Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Quality Authority Regulation Directorate monitoring inspection of Foster Care Services

Name of service area:	Waterford/ Wexford
Type of inspection:	Risk Based
Date of inspection:	25 – 28 July 2023
Fieldwork ID:	MON_0040502
Lead Inspector:	Hazel Hanrahan
Support Inspector(s):	Mary Lillis Lorraine O'Reilly Adekunle Oladejo

About this inspection

HIQA monitors services used by some of the most vulnerable children in the State. Monitoring provides assurance to the public that children are receiving a service that meets the national standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continual improvement so that children have access to better, safer services.

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)[1] and to report on its findings to the Minister for Children, Equality, Disability, Integration and Youth.

This inspection was a focused inspection of Waterford/Wexford service area to assess eight of the National Standards for Foster Care (2003). The scope of the inspection included standards 1, 2, 3, 6, 8 and 21 of the National Standards for Foster Care (2003).

Due to the risk identified during this inspection, it was decided to change the designation of the inspection from a focused inspection to a risk-based inspection and two additional standards were added during fieldwork (standard 5 and 19)

This inspection identified serious concerns about the capacity and sustainability of fostering arrangements in the Waterford/Wexford service area and the impact this was having on children.

[1] Tusla was established on 1 January 2014 under the *Child and Family Agency Act 2013.*

How we inspect

As part of this inspection, inspectors met with the relevant managers, child care professionals and with foster carers. Inspectors observed practices and reviewed documentation such as children's and foster carers' records, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data submitted by the area
- interviews with:
    - the area manager
    - the principal social workers for children in care
    - the principal social workers for the foster care service

- focus groups with:
    - eight social work team leaders
    - eight front-line staff

- observations of:
    - one access centre

- the review of:
    - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
    - staff personnel files
    - a sample of 33 children's' and eight foster carer records

- visits or phone calls with:
    - one child
    - two parents
    - four foster carers

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

Profile of the foster care service

The Child and Family Agency

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

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

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

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

Waterford/Wexford is one of the 17 areas within Tusla's Child and Family Agency. It is situated in the South East of Ireland, Waterford/Wexford area comprises of Waterford, Wexford and South Kilkenny and has a population of 280,260 (Census 2016). According to data published by Tusla in 2018, the service area had a population of 73,130 children aged between of 0-17 years. In Wexford, the area saw a significant increase in population in recent years especially in the Gorey area in the north which had seen large migration from the greater Dublin area. In Waterford, 21% of the population live in disadvantaged areas (national rate 14%). Wexford and Waterford are the fourth and fifth most deprived local authority areas in the country.

In Waterford, 58% of the population lives within 15km of the city and there is only one other large urban centre in the Dungarvan area. The rural county area has a deficit of services to meet the needs of the population. In Wexford, the population is more evenly spread across the county and services are delivered from four urban centers, Wexford Town, New Ross, Enniscorthy and Gorey. Wexford/Waterford are the fourth and fifth most deprived local authority areas in the country.

The area is under the direction of the regional service director for Tusla, South East, and is managed by an area manager. There are currently nine principal social workers comprised of:

- Principal Social Worker- Waterford Child Protection and Welfare
- Principal Social Worker- Wexford Child Protection and Welfare
- Principal Social Worker- Waterford Children in Care and Aftercare
- Principal Social Worker- Wexford Children in Care
- Principal Social Worker – Fostering across the area
- Principal Social Worker- Waterford Child Protection Conference Chair
- Principal Social Worker- Wexford Child Protection Conference Chair
- Principal Social Worker – Quality Assurance and Service Improvement
- Principal Social Worker – Child Abuse Substantiation Procedure across the area

The child protection and welfare teams, children in care teams and the foster care teams are based in offices throughout the service area, in both Waterford/Wexford. At the time of the inspection there were 364 children in foster care with 342 placed in the area. Of these 364 children, 9 were placed in private foster care placements. The number of children placed outside of the area was 22. There was also 56 children placed in foster care who had a disability. In addition, two children who were seeking international protection were placed in a foster care placement in the area.

The service area commenced a change project in June 2022 to restructure the teams in the service. The aim was to operate as a one area team so that children and families will receive a consistent and high-quality service. Also, to revise the structure of the teams to improve practice, leadership, governance and managerial oversight of the service. In addition, the change project would look to develop and implement an area wide practices that would improve consistency across teams. The change project is a three year plan that showcases this vision for change by breaking down the long-term objectives into smaller goals.

Compliance classifications

HIQA will judge whether the foster care service has been found to be **compliant, substantially compliant** or **not compliant** with the regulations and or standards associated with them.

The compliance descriptors are defined as follows:

Compliant: a judgment of compliant means the service is meeting or exceeding the standard and or regulation and is delivering a high-quality service which is responsive to the needs of children.

Substantially compliant: a judgment of substantially compliant means that the service is mostly compliant with the standard and or regulation but some additional action is required to be fully compliant. However, the service is one that protects children.

Not compliant: a judgment of not compliant means the service has not complied with a regulation and or standard and that considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk-rated red (high risk), and the inspector will identify the date by which the service must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of children using the service, it is risk-rated orange (moderate risk) and the service must take action within a reasonable time frame to come into compliance.

This inspection report sets out the findings of a monitoring inspection against the following standards:

National Standards for Foster Care		**Judgment**
Standard 1	Positive sense of identity	Substantially Compliant
Standard 2	Family and friends	Substantially Compliant
Standard 3	Children's Rights	Not Compliant
Standard 5	The role of the social worker	Not Compliant
Standard 6	Assessment of children and young people	Not Compliant
Standard 8	Matching carers with children and young people	Substantially Compliant
Standard 19	The management of the foster care service	Not Compliant
Standard 21	Recruitment and retention of an appropriate range of foster carers	Substantially Compliant

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
25 July 2023	9:00hrs to 17:00hrs	Hazel Hanrahan	Lead Inspector
25 July 2023	9:00hrs to 17:00hrs	Mary Lillis	Support Inspector
25 July 2023	9:00hrs to 17:00hrs	Lorraine O'Reilly	Support Inspector
25 July 2023	11:00hrs to 17:00hrs	Adekunle Oladejo	Support Inspector
26 July 2023	9:00hrs to 17:00hrs	Hazel Hanrahan	Lead Inspector
26 July2023	9:00hrs to 17:00hrs	Mary Lillis	Support Inspector
26 July 2023	9:00hrs to 17:00hrs	Lorraine O'Reilly	Support Inspector
26 July 2023	9:00hrs to 17:00hrs	Adekunle Oladejo	Support Inspector
27 July 2023	9:00hrs to 17:00hrs	Hazel Hanrahan	Lead Inspector
27 July 2023	9:00hrs to 16:00hrs	Mary Lillis	Support Inspector
27 July 2023	9:00hrs to 17:00hrs	Lorraine O'Reilly	Support Inspector
27 July2023	9:00hrs to 16:00 hrs	Adekunle Oladejo	Support Inspector
28 July 2023	9:00hrs to 17:00hrs	Hazel Hanrahan	Lead Inspector
28 July 2023	9:00hrs to 13:00hrs	Lorraine O'Reilly	Support Inspector

Children's experience of the foster care service

Children's experiences were established through speaking with one child at their foster care placement, parents and foster carers. The review of children and foster carer case files, complaints and feedback also provided additional information on the experience of children in foster care.

Hearing the voice of children is very important in understanding how the service worked to meet their needs and improve outcomes in their lives. However, for 131 children they were awaiting allocation to a social worker. Of the 131 children without a social worker, 28 of these children had a mild to profound disability. The impact was that a child's opportunity to be seen and heard was lost along with seeing if they were safe and their needs were being met in line with their best interests. For some children their stories have been told below:

- A one year old child placed in foster care had not been seen by a social worker in ten months.
- A child aged eight years old was last seen by a social worker two years prior to the inspection.
- A child aged 12 years old had not been seen by a social in a year.
- A 14 year old child with a profound disability who was non-verbal in communication had not been seen by a social worker in over a year.
- A child aged 16 years old with a diagnosed disability had not been seen by a social worker in over a year.

For this inspection, children were asked by a social worker if they wished to speak with inspectors about their experiences. Children were provided with the freedom to choose to participate or not. Inspectors spoke with one child in their foster care home and also observed access arrangements with a child and their parents.

One child was visited in their foster home by an inspector, and it was clear that the child's rights to play, recreation, education and to be heard was a natural part of their life. The child showcased their skills in how they had made different objects from wood by shaping and carving the pieces. The child talked through the different pieces they had created and how they had used them as decorative and useful items in their bedroom. The inspector found that woodwork had created an outlet for the child to express their creativity and imagination.

The child spoke positively about their foster carers, to the inspector. They said that the foster carers had helped them to realise their sporting interests by taking them to and from activities and by also purchasing them the necessary equipment. The relationship between the foster parents and the child appeared effortless in their exchanges in

front of the inspector, with the child appearing at ease, smiling, laughing and engaging in conversation. The child told inspectors that they had recently been allocated to a social worker and that they "liked them". The child said that their social worker had visited them at their home and that they had showed them the different rooms in the house. The child told inspectors that they:

- were "happy at home"
- talked of being 'nervous' about returning to school and the different options of classes they might take
- enjoyed playing online gaming with their friends and that.
- if they had any worries that they would talk to their foster carers.

The inspectors spoke with three foster carers who provided negative feedback on their experience of the service.

- "no social worker for three years"
- "never felt we were given support"
- "no support or advice given' for child with disability"
- "no one advocates for us"
- "left all at sea by ourselves"
- 'felt that we "are babysitters for Tusla"
- "no support, I've been critical of that".

The foster carers also had mixed feedback in their experience of working with social workers:

- "New social worker keeps saying not going to be on board for long ... just filling a gap ... what's the point of social worker getting to know the child"
- "Social worker gave [foster carers] a book to read to [the child] to explain about how families are different and their identity"
- "Social worker was fantastic to build up the relationship with the child and us around supervised access"
- Foster link social worker "knows when to be there to give support, doesn't overcrowd us".

The foster carers described the impact of not having a social worker on children:

- "So many changes with social worker – had three different ones"
- "All three children have no social worker"
- "think it's so bad for children that they don't have one face who sticks with them the whole way"
- "the children don't know who their social worker is ... they have no consistency"
- "Sense of no permanency with social worker".

The inspectors spoke with two parents to listen to their experiences of the service in relation to contact with their child. The parents described the service as:

- "supervised access has been good"
- Tusla do not have enough places for children
- Parent has never been to the foster care placement and don't know if it promotes the child's sense of identity and rights
- Parent said they are not getting enough information about their child.
- Parent attended the child-in-care review and was able to contribute to the meeting.

Summary of inspection findings

Tusla has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in foster care require a high-quality service which is safe and well supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This service was initially inspected as part of a routine focused foster care inspection that looked at how children rights were respected and promoted in the area. However, due to risks identified on inspection, inspectors also reviewed the governance and management of the service and the role of the social worker.

Prior to the inspection, the service area submitted a self-assessment questionnaire (SAQ) of its performance against the six selected standards, as outlined in the initial inspection programme (standards 1, 2, 3, 6, 8, 21). Local managers rated their performance as substantially compliant in the eight standards. Information was not requested on standards 5 and 19 prior to the inspection. The SAQ provided analysis of organisational priorities and areas of practice they had implemented and were working to continually improve; these will be further commented on in this report.

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

- four standards were substantially compliant and;
- four standards were not compliant.

The inspection found that Tusla was operating a service that was crisis driven against the backdrop of staffing deficits and had been since the previous inspection in 2022. The governance and oversight of services provided to children and foster carers

remained inadequate and required significant improvement. Tusla did not have in place, effective interim measures to address the risks found on inspection that had already been identified by Tusla, to provide a safe and effective service to children in care. The monitoring and reviewing systems in place for children-in-care required attention to ensure the effective translation into practice of risk management strategies.

The inspection found that not all children-in-care had an allocated social worker and that significant improvement was required in statutory visits being undertaken in line with regulations. In addition, significant improvement and action was needed by Tusla to ensure that child-in-care reviews were held in line with the Child Care (Placement of Children in Foster Care) Regulations, 1995 regulations, as there were significant delays for children-in-care, in particular those who had disabilities. As a result, not all children in care were supported to express their views, wishes and feelings to inform the planning of their care. It was also found that case records required significant improvement as gaps were identified, with some case records missing from the case management system. This practice did not adequately promote the recording of the child's journey through care.

The service had and were experiencing staffing deficits across the service and the management of these risks were poor despite these being identified and risk escalated to the national office. There were no effective interim measures in place to mitigate against these risks. Tusla had identified the risks to the delivery of service that related to staffing deficits and practice improvements and had approved a change project to restructure the service. A long-term plan was put in place through a restructuring of the service. However, there was an over reliance from Tusla on the change project to respond to the presenting needs of children-in-care, as a result the area did not effectively manage urgent risks. It was recognised that staff challenges was a barrier to the successful implementation of the change project and that no immediate relief was going to be seen in the short-term.

Quality assurance required improvement as it was not effective in evaluating, identifying, consolidating strengths and addressing weaknesses. Quality assurance audits and trackers identified shortcomings in the management of unallocated children in care and child-in-care reviews but despite this – effective action was not taken to address these. Furthermore, no consideration or monitoring on whether the foster placement was continuing to be appropriate and meeting the needs of the child was taking place.

The inspection found ineffective governance, oversight and management of children awaiting allocation to a social worker. This was escalated to the interim regional chief officer in Tusla through a provider assurance report. The response received was not

satisfactory to address the concerns surrounding these system risks, and did not adequately outline steps to ensure that the service area was brought into compliance with the standards. As a result a cautionary provider meeting was held with the interim regional chief officer on the 22 August 2023. Subsequent assurances provided were not satisfactory and the risks were escalated to the interim national director of services and integration where a warning meeting was held on the 25 September 2023. Assurances received from Tusla following the cautionary and warning meetings were not satisfactory in respect to standard 5.

Although Tusla had systems and tools in place to promote children's rights in terms of family contact, promotion of their identity and their right to be heard, the impact of staffing deficits and service instability did not ensure that all children were supported equally. Tusla promoted protecting family relationships for children-in-care and had established a youth participation forum that provided a platform for children to have a voice and to be part of service improvement and planning. Improvement was needed from Tusla to meaningfully listen to and hear the voices of children-in-care and to ensure that their identity and right to family contact was promoted and realised. Specific attention was needed for children who were awaiting allocation to a social worker and had a disability.

Assessment of children's needs were required improvement. Staffing deficits impacted the effective implementation of Tusla's model of care in the assessment of children's needs. In addition, not all assessments were informed by the voice of the child.

It was clear that staff had worked hard through a difficult period, since September 2022 to the time of the inspection, whereby due to staff and service instability, the area had competing priorities and had difficulties in meeting the needs of children-in-care. The impact of staffing deficits and the shortage of foster carers impacted on the successful matching process of children-in-care to foster carers. It was found that a child's identity was central to the decision making when matching took place. Tusla were proactive in their approach to place children with their relatives where possible if it was in the best interests. Overall, there was good practice was seen in identifying suitable foster carers for children-in-care and of interagency working between service areas with foster carers.

Standard 1: Positive sense of identity

Children and young people are provided with foster care services that promote a positive sense of identity for them.

The service area rated its performance against this standard as substantially compliant and inspectors agreed with their judgment.

Overall, the inspection found that improvement was needed in the promotion of a child's identity in foster care who were awaiting allocation to a social worker. In addition, weaknesses were identified in the promotion of children's disability as part of their identity and this required further improvement. There was good practice whereby children's identities was central to their care plan and this formed a key part of planning to ensure that children were aware of who they were and that they were aware of their family background.

Tusla's assessment process of children's care planning provided important information to fully understand the child's identity before making decisions. Data received prior to the inspection indicated that Tusla had placed 312 children with foster carers of the same cultural, ethnic or religious background. This supported the promotion of children's identities to be nurtured.

A review of Tusla matching documents showed that a child's identity was central to decision making when matching a child in care with a foster carer. The matching process took into account different factors related to a child's own personal circumstances such as religion and cultural background. This ensured that the foster carers understood the child's faith and cultural identity, and had the capacity to ensure that the child was supported to achieve good outcomes. Tusla had placed 26 children in relative foster care and 65 children were placed in foster care within their own community. This helped keep children-in-care connected with their siblings and their local communities. The impact of this is it supported the child's need for safety, well-being and to continue their family traditions.

Tusla, where possible, placed children together with their relatives if it was in the best interests of the child and in line with the assessment. Tusla could not always guarantee that siblings could be placed together based on their individuals needs and the capacity and capability of the foster carers. The decision-making was reflected in the matching and placement planning meetings held by Tusla.

In all cases reviewed they showed that foster carers promoted the continued development of a child's identity in partnership with parents and social workers when it came to food and religious ceremonies. Evidence was found in some files, where life story work was carried out or was in the process of being initiated to

help a child understand their journey through care and their family dynamic. Life story work offered a child a safe space to start to understand and accept their history and to move towards the future. Staff and foster carers were aware of the importance of a child having a strong identity in supporting them to be confident in who they are.

However, for 131 children in care who were awaiting allocation to a social worker there were ineffective monitoring and oversight of the child's foster placement. As a result, Tusla did not have insight into whether the foster carers were supporting the development of a positive sense of identity for the child. Furthermore, it was not known if the foster carers provided opportunities to develop positive relationships and friendships for the child as the child's care was not being reviewed regularly. Out of the 131 children, 28 of these children in foster care had a disability and some had significant gaps in statutory visits and child-in-care reviews were not in line with the regulations. The impact was that Tusla could not ensure that the appropriate arrangements were continuing to be made to meet their needs as part of respecting the child's identity. This is discussed in more detail further in the report under standard 5.

A child's disability is a part of their identity and there was mixed evidence of how Tusla promoted this in practice. Evidence was found where Tusla linked children and foster carers with services that supported, embraced and affirmed their abilities. This related to access to assessments and educational needs and learning new means of communication. However, for 28 children with a diagnosed disability, awaiting allocation to a social worker, Tusla were limited in the support they provided to them as their child-in-care reviews were not in line with regulations and there were significant gaps in when they were last visited by a social worker. This in turn impacted on Tusla's ability to ensure children's identities were promoted. The service did not provide children with a disability with a consistent service which acknowledged there vulnerability.

It was found that when child-in-care reviews occurred that the child's identity was recorded and how this was being met in their foster care placement. In addition, any family events and family occasions were recorded in the child-in-care review and in statutory visits undertaken.

Further work was needed in the promotion and development of children's identity when placed in foster care. Although Tusla had systems and tools in place to promote and undertake this work, the impact of staffing deficits and for some children-in-care not having an allocated social worker did not ensure that all children were supported equally. Further improvement was needed to ensure all children were able to benefit from any opportunities to develop their sense of identity. For these reason this standard was deemed substantially compliant.

Judgment: Substantially Compliant

Standard 2: Family and friends

Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.

The service area rated its performance against this standard as substantially compliant and inspectors agreed with this judgment.

Overall, the inspection found that the service promoted the rights of children to maintain contact with their family and their siblings while in foster care placement. The service also had in place two access teams to support supervised contact for children with their families. However, there were 131 children awaiting allocation to a social worker, this impacted Tusla's ability to ensure that contact with children and their families were prioritised and maintained.

The access centre was managed by an access manager who had a team of social care workers. One access centre was observed as part of the inspection and was found to be child centred that provided a safe space for supervised access to take place. The access centre provided a number of opportunities for a family to copy family life through a range of activities that included play and preparing meals together. Family access was supported by foster carers, social care workers and social workers who took children to and from the identified location.

The inspectors were provided with an observational opportunity to view an access centre where supervised contact is arranged between a child and their parent(s)/guardian to maintain their relationships. The centre was decorated in a child friendly way, with age appropriate toys, seating area and educational material for children of all ages. The centre was also equipped with an outdoor garden that provided further opportunities for children to engage in play. This was to help the children to communicate, to understand and process their emotions. The centre was made up of a number of different rooms which had their own function. For example; a parenting room and a sitting room. The centre was also furnished with a kitchen showing the importance of family bonds and how families often gather in the kitchen to socialise, eat and cook together.

Data provided prior to the inspection indicated that there was 83 sibling groups in foster care in the service area. In addition, there was 44 children placed together in general foster care, 25 children placed together in relative foster care and seven children who were not placed with their siblings contrary to their assessment.

Good practice was seen where Tusla promoted protecting family relationships and bonding with children-in-care. In one case, Tusla promoted the right of the birth mother to breast feed her child who was in a foster care placement. In a second example, Tusla supported and facilitated the transport of food to the foster care placement. This in turn promoted what was in the best interests of the child in terms of health benefits to meet their developmental milestones. In another example regular discussions were had to ensure that sibling access was maintained to nurture their bonds. This ensured that the children's right to maintain family ties were not lost in the care planning process.

However, a number of deficits were identified in assessing Tusla's compliance in implementing the rights of children to maintain family relationships. There were 131 children awaiting allocation to a social worker, there were significant gaps in child-in-care reviews and statutory visits were not being undertaken in line with legal requirements. This in turn would impact the services ability to monitor and ensure that the child and families right to maintain and develop family relationship was being realised. For these reason this standard was deemed substantially compliant.

Judgment: Substantially Compliant

Standard 3: Children's rights

Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and their views, including complaints, heard when decisions are made which affect them or the care they receive.

The service area rated its performance against this standard as substantially compliant however, inspectors did not agreed with this judgment and found the service area to be not compliant.

Data provided as part of the inspection indicated that there were 131 children-in-care awaiting allocation to a social worker and that 28 of these children had a disability. The impact of this was that Tusla were not operating an appropriate foster care system for children-in-care that worked towards children's best interests. Although Tusla put in place social care workers to carry out support visits to some children-in-care, these were not found to be happening on a regular basis and were more crisis driven. Every child-in-care's right to have an allocated social worker was not realised which in turn impacted on their right to have their views heard when decisions about their care were being made.

Concerns regarding the quality and safety of care being delivered to children was identified on inspection. These concerns related to significant gaps in statutory visits

being completed and the child's care needs being assessed effectively. Children who are awaiting allocation to a social worker have the same rights as any child, to have a voice and to participate in any decisions about their care planning that may affect them. However, Tusla were failing children who were awaiting allocation to a social worker in realising their rights as a child to equal treatment. For a child who had a severe disability they were last seen by Tusla ten months prior to the inspection. In another case, a nine year old child with a disability had significant gaps in statutory visits with the child not seen by a social worker in one year at the time of the inspection.

An audit carried out by Tusla in June 2023 found that for the 192 children-in-care in the Waterford area, 70% of children did not have a statutory visit that was in line with requirements. This was broken down into;

- 29 children were overdue less than three months,
- 52 children were overdue less than six months,
- 33 children were overdue between six and 12 months and;
- 20 children had no statutory visit recorded or was overdue by more than a year.

A tracker in operation by Tusla had identified that there were 139 children whose child-in-care reviews were significantly outside the statutory requirements. Children's right to have their voice heard when people are making decisions about them or about something that would affect their care planning was not happening. The child's views could not be included in the assessment of the child's best interests at this forum as they were not taking place for all children. As a result of child-in-care reviews not being in line with statutory requirements, this meant that for these children they did not have an up-to-date care plan, with actions to meet their needs. The impact was that actions were not monitored or reviewed in a timely manner to ensure the best interests of the child were paramount.

Furthermore, Tusla's national approach to practice was not fully implemented to ensure that a safety approach was undertaken. Instead Tusla's approach was crisis driven and there was a lack focus on continually assessing a child's safety throughout their time in care. Some children were considered to be in stable foster care placements and ongoing assessment of need was not being undertaken.

Further improvement was needed from Tusla to meaningfully listen and hear the voices of children with communication, speech and language needs to gain insights into their experiences as this was limited or not happening. Inspectors found that not all children with disabilities and or additional needs attended their review as not all child-in-care reviews were occurring in line with statutory requirements. Further work was needed in this area, to ensure that the views and feelings of children with complex needs were heard, to actively shape the support available to them. For example, a case reviewed indicated that a child with communication needs was not

supported by an independent advocate who had the appropriate expertise of the child's communication needs. Further improvement was needed from Tusla to provide a range of approaches and alternative means of communication to understand the child's communication style. This would in turn provide a space for the child to be visible, to be heard and to participate in the world around them and the decisions made about their lives. In addition, further improvement was needed in the training of staff in the use of alternative approaches to communicate effectively when working with and for children with a disability and those with communication needs. Children with disabilities have the right to have information adapted to their needs, as well as the right to freely express their views.

Good practice was seen in a case where the child was diagnosed with a severe sensory and hearing impairment, and the child was learning to communicate through a manual sign system used by children and adults with an intellectual disability and communication needs. The foster carers supported the child to undertake this system.

Tusla had established a youth participation forum for children-in-care that provided a platform for their voice to be heard in service planning. The forum had scheduled six meetings for 2023. Three of these meetings were reviewed and it was found that the experiences of these children were documented in relation to the topics of care planning and the care review process, bullying, impact from change in placements and photography workshop. Actions from these forums were documented and feedback presented to the child-in-care teams.

Although Tusla had a forum in place to hear the views of children-in-care in order to help shape service delivery, Tusla's approach to practice was crisis driven. Tusla had a significant number of children-in-care whose child-in-care reviews were not in line with statutory requirements. In addition, there were a number of children whose statutory visits by a social worker had not occurred. The impact of this was that Tusla were not able to ensure that all children in foster care voices were heard or that they received a service that continually assessed their placement to rigorously review their safety. For these reasons the area was judged to be not compliant.

Judgment: Not Compliant

Standard 5: The role of the Social Worker

There is a designated social worker for each child and young person in foster care.

From the inspection, it was found through documentation and interviews held, that the area had experienced a number of social worker vacancies on the child-in-care team for much of 2022 and that continued into 2023. At the time of the inspection there were 18 vacant positions on the child-in-care teams that included the roles of team leader, social worker and social care worker. Managers recognised that the service would not be able to respond to the needs of children-in-care in a timely manner, statutory visits would not be in line with legislation, care planning and access to therapeutic support would be delayed, along with increased risk of placement breakdown. In an attempt to manage this situation, the area manager had put in a number of measures such as utilising fostering link workers to meet with children in their foster placements, allocation of social care staff and a change project to restructure the fostering service.

Tusla had a standard operating procedure in place for the management of children who were awaiting allocation to a social worker. The aim of the policy was the implementation of safe and effective services for children in care when impacted by staffing deficits. A duty system to manage children awaiting allocation to a social worker remained in place at the time of the inspection. Tusla did not have effective oversight of unallocated cases and the procedures in place to review unallocated cases. Factors that may have increased risk such as new information was not re-assessed and considered. Moreover, the policy in place was ineffective, as the risk associated with children awaiting allocation to a social worker was not always monitored successfully to combat against risk of 'drift' in these cases. Professionals such as a social care worker, social worker and social work team leader were assigned to work with children awaiting allocation only as the need arose. This was not in the best interests of children-in-care.

As already outlined, 131 children were awaiting allocation to a social worker at the time of the inspection. Inspectors reviewed 14 children's case files for the purpose of reviewing the management of children awaiting allocation to a social worker. Information reviewed as part of the process identified concerns in relation to nine cases regarding the quality and safety of care being delivered to children. Visits by a social worker to all nine children was not in adherence to statutory requirements with some having significant gaps. Six of the nine children had a diagnosed disability with one child being non-verbal in communication. For one unallocated child their most recent statutory visit by a social worker was in July 2022 and previous to this the child was seen in October 2021. In another case the child's statutory visit was overdue by eight months. In another example there were significant gaps identified in statutory visits by a social worker with the last recorded to have taken place in June 2021.

In addition, five out of nine of the children's child in care reviews were overdue by between one and three years. It is the responsibility of Tusla to ensure that children are seen on a regular basis, that the plan for the child is being progressed in a timely manner and that good communication is maintained between the child, family and professionals that are involved in their care. However, this was not occurring for all children. The impact was that for five children who were awaiting allocation to a social worker, therapeutic intervention and permanency planning was put on hold.

Inspectors reviewed 25 children's case files for the purpose of reviewing the timeframes of statutory visits over twelve months prior to the inspection. Of the 25 children's files sampled by inspectors, it was found that seven of these children in care were being visited in line with national standards. However, for 18 children the frequency of statutory visits was not in line with regulations. Out of these 18 children, six children were not allocated to a social worker and two of these children were placed outside of the area. Three of the six children not allocated to a social worker had a disability and or additional needs. For three children there were significant gaps between visits that ranged from eight, nine and 10 months. Inspectors reviewed eight cases of which children were aged two years and under. These case files were reviewed for the purpose of statutory visits. It was found that only 50% of these vulnerable children were seen by a social worker in line with legal requirements which meant that the vulnerability of children/needs was not factored into the system of review.

Inspectors reviewed 20 children's case files for the purpose of reviewing the timeframes of child-in-care reviews over twelve months prior to the inspection. Out of the 20 case files reviewed 11 child-in-care reviews were not in line with statutory requirements. Nine child-in-care reviews had been conducted in line with statutory requirements. Tusla had a child-in-care review tracker in operation and this was reviewed by inspectors. The tracker had identified that there were 139 children child-in-care review were significantly outside the statutory requirements. This data was further broken down into the years the last statutory child-in-care review was due to be completed for these children:

- 10 in 2021
- 44 in 2022
- 85 in 2023

The impact of the significant delay in the above child-in-care reviews for children in care may result in significant changes and life event or where a significant change to the child's care plan is required would not have taken place.

From the inspection findings, HIQA brought 23 cases to the attention of the management. Assurances were sought regarding the risks being appropriately recognised as it was found that the assessment of their needs was not timely. The response received was not satisfactory and a cautionary meeting was held with Tusla on the 22 August 2023. Followed by a warning meeting on the 25 September 2023.

Inspectors found that Tusla had introduced a stable cases team as part of the children-in-care teams in line with the restructuring of the service area. This team had been established to provide a structure for tasks to be completed such as statutory visits and child-in-care reviews as and when required. The stable cases team was in its infancy stage having commenced in April 2023 and therefore, it was difficult to assess its impact on improving outcomes for children.

Eight cases of children aged two years old and under were reviewed to examine the quality of oversight in planning and making decisions about their care. Six of these were allocated to a social worker with two children aged one years old was awaiting allocation to a social worker. Good practice was found where oversight of the case provided a clear summary and rationale of Tusla's involvement in the child's life and decision-making. In two cases reviewed there was good recording of assessment made where siblings were not placed together in the same foster care placement. This practice promoted future understanding for the child about their journey and how decisions were made about the life. There was good recording of observational opportunities by social workers of children as they interacted with their surroundings and their foster carers and how children were meeting their developmental milestones. However, in one example recording of information on a child's file was copied and pasted from the previous record and in another example there was one line description documented. This practice did not promote the monitoring of progress in a child's case to ensure that the desired outcomes are achieved.

Concerns remained regarding the absence of case records as evidence that statutory visits and other work had occurred. Inspectors found that there was inconsistency in the quality of recording statutory visits across the different teams of social workers. There were examples found where statutory visit records were not always up to date and did not always influence the next steps in the child's care planning. In addition, statutory visit records were missing from Tulsa's case management system (TCM). For a child who was non-verbal in communication, their case record was not kept up-to-date, the file had significant gaps in recording, and it did not provide a chronology of events through the child's life.

Evidence of audits undertaken by the child–in-care team and the fostering team were reviewed. This will be discussed further under standard 19. The audits found that Tusla were not delivering a safe, timely and child focused service that improved the quality of outcomes for children. Audits undertaken by the child-in-care team in February and March 2023 identified interventions and actions to be completed. However, at the time of the inspection the majority of these interventions and actions remained outstanding. The audits identified that needs and risks had been recognised and not responded to over time and that it was impacting on current outcomes for children. In one case the child was awaiting allocation and their child-in-care review was last conducted in 2019. In another case the child was awaiting allocation to a

social worker, had not been seen by a social worker in over a year and their child-in-care review was two years overdue.

Inspectors found that children in care continued to face changes in their social worker. In two cases the child's social worker had changed three times whilst in another case, the child had no social worker for three years. The impact is that frequent changes in social workers are associated with a lack of trust among children in care.

Evidence was found where access visits with siblings and family members were encouraged and supported by the foster carers. The access centres aimed to ensure ties remained strong and intact where possible. There was also good use made of professionals meetings to plan family access and determine the need for long-term care, and cases were brought to the complex case forum for further support and direction. There was evidence that enhanced payments had been made available to the foster carers.

The inspection found that significant difficulties had and were being experienced by Tusla that impacted the services ability to meet the national standards and regulations. The instability in staffing and the high number of staff vacancies continued to negatively impact on the quality of support provided to children in care, with statutory visits and child-in-care reviews at times significantly outside of regulations. Not all children-in-care were allocated a social worker, and the systems of oversight of unallocated children-in-care required significant improvement. The majority of children's records contained gaps and key case notes and activities were not recorded on the case management system. For these reasons the area was judged to be not compliant.

Judgment: Not Compliant

Standard 6: Assessment of children and young people

An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

The service area rated its performance against this standard as substantially compliant. However, inspectors did not agreed with this judgment and found the service area to be not compliant.

Overall, individual assessments of children's needs were required improvement. Staffing deficits impacted the effective implementation of Tusla's model of care in the assessment of children's needs. Foster care reviews that form an essential part of the assessment of children's needs in foster care placement was placed on hold for one year. Therefore, ongoing review of the foster carer's ability to meet the needs of the

child was not undertaken. Also for 139 children their child-in-care reviews were significantly out of date and as a result did not provide an ongoing assessment of their needs. In addition, not all assessments were informed by the voice of the child. However, good practice was seen in the quality of assessments undertaken for children placed in emergency foster care placements.

Tusla's model of care is the primary approach in the assessment of children's needs and is grounded in partnership and collaboration with children, families and the wider networks of support. This was not effectively being implemented against the backdrop of staffing deficits, resulting in assessments being significantly overdue.

Data submitted prior to the inspection indicated that the number of children placed in a foster care placement in the 24 months prior to the inspection was 108. It also showed that 26 assessments were completed within six weeks following an emergency placement in foster care in the previous 24 months. Three emergency placement case files were reviewed to determine the quality of the assessments undertaken. All children were placed in relative foster placements and had good quality care plans in place. Two of the children had a diagnosed disability. In one example; a child with a disability was placed with unapproved relative foster carers without evidence of a robust assessment or checks undertaken. The statutory visit assessed that the relative foster carers did not have the capacity to care for the child long-term however, this was a recent placement and further work was being undertaken.

All children placed in relative foster placements had good quality assessments in place. Six case files were reviewed where there was good evidence of assessments that looked at maintaining siblings in the same placement, discussion around health needs and therapeutic intervention and the support to be provided. These assessments were carried out through child-in-care reviews and/or statutory visits.

Two of the children had a diagnosed disability. In one example; a child with a disability was placed with unapproved relative foster carers without evidence of a robust assessment or checks undertaken. The statutory visit assessed by Tusla that the relative foster carers did not have the capacity to care for the child long-term however, this was a recent placement and further work was being undertaken.

Social workers used a variety of tools to inform their assessment of a child or young person's care needs. The child-in-care review provided one platform for each child-in-care interests, strengths and needs to be assessed. However, as discussed previously in the report, for 139 children-in-care in foster care their child-in-care reviews were significantly outside the statutory requirements. Of the 11 case files reviewed, five were identified where the child had a disability whose child-in care review was overdue. Some of whom had difficulties in communication. As per Tulsa policy, assessments undertaken by a social worker must be informed by the views of the

child and a child's wishes and feelings must be sought regarding the provision of services to be delivered. However, for these children this was not taking place.

In the foster care committee (FCC) Annual Report 2022, it was identified that the timescale for presentation of general and relative foster assessments to the FCC was a concerns as it 'fell well outside' the requirements of standards and procedures. In addition, the report documented that foster care reviews were placed on hold during 2021 and 2022 due to staffing and resourcing issues whereby the fostering team assisted the child-in-care team and held cases. It was documented that 'this had an impact on long-term matching being signed off'. Though staffing deficits was a contributing factor to the challenging circumstances, poor service planning and management oversight by Tusla was evident.

Inspectors found that the Joint Protocol for interagency collaboration between the Health Service Executive (HSE) and Tusla to promote the best interests of children and families', was in operation and informed the assessment process for children-in-care. Inspectors found from document review and interviews that the interagency meetings with the HSE had taken place and acted as a referral pathway and gateway to unblock barriers. From case files reviewed inspectors found that there was not always timely and consistent access to assessments and specialist interventions for children with disabilities. It was not always evident from children's case files if the appropriate services were in place for children with disabilities due to the lack of case notes and documents on TCM. Good practice was found in some case files reviewed where respite care, psychotherapy, special education schooling and disability equipment was sourced and put in place to meet the child's needs.

Overall, the service had experienced significant difficulties in undertaking multi-disciplinary assessments of children-in-care. As noted, 139 child-in-care reviews were outstanding at the time of the inspection, with an additional 42 foster care reviews overdue. For these children their needs were left unassessed and the capacity and capabilities of the foster carers were left unknown as to whether the placement was still meeting the needs of the child. There were no effective measures in place to manage this. For these reasons the area was judged to be not compliant.

Judgment: Not Compliant

Standard 8: Matching carers with children and young people

Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children and young people.

The service area rated its performance against this standard as substantially compliant and inspectors agreed with this judgment.

The service area was experiencing a shortage of foster carers at the time of the inspection and this was one barrier in making successful matches for children-in-care. Data received from the service area prior to the inspection indicated that the service area had two available foster placements for a child needing a foster care service. Furthermore, the data indicated that there were 15 children who were awaiting a foster care placement. In addition, 139 child-in-care reviews were significantly out of date and were not in line with statutory requirements. This is an important forum where discussions around the plan for permanence would be recorded in a child's care plan and if the foster carers continued to have the capacity to meet the child's assessed needs.

The impact from limited placement availability meant that Tusla's ability in making matching decisions in the best interests of a child was often a balancing act of what was possible. Tusla had ongoing recruitment campaigns to attract people to the role of foster carer. Tusla recruitment campaigns had also focused on targeting of foster carers from ethnic, cultural and religious backgrounds.

The service area had a standard operating procedure for placement requests in operation and was being applied at the time of the inspection. Three case files were sampled to review the quality of requests for placements submitted. The quality of the case recording was good that considered the availability of foster carers, the type of placements being sought, the age profile of the child, placement strengths and weaknesses of each identified family. Children's cultural needs were also considered. The location of the foster carers was also a key matching consideration for decision-makers in all three case files reviewed. This ensured that the least disruption to a child's life in terms of education, family access formed part of the assessment to ensure stability remained intact in other parts of their lives in the midst of change. Foster carers told inspectors that location to a child's school and their family played a factor in their decision to be able to meet the child's needs. In one case example the foster carers own biological children were included in the decision-making to help them understand how matching decisions were made and the next steps. However, children case files did not provide a clear picture of the matching process as they were not available on children's case files or consistently available on the foster carers' case files. As a result, there was no evidence that the wishes and feelings of children-in-care were represented.

A practice guidance for staff on matching foster carers with children was in operation to ensure that children are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people. Eight case files were reviewed to assess the quality of the matching process for children-in-care. Seven of the case files provided access to a comprehensive history of the child's experiences and explanations of earlier decisions made for the child as part of a child-centred matching process. It was found that social workers and foster carers were involved in developing plans that carefully considered a child's day-to-day short and/or long-term placement needs. Good practice was seen when social workers from different service areas worked together with a foster carer providing placements for children seeking international protection. This ensured that further information requested by the foster carer to make an informed decision about matching was made available.

A review of placement meetings held by the fostering service highlighted that these meetings occurred on a regular basis and the discussions held were detailed in terms of the knowledge held by staff in regards to the child's circumstances and needs and the availability and capacity of the foster carers in the area. Detailed information was provided on new placement requests. Decision-making was recorded and actions to be completed in a required timeframe.

Data received prior to the inspection indicated that no children were awaiting approval of a long-term placement. In the last 24 months, six children had been adopted by their foster carers which supported Tulsa process of permanency planning to eliminate drift and delay. However, for one child awaiting allocation to a social worker, their last statutory visit was overdue by one year. The child was experiencing drift in the commencing of the adoption process to secure a permanent family environment as early as possible. A total of seven long-term placements had been approved in the previous 12 months. In the 24 months prior to the inspection, 16 foster carers had obtained enhanced rights in respect of children or young people who had additional needs which enabled them to respond to the long-term identified needs in caring for children who had been placed with them.

Data provided prior to the inspection indicated that the number of children in special foster care placements was 16. Two case files were sampled and found that for one child, they were in a long-term foster placement where the number of unrelated children placed exceeded standards. Permanency planning was central to their child-in-care review to enable the child to enter into a permanent placement as soon as possible through the adoption process. However, there was no evidence that the FCC were informed and had assessed the information for consideration if approval was in the best interest of the child. In the second example a child, their placement was at risk of breakdown for a period of five months. It was found that Tusla needed to further strengthen its assessment and matching processes of children who had a

disability to ensure that foster carers were sufficiently skilled and knowledgeable in the area.
Inspectors sampled three case files of foster carers from a diverse background to assess how the service area promoted and matched children's needs in terms of diversity. It was evident that the service promoted the cultural and diversity needs of children-in-care from the outset. This was done through the FCC decision-making, staff completed cultural awareness training, availability of information booklets for children and parents in their language and providing information and training to foster carers on the child's cultural needs to maintain their connections with their cultural heritage.

At the time of the inspection there were 14 foster care households where the number of children exceeded standards. Of these, 13 foster care households had three children in placement. One foster care household with five children.

Some foster carers, felt that they were not supported in the matching process and that little information was provided to help them make an informed decision. For one foster carer while they were in the midst of the matching process the social worker position became vacant before the child moved into their placement. This in turn created gaps in support and lost knowledge of the child's history. In another example a foster carer said that they felt pressured to provide a placement for children when asked by Tusla. The impact of this practice may not help support the foster carers to have a choice, have the space to understand the individual child needs or the time to adapt their support strategies accordingly. In turn, this practice would not help the relationship between the foster carer and child to flourish and may result in placement breakdown.

Overall, the inspection found that staffing deficits impacted Tusla's ability to implement their national approach to assessments. In addition, limited placement availability impacted Tusla's ability in making matching decisions in the best interests of the child. Despite these constraints, examples of good practice was seen in identifying suitable foster carers for children-in-care. In addition, comprehensive history of the children experiences and explanations of decisions formed part of a child-centred matching process. Practice guidance was in operation along with placement planning meetings that occurred on a regular basis and were of good quality. There was good practice of interagency working between service areas with foster carers. For these reasons the area is judged to be substantially compliant with this standard.

Judgment: Substantially Compliant

Standard 19: The management of the foster care service.

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

The governance of the service required significant improvement in order to provide a rights based, safe service to children in foster care. Risk management was poor and despite risks being identified and escalated to national level, plans to mitigate risks directly related to the delivery of services to children were inadequate. Plans were in place to restructure the service through a three year change project that would see changes to better improve service delivery. However, there was no effective interim measures in place to manage the impact of change and staffing deficits to children-in-care and foster carers.

The service areas governance and management structures to oversee the quality of its foster care services, had changed since the previous HIQA inspection. At the time of the inspection there were 18 vacant positions on the child-in-care team and four vacant positions on the fostering team. This had presented a significant risk to Tuslas ability to deliver a safe service and effective foster care service to children-in-care. Due to the staffing challenges experienced, the area had introduced an extensive change project to improve its governance and oversight. The managers had identified the need for the development of a plan to restructure the service to tackle the complexities faced. However, inspectors found that the change project was extensive and ambitious and that change would not happen immediately instead it would take time to see results.

The service was managed by an experienced area manager who was in position since 2021 and was striving to make improvements to the fostering and children-in-care service. The area manager was aware of the risks that the service faced and was honest about the hurdles that they were experiencing in staff vacancies and that the service was limited to what it could achieve as a result. There was a two year business plan developed for 2023-2024 that included four goals that were aligned to the strategic areas of practice, culture and structure. This business plan focused on addressing the service areas challenges and ensuring the process of continuous improvement. All of the relevant goals had priority actions that had assigned timeframes for completion.

The area manager told inspectors that they had taken the initiative to commission a change project as the service could no longer wait for a national response from Tusla to tackle the pressures faced from staff crisis. Documents reviewed showed that the change project was approved by the national office and the area manager was working with them to align the change project to Tusla's national approach to foster care. Managers developed a plan that showed all the steps that needed to be taken from identifying the change to realising it. However, the area manager

recognised that challenges remained to successfully implement the change project due to the staffing shortages on a rolling basis and that this was not going to improve in the short to medium term. In the previous HIQA inspection in 2022, staff vacancies was an ongoing organisational risk which challenged the service areas capabilities to effectively monitor the operations of the service and to drive improvement in line with the vision of the service held by managers.

Regular senior management team meetings were held and attended by the area manager, principal social workers from the child abuse substantiation procedure (CASP), child-in-care team and foster care teams, Prevention Partnership & Family Support (PPFS) managers. The minutes were detailed and discussed key information around the governance of the service. Also discussed were business cases submitted to the regional chief officer to increase staff vacancies that were approved. Emphasis was placed on the staff team submitting 'Need to Knows' to the national office to highlight service pressures being experienced. Weaknesses were identified in the service areas performance against standards, legislation and regulations and these were placed on the risk register. However, inspectors were concerned that weaknesses identified in the governance and oversight of the management of cases awaiting allocation had no interim measures discussed or actioned.

Monitoring systems were ineffective. The area manager and the management team had developed a number of 'trackers' to assist them in monitoring unallocated cases including children's child in care reviews, statutory visits and foster care reviews. Inspectors reviewed the live trackers and found that they were detailed but were not always effectively used to inform service provision. As discussed previously the child-in-care review tracker had identified 139 children whose child-in-care review were significantly outside the statutory requirements and remained outstanding at the time of the inspection. The foster care review tracker identified 65 foster care reviews to complete in 2023, with 42 being overdue, with the longest overdue since 2019. There was also 12 foster carers who were awaiting allocation to a foster link social worker. The trackers did not provide an additional safeguard in the identification of performance issues and risks as staffing deficits impacted on how and when completion of tasks could occur. These trackers did not take into account children with additional needs and or disabilities. Managers said that a lot of challenges were being faced by the service.

Audits were undertaken that form an essential part of the quality assurance arrangements that examined practice against national standards, legislation and guidance. The audits found that Tusla were not delivering a safe, timely and child focused service that improved the quality of outcomes for children. The audits identified that needs and risks had been recognised and not responded to over time and that it was impacting on current outcomes for children. Immediate concerns were identified through the audits undertaken regarding Tusla's lack of oversight on children-in-care to determine their well-being and safety. The rationale for this was recorded as relating to the staffing crisis. Tusla oversight did not ensure that decision-

making was effective or proportionate as all children audited remained on the waitlist. Tusla response was slow in prioritising reduction of risk and need.

A child's right to participate in decisions that affect them was not always promoted. As in some cases there was no social worker assigned to carry out statutory visits and some children-in-care reviews were significantly overdue. In addition, there was limited evidence that methods were used for the participation of children with speech, language and communication needs that offered them the potential to be involved in decisions impacting their care as there was no evidence on case files. The fostering service was not adapted to meet the communication needs of children with disabilities in order to actively shape the support available to them as no tools were found to aid their communication. The needs and voice of children who were awaiting allocation to a social worker or had a diagnosis of a disability were not placed centre stage, rather than becoming lost in the system.

Oversight across the service required significant improvement to ensure that relevant actions had been addressed in a timely manner to ensure that due diligence takes place before key decisions are made. That key risks and developing areas of concern are identified monitored, and responded to. The area manager described the service as being 'under severe pressure'.

The arrangements in place for the interim regional chief officer (IRCO) to govern and oversee the performance of the service was not adequate. The area manager provided regular performance reports to the IRCO noting staff deficits on a rolling basis, description of the service as an "already creaking service" and a lack of clarity on planning from the national office that was impacting on the areas service planning. Despite identifying risks in relation to staffing challenges and the services inability to manage children in foster care in line with regulations and standards, there was no effective mitigations in place, despite this risk being escalated to national level. This highlighted a weakness in Tusla's governance structure to respond to the insufficient staffing to put in place interim measures to manage the increasing risk to service delivery.

The management of risk for the service required further improvement to align with Tusla's national risk management framework in adopting a proactive approach to risk management. Following review of the risk register in place, inspectors were concerned that the identification, evaluation and prioritisation of all organisational risks did not ensure that timely action was taken to mitigate against them. For example, the risk related to waiting allocation to a social worker, this initially had a risk rating level of very high but was then reduced to medium, even though the risk remained in the absence of effective control measures. In another example; ongoing staff vacancies had a risk rating level of medium in the midst of an ongoing crisis that was causing significant challenge and impact for children-in-care not receiving their recognised statutory requirements.

Due to the risks identified, a provider assurance report was issued on the 3 August 2023 to the interim regional chief officer as significant risks relating to the systems in place regarding the oversight and management of children awaiting allocation to a social worker were ineffective. The assurances provided were not satisfactory to address the concerns surrounding these system risks, and did not adequately outline steps to ensure that the service area was brought into compliance with the standards. As a result a cautionary provider meeting was held with the interim regional chief officer on the 22 August 2023 and a warning meeting on the 25 September 2023.

Staff were working in a crisis led environment that was impacted by inadequate staffing and this contributed to workload pressures. Working in this can impact negatively on a service in achieving positive outcomes for children, as seen by the number of children awaiting allocation to a social worker and child-in-care reviews significantly outside of timeframes. Managers in the service area had devised a change project to support and help teams in making service changes to redirect and redefine the use of resources to better improve service delivery. However, the impact of change is unpredictable and difficult to assess at the initial stages of implementation. Staff were supported by a strong area manager who had recruited a professional to a therapeutic post to specifically offer support to staff and their teams during this time.

The quality of supervision across teams was good and provided space to reflect on children cases. Managers and staff understood the key developments, trajectory and standard of casework. However, resources in the service were stretched that resulted in drift in cases and statutory requirements not being achieved. Documenting of cases that experienced drift could only be found to have commenced in 2023 and required further work in terms of follow-up actions. A key theme that presented itself in supervision was the impact the staffing crisis would have on work undertaken with children-in-care.

Overall, the inspection found that managerial oversight required significant improvement. Tusla were relying on the fostering change project that commenced in June 2022 to restructure the service area to improve the quality of service to children, families, and foster carers. However, there was no effective interim plan in place to safely manage the unsafe practice of children awaiting allocation to a social worker and the high number of child-in-care reviews and statutory visits that were outstanding. Staff deficits and vacant posts remained a significant factor that influenced the service's ability to progress and maintain improvements in the quality of service provision. For these reasons the area is judged to be not compliant with this standard.

Judgment: Not 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 service area rated its performance against this standard as substantially compliant and inspectors agreed with this judgment.

The service area had a wide pool of foster carers, with different skills, backgrounds, cultures, and experiences to best meet the diverse needs of children-in-care. However the service area did not have sufficient foster carers to meet the needs of the service. Data submitted by the service area provided prior to the inspection indicated that there were 349 foster carer households in the service area and this was broken down into:

- 248 general foster carers
- 99 relative foster carers and
- 2 available foster care households.

Within the 248 general foster carers there were 16 special foster care households. At the time of the inspection the service area had increased their available foster care placements to six for the entire area.

Recruitment and retention of foster carers was an ongoing challenge for the fostering service. Managers and staff had identified the lack of available foster care placements as a risk for the service. This was raised at national level and is a national challenge for Tusla. This identified risk was placed on the service areas risk register and continued to be a concern for the area since the last HIQA inspection in 2022. The impact of this was that 14 children were placed in households where the number of children placed exceeded the standards and 15 children were waiting for full-time foster care placements.

The managers and staff proactively worked with Tusla to come up with innovative ideas and approaches in order to meet the needs of children-in-care by having sufficient foster care placements into the future. In the 12 months prior to the inspection Tusla had carried out six national recruitment campaigns to generate new enquiries and applications from a wider demographic audience. The recruitment campaign was based on a mixture of online and traditional channels including radio, online advertisement, Facebook and a national online information session. Tusla had also developed merchandise to target priority groups from specific demographic backgrounds to meet the diverse needs of children-in-care. A champion co-ordinator was in position to take responsibility for target recruitment campaigns and work together with other champions. In the previous 12 months the service area had received 44 new enquiries about becoming a foster carer. Of these, eight had

progressed to application stage. Tusla provided a timely and efficient response to new enquiries to minimise delay and to improve application rates.

A panel of approved persons who were willing to act as foster carers in compliance with the Child Care (Placement of Children in Foster Care) Regulations 1995 was developed and in operation. Managers maintained oversight of the panel and there were systems in place to ensure that it was updated with all necessary information in relation to the foster carer.

The service area had approved eight new foster carers in the 12 months prior to the inspection. Two case files were reviewed where the children were placed with relatives. Although there was a delay in the foster care assessment to the FCC, the assessment once submitted was detailed and provided an in-depth assessment. Staff said that there was a "need for the service to improve timeliness" in the completion of assessments. Also that the service was experiencing a deficit in the number of fostering assessments it was able to conduct. As a result, a decision was made by managers to contract out ten foster care assessments to a private provider. Upon reviewing the two case files and FCC meeting minutes it was found that one of the most important considerations for the FCC when deciding on matching was the experience, skills and the foster carer's ability to meet the child's individual needs. Where foster placement breakdown occurred or came to an end, the FCC were proactive in actioning a report to be provided from the private provider to review the chronology of events for learning and to improve practice. The minutes of the meetings and the decisions made by the FCC were documented to a high standard.

In the previous 12 months, 13 foster carers had left the service voluntarily. Staff and managers conducted exit interviews with foster carers to understand not only the current landscape but also provide insight into where processes needed improvement. Exit interviews were offered to all foster carers leaving the fostering service. Some of these were sampled as part of the inspection and they were found to be detailed in the range of questions asked in order to understand what was working well and what was not, highlight hidden challenges and opportunities with the overall aim of informing service improvement. The exit interviews also asked departing foster carers if they wished to become ambassadors to help promote recruitment campaigns with the foster carers. The foster cares asked did not agree to undertake this task.

The service area had a wide pool of foster carers, with different skills, backgrounds, cultures, and experiences to meet the diverse needs of children-in-care. The data received from Tusla prior to the inspection indicated that 313 children-in-care were placed with foster carers of the same cultural, ethnic or religious background. Tusla had also commenced the introduction of innovative campaigns targeting under-

represented groups to attempt to break down myths and attract diverse foster carers to the service.

There were strategies in place for the retention of foster carers in the area with some improvements identified. The service area had conducted a training needs analysis of foster carers. A full calendar of events was scheduled for 2022 and 2023 that offered ongoing training to enhance the existing skills and develop knowledge of foster carers. In addition, support groups became a key feature of social events that provided access to a variety of support provided by their fostering service. In addition, further improvement to ensure that all foster carers completed identified training linked to their approval status or training based on the assessed needs of children with disability needs. However, providing support initiatives to foster carers to retain placement was impacted by staff deficits and vacancies. For example; 12 foster carers were awaiting allocation to a foster link social worker. There was four vacancies on the foster care team and the foster link social workers duties were being stretched to provide support to the child-in-care team whose department had 18 vacancies and 131 children awaiting allocation to a social worker.

The change project initiated in June 2022 recognised and would provide one recruitment and assessment team and two supervision and support teams. This was still being implemented at the time of the inspection. The change project would create a dedicated recruitment and assessment team that was envisaged to strengthen recruitment and assessment of foster carers in accordance with national standards. It was also envisaged that the supervision and support teams would provide the level of support to foster carers and maintain placements. The fostering team restructure was already underway at the time of the inspection with an area fostering team framework in place. This outlined the new teams for the recruitment and assessment team in place, support and supervision team, placement committee and social care team. However, this change project is a three year project and measuring results from this would not be achieved in the near future. There for standard is deemed substantially compliant.

Judgment: Substantially Compliant

Appendix 1:
National Standards for Foster Care (2003)
and
Child Care (Placement of Children in Foster Care) Regulations,[2] 1995

Standard 1	Positive sense of identity
Standard 2	Family and friends
Standard 3	Children's rights
Standard 5 Regulation Part IV, Article 17(1)	The child and family social worker Supervision and visiting of children
Standard 6 Regulation Part III, Article 6	Assessment of children and young people Assessment of circumstances of child
Standard 8 Regulations Part III, Article 7 Part III, Article 7[3]	Matching carers with children and young people Capacity of foster parents to meet the needs of child Assessment of circumstances of the child
Standard 19 Regulations Part IV, Article 12 Part IV, Article 17	Management and monitoring of foster care services Maintenance of register Supervision and visiting of children
Standard 21	Recruitment and retention of an appropriate range of foster carers

[2] Child Care (Placement of Children in Foster Care) Regulations, 1995

[3] Child Care (Placement of Children with Relatives) Regulations, 1995

Compliance Plan for Waterford/Wexford Foster Care Service OSV – 0004387

Inspection ID: MON_0040502

Date of inspection: 25 to 28 July 2023

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for Foster Care, 2003.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which standards the provider must take action on to comply. In this section the provider must consider the overall standard when responding and not just the individual non compliances as listed in section 2.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard, but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector has identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the standard in order to bring the service back into compliance. The plan should be **SMART** in nature. **S**pecific to that standard, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each standard set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	**Judgment**
Standard 1: Positive sense of identity	**Substantially Compliant**

Outline how you are going to come into compliance with Standard 1: Children and young people are provided with foster care services that promote a positive sense of identity.

1.1 Further embedding and improvement of the area Stable Cases team will ensure improved compliance with child in care review processes for all children awaiting allocation. The team is now in place and unallocated children in care will rotate on a six monthly basis ensuring that any child who is unallocated will have their statutory needs met inclusive of a child in care review and statutory visits. These tasks will provide significant information on the child and determine if priority needs to be amended and if further actions are required based on need and levels of vulnerability. If further actions are identified, they will be allocated to a social care worker/ social worker depending on identified need and most appropriate person to complete the piece of work. If there is an immediate need identified for a child in care, the Stable Cases social worker will complete the actions required and the case will be escalated to the CIC PSW for allocation.

Timeframe: In place **-** Rotation of cases allocated to Stable Cases team every 6 months
Person Responsible: PSW CIC
Monitoring of Action: PSW CIC Governance review meeting every 6 weeks.

1.2 All unallocated CIC will receive a child in care review within statutory regulations timeframes. There is a schedule in place with the CICR chairs and SWTLS/PSWs to ensure all children have a care plan completed by the end of year.

Timeframe: Dec 2023
Person Responsible: PSW CIC
Monitoring of Action: Task Force for CIC will have oversight of compliance for CIC

1.3 All unallocated CIC will receive a statutory visit within regulatory timeframes. This will be achieved through allocation of cases to the Stable cases team on a rotational basis. As the rotation is every 6 months this would ensure that each child in care has a statutory visit in place as per regulations. While cases are unallocated to a social worker, a social care worker will be assigned to complete a support visit. These visits provide a voice for the child and identify any unmet needs which in turn would inform prioritisation for allocation to the Stable cases team on rotation. It would also flag any cases that require immediate allocation.

Timeframe: Jan 2024
Person Responsible: PSW CIC
Monitoring of Action: Task Force for CIC will review compliance with statutory visits as a standard metric being tracked.

1.4 Child in care reviews will focus on generating the necessary improvements required to promote identity, relationships, and friendships. Tasks will be agreed for each individual within the child's network to ensure these important areas are monitored and actioned. Networks will include social workers, social care staff, foster carers, parents, family and all others that play a role in the development of the child and their needs.
To enhance each child's connection to their network, the area has requested the Signs of Safety Training and Development officers to provide a training session for Fostering link worker and foster carers to help them to build networks around the child. Training will support FLW and FC to build on the naturally occurring network around the child and help a child feel more connected to their families and communities.

Timeframe: Dec 2023
Person Responsible: PSW CIC
Monitoring of Action: Task Force for CIC will review compliance as a standard metric being tracked.

1.5 Compliance with child in care reviews and statutory visits will ensure that children with increased vulnerabilities, such as children with disabilities, will regularly have their voices heard and key tasks identified and actioned within strict timeframes. Further training for Tusla staff is being sourced to assist develop increased skill sets in hearing the voice of children with additional vulnerabilities and to recognise the child's disability as part of the child's identity. This will include sign language training which is being sourced externally. Requests have also been made to the regional manager for therapeutic team and to Workforce Learning and Development Team for additional training for staff in communicating with Children with Disabilities.

Time Frame: December 2023. Dates to be finalised for sign language training.
Person Responsible: Area Manager

Monitoring of Action: Audits completed by PSWs /SWTL will provide feedback to the Task Force for CIC on impact this training has had on our service in ensuring the voice of a child with a disability is heard as well as identifying additional training needs of staff.

1.6 To support adherence to child in care review regulations a Children in Care Review Team (CICR team) is now being developed. Expressions of interest have been generated for a new SWTL to lead and coordinate an area team with a sole focus on child in care reviews, tracking regulatory timeframes and analysis of metrics in this important area. This approach will add greater structure and efficiencies to the existing processes. A second expression of interest will also be generated for a social work grade to assist build this team's capacity. The area target is to have met have all regulatory responsibilities as they relate to statutory visits and childcare reviews

Time Frame: March 2024 to have the CICR team operational. Date for Care plans to be up to date is December 2023.
Person Responsible: PSW CIC
Monitoring of Action: Task Force for CIC will have overall oversight through tracking of metrics the impact a CICR team is having in terms of compliance with Child in care reviews.

1.7 All area foster carers have been allocated a fostering link social worker

Time Frame: Completed 13th Sept 2023
Person Responsible: PSW Fostering
Monitoring of Action: If a child becomes dual unallocated, this will be escalated by SWTL to the PSW for fostering in supervision.

1.8 Actions will be measured through strengthened tracking systems; such improvements include all trackers being reviewed by Professional Services Manager and there is a mechanism in place for updating trackers on a monthly basis. This is monitored by Task Force for CIC through standard metrics review at every meeting.
Schedule of audits completed by the QRSI team is in place and focuses on the areas of non-compliance identified by the recent inspection

Time Frame: Trackers were reviewed September 2023. Schedule for Audits includes:

- Statutory visits to Children in Care Nov 2023
- Care Plans and Care plan reviews Dec 2023
- Foster Care committee Jan 2024
- Support visits to Children in Care Feb 2024
- Quality of recording on CIC cases Mar 2024

Person Responsible: PSW QRSI
Monitoring of Action: Outcome of Audits will be brought to the CIC Task Force Forum for discussion and future planning based on recommendations from audits.

Standard 2: Family and friends	Substantially Compliant

Outline how you are going to come into compliance with Standard 2: Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.

2.1 All unallocated CIC will receive a child in care review within statutory regulations timeframes.

Timeframe: Dec 2023
Person Responsible: PSW CIC
Monitoring of Action: Task Force for CIC will have oversight of the metrics for CIC Reviews as a Standard metric being tracked.

2.2 All unallocated CIC will receive a statutory visit within regulatory timeframes

Timeframe: Jan 2024
Person Responsible: PSW CIC
Monitoring of Action: Task Force for CIC will review metrics for compliance on an ongoing basis.

2.3 Child in care reviews will focus on generating the necessary improvements required to promote identity, relationships, and friendships. To enhance each child's connection to their network the area has requested the SofS Training and Development officers to provide a training session for Fostering link worker (FLW) and foster carers (FC) to help them work with CIC social workers to build stronger networks around the child. This training will support FLW and FC to build on the naturally occurring network around the child and help carers to support a child feel more connected to their families and communities. This training will enhance the quality of care planning, as actions arising from care plans would be more inclusive and directly linked to the child's network.

Timeframe: Feb 2024
Person Responsible: PSW Fostering
Monitoring of Action: SofS Building a network training to be available to fostering link workers and foster carers.

Standard 3: Children's rights	**Not Compliant**

Outline how you are going to come into compliance with Standard 3: Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and have their views, including complaints, heard when decisions are made which affect them or the care they receive.

3.1 A Task Force forum for children in care has now been developed and fully