the time of this inspection, the service area had seven general foster carer assessments in progress. All were allocated a social worker who was accountable for presenting their report to the FCC. The relative foster carer tracker indicated that all 10 assessments in progress had been relatively timely, and all had an allocated social worker. Trackers evidenced appropriate management decision-making and recording of outcomes at all stages of the process for both relative and general foster carers.

Ensuring foster carers had good access to advice and support formed an integral part of its recruitment and retention processes. Key features included regular communication and home visits, a comprehensive monthly training programme co-delivered with an advocacy organisation and partner agencies, access to a two-year certificate in Therapeutic Foster Care, with additional targeted support from its directly provided and locally commissioned fostering support agencies. Social care leaders along with fostering social workers delivered 'New Beginnings' training to the birth children of foster carers. Foster care review recommendations highlighted an expectation that foster carers attended a minimum of six events, including support groups each year. Training in *Children First: National Guidance for the Protection and Welfare of Children (2017)* was recorded at almost 100%. The Self Care-Safe Care course aimed to promote good communication and teamwork in fostering.

Recent developments such as the 'Children who Foster' initiative helped recognise and reinforce the nature of the fostering task as a whole family commitment. This new group aimed to encourage peer support for children and young people who shared the common experience of having other children living in their home. Link worker records indicated regular checks were made of the views and experiences of birth children. For example, a meeting with one child to discuss their feelings about a placement ending recognised the importance of their relationship and the need for closure when the child moved on.

The service area had a total of 20 foster carers who had left the panel in the last year. However, only four foster carer exit interviews had been conducted, with some foster carers choosing not to engage in the process. An inspector sampled two exit interviews and found that the process effectively mapped the experiences of foster carers over time, and provided important feedback about what had worked well and areas of practice to strengthen.

Overall, the service area had a number of strengths in its approach to recruiting, training and retaining its foster carers. However, there remained gaps in its capacity to meet the diverse needs of children, particularly in the availability of emergency and

long-term placements. Foster carer exit interviews to inform wider organisational learning was an area for further improvement.

**Judgment: Substantially compliant**

## Standard 22: Special Foster Care

Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.

The area judged themselves to be substantially compliant with this standard. Inspectors did not agree with this judgment and assessed this standard as moderate non-compliant.

Tusla's national office had not yet developed specific policies or guidance on what was required in the provision of special foster care. The service area did not have any special foster care arrangements, and had not undertaken any recruitment campaigns to attract multi-skilled specialist foster carers. Service managers recognised gaps in its current arrangements, where as a consequence of not having sufficient skilled foster carers with capacity to provide high levels of intensive support, and some young children had been placed in residential care. These issues had been highlighted within the area's 'Need to Know' notifications.

The new area manager had conducted a review of children-in-care with high and complex needs and was working with the HSE to strengthen local approaches to joint commissioning and service delivery. A new regional therapeutic team was in the process of being recruited at the time of this inspection to enhance access to specialist support. These initiatives were still at a relatively early stage of development.

The service area had a growing number of bespoke foster care arrangements, some dating back many years, funded through Tusla's nationally approved process for enhanced payments. One-off payments were also made by Tusla for funding additional equipment or specialist services where there were gaps in assessments or awareness about a child's individual support requirements. These arrangements were experienced as disjointed, slow and protracted by frontline practitioners. Examples were given that despite children having met the criteria, significant additional detail was required about their day-to-day care costs. Foster carers also reported high levels of frustration and delays in what they experienced as a cumbersome process.

The identification of children’s diverse needs and co-ordination of their care was further impacted by their not having an allocated social worker. In the case of one child, there had been significant delay in progressing relevant assessments to identify the levels of support they needed to start school.

The sample of case records reviewed by inspectors of children with complex health needs and disabilities indicated foster carers overall were providing a high standard of care. Fostering support agencies provided important back-up support in helping foster carers develop routines and behaviour management strategies that worked best for the child. The service offered was good and could include weekly visits by a therapeutic fostering social worker who was able to work with children 0-13 years of age for extended periods of time. The service area also commissioned one-to-one support for older children with additional needs to help reduce placement pressures and enable them to engage in a number of activities outside the home.

Overall, the service area had some effective bespoke arrangements for children with complex needs. However, there remained gaps in foster care provision to meet the complex needs of children in care, including developing alternatives to residential care for younger children. Improvements were needed in the co-ordination of care for children who were unallocated, and in the area’s processes for accessing additional funding, including enhanced payments. Work was required by Tusla’s national office to provide clear guidance about alternative models of foster care, including special foster care.

**Judgment: Non-Compliant Moderate**

## Standard 23: The Foster Care Committee

Health boards have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards’ policies, procedures and practice.

The area judged themselves to be substantially compliant with this standard. Inspectors agreed with this judgment.

The membership of the FCC included experienced social work professionals and foster carers who understood their role and accountabilities for decision-making in line with Tusla’s policies, procedures and guidance. However, there were important gaps in its representation that it was working to address. The leadership of the FCC in the past

year had been impacted by absences of its chairperson, and the interim arrangements put in place had not been independent of the service, as required. This has now been addressed with the appointment of a new chairperson.

These gaps in capacity had led to delays in implementing planned improvements, which had been re-scheduled for later in the year. These included the delivery of training to FCC members and sharing of learning from evaluation of placement disruptions and foster carer allegations. Reporting of the outcomes of serious concerns and allegations to the FCC overall was not timely, and its arrangements for managing appeals required further review. The 2021 annual FCC report was incomplete and did not fully meet the reporting criteria in line with the annual Adequacy of the Child and Family Support Services report.

Over the past year, while attendance at the FCC meetings was in line with minimum requirements set out in procedures, gaps in membership included a representative with care experience, medical advisor and representation from community and voluntary care agencies. These gaps were recognised, and some were being addressed at the time of this inspection. Review of FCC members' personnel records indicated that all had received a letter of appointment, had up-to-date Garda vetting and had been briefed on their statutory accountabilities on their appointment to the role. The FCC had taken learning from previous HIQA inspections and had effective processes in place for ensuring foster carer assessments and reviews generally took place in line with the expected frequency and standards of practice. FCC members were responsive to the need for additional meetings to ensure timely approval of new foster carers.

The area manager had good oversight of the work of the FCC and its plans for improvement. Tusla's policy and procedures highlighted the need for independent review of the work of the FCC by Tusla's practice assurance and monitoring team. The committee's work had not been internally reviewed in recent years. The FCC had identified risks in ensuring Garda vetting for its members given that Garda vetting procedures no longer require FCC members to be vetted. An interim compromise had been reached by Tusla for FCC members to sign sworn affidavits<sup>5</sup> that they did not have offences that might make them unsuitable for the role.

The business of the FCC was well-managed by an experienced co-ordinator who ensured a high standard of planning and record-keeping. This included quality checks that all relevant information was in place for assessments, reviews and removal of foster carers from the panel. The co-ordinator assisted the work of the chairperson through their management of the panel of approved foster carers and maintained

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<sup>5</sup> A legal statement



trackers for long-term matches, disruption reports and serious concerns and allegations.

FCC members paid good attention to the assessment, matching and the approval of foster carers. The best interests of children were at the heart of decision-making. The area's use of interim assessment reports helped to promote consistent practice and guidance for fostering teams about the suitability of prospective foster carers. FCC meeting records highlighted appropriate use of challenge to prompt follow-up actions where there were delays or gaps in support for children or their foster carers. For example, the need to urgently progress access to therapy for a child, given this had been a recommendation made some time previously. Records of discussions also captured additional future supports that might benefit the foster carer or children in their care. The decisions made by the FCC were well-recorded. Recommendations were clear, had timeframes for action, and sought to learn from foster carers' experiences. Priority was given to the continuous development of foster carers' knowledge, skills and resilience.

The quality of assessments of foster carers awaiting committee approval was good, and indicated relevant checks of suitability had been made. A range of training was provided to foster carers undergoing assessment relevant to their particular needs and circumstances. There were relatively few foster carers overdue a review, and the reasons for delays were clearly recorded. The service area had identified a total of 80 members of foster carer households that required updates to Garda vetting and 10 foster carers were overdue their medical. These were being actively followed up, with updates regularly provided to the FCC.

The 2021 FCC annual report was still in a draft format at the time of this inspection. Additional work was required to ensure the report reflected and was aligned with priorities highlighted in wider service improvement plans and reflected essential information in relation to adequacy of local provision. Partner agencies and foster carers advised inspectors that they had little awareness of the activity of the FCC, and relatively few foster carers chose to attend in person.

Overall, the business of the FCC was well-managed, with a strong focus on meeting the requirements set out in procedures and regulations, with plans progressing well to strengthen its leadership and membership, however, the overall effectiveness and impact of its work was not always evident. Gaps in the delivery of its training and development plans, foster carer Garda vetting and medicals were areas for further improvement. The management of serious concerns and allegations against foster carers and appeals by foster carers required development.

## Judgment: Substantially Compliant

### Standard 24: Placement of children through non-statutory agencies

Health boards placing children or young people with a foster carer through a non-statutory agency are responsible for satisfying themselves that the statutory requirements are met and that the children or young people receive a high quality service

The area judged themselves to be substantially compliant with this standard. Inspectors agreed with this judgment.

Service managers sought to ensure statutory requirements for children placed with non-statutory agencies were met. This included ensuring foster carer assessment and review arrangements met the standards of performance set out in regulations, and that there was appropriate oversight of children placed in their care. The service area had relatively low use of non-statutory foster care agencies. At the time of this inspection, there were three children placed with two different agencies. One child was awaiting a placement and another children was in the process of transition to a new placement. Managers ensured the care delivered was in line with requirements set out within foster carer contracts and national service level agreements.

Inspectors reviewed two children's records and found that one child placed out of area had been without a social worker for over a month at the time of the inspection. Managers' recent review recognised the need for the child to be allocated. Prior to this, statutory and safeguarding visits had been made at an appropriate frequency in response to changes in the child's specific needs and circumstances. In another child's case, the risk of placement breakdown was effectively managed through fortnightly core group meetings involving the team leaders, frontline staff, foster carer and the child's guardian ad litem. Additional support had been provided as required, including access to therapeutic interventions and activity-based programmes, with an appropriate transition plan in place.

Service managers had recently met with non-statutory provider management teams and had received assurances that the FCC and local fostering teams would be informed about children placed by Tusla's other service areas in its locality. The annual meeting with private providers also tracked the outcome of referrals made to non-statutory foster care agencies over the past months. This reflected the capacity challenges also currently faced by non-statutory foster care agencies. In the case of

one agency, five placements had been secured from a total of 35 referrals made through the Placement Committee.

Overall, foster carer approval and review arrangements were in line with fostering regulations. However, wider social work capacity gaps also risked impacting on statutory work with children whilst they remained unallocated. Managers had appropriate oversight of providers' adherence to individual foster care contracts and service level agreements. Given the small numbers of children placed with non-statutory agencies' and their lack of capacity to respond to referrals from the service area, further consideration needed to be given to this sector's contribution within the area's future fostering strategies.

**Judgment: Substantially Compliant**

## Standard 25: Representation and complaints

Health boards have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including Complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.

The area judged themselves to be substantially compliant with this standard. Inspectors did not agree with this judgment, and assessed this standard as moderate non-compliant.

The service area had implemented Tusla's representations and complaints procedures for receiving feedback on the quality of its fostering services. This included the provision of child-friendly leaflets on how to make a complaint, with contact details of advocacy organisations available to assist. Frontline staff and managers recognised their responsibilities for the management of complaints. They had attended training in relation to their accountabilities for driving improvement in this area. However, the small number of formally recorded complaints about foster care services combined with feedback to inspectors from children and foster carers indicated there was work to do to build understanding, trust and confidence in the process and ensure complaints were actively used as a driver for improvement. The area's systems for reviewing and monitoring such feedback to help direct the delivery of its service improvement plans overall was under-developed.

The service area reported it had received 9 compliments and 10 complaints about its foster care services in the past year. These included four from foster carers, four from parents, and a further two complaints had been raised by a young person's advocacy organisation on behalf of parents. Two out of the 10 were excluded as the issues raised related to other agencies outside Tusla. In these circumstances, the person making the complaint was referred to the appropriate agency and their closed was promptly closed.

Inspectors reviewed six relevant complaints received at various points over the last seven months. Five were ongoing at the time of the inspection. All cases indicated contact and action had been taken to speak to and or meet with the persons making the complaint. The two complaints investigations nearing completion contained clear outcomes, with findings about why they had not been upheld, were partly upheld or upheld. Complainants were advised of their right to use the appeals process. Two complaints were being investigated outside the service area given their history or complexity, and one of these had been ongoing for over seven months.

Overall, the service area's capacity to manage complaints in line with the expected timeframes, required further review. Tusla's national monthly report for April 2022 indicated that the service area had 3 complaints (all services) that had were open for more than 12 months, five were for longer than nine months, and eight longer than six months. Letters had been sent to the complainants, in line with Tusla's procedures, advising them of the need to seek further extensions of time. Issues raised in complaints about foster care services included matters in relation to permanency planning for children, communication and access, and children not having a social worker.

There had been no complaints made by children and young people. Practitioners advised inspectors, that in line with Tusla guidance, efforts were made to address complaints at an early point, and informally where possible. Complaints and feedback from children about the quality of service they received was rarely noted on the sample of children's records seen. Only one record indicated that a child had verbally complained about the number of people from different departments visiting them. This had not been formally logged as a complaint. Further discussions with a frontline practitioner indicated that these concerns had been followed up, with agreement on the most appropriate person to visit and frequency. Further work was required to identify issues and themes raised by children and young people to inform wider service improvement activities.

The service area had recognised the need to encourage stronger feedback from children and had recently held a meeting with an advocacy organisation for children-in-care to help move the agenda forward.

The template used to record safeguarding visits to children included a prompt to discuss the complaints process with children. There was some evidence that this was being increasingly done. However, given the number who did not have an allocated social worker or who experienced visits from different secondary workers, children may not have been sufficiently aware or confident in the use of the complaints process. Most foster carers said they had been provided with relevant information on how to make a complaint, but a minority also said they would feel anxious about making a complaint. A few foster carers said they had benefited from support from an advocacy organisation in relation to their right to challenge decisions.

The service area had two designated complaints officers who fulfilled this role alongside other specific duties. The service area also reported good support from Tusla's regional complaints officer. Two principal social workers were accountable for investigating complaints alongside their other duties. The service area did not produce quarterly or annual complaints reports, and issues in relation to complaints were not routinely raised or recorded within area management meetings. These gaps in reporting, detracted from organisational learning about complex issues. There was limited evidence of tracking to ensure improvement actions had been effectively completed.

Overall, the service area had relevant policies and procedures in place to promote feedback from children, their families and foster carers. However the voice of children and local management capacity to investigate and learn from complaints required improvement. Investigation of some complaints were not timely. There was work required to embed learning from complaints within service improvement plans and also encourage feedback and wider learning about what was working well.

**Judgment: Moderate Non-Compliant**

## Appendix 1: National Standards for Foster Care (2003)

This thematic inspection focused on the following national standards that relate to the governance of foster care services.

Standard 18	Effective policies
Standard 19	Management and monitoring of foster care services
Standard 20	Training and qualification
Standard 21	Recruitment and retention of an appropriate range of foster carers
Standard 22	Special foster care
Standard 23	The Foster Care Committee
Standard 24	Placement of children through non-statutory agencies
Standard 25	Representations and complaints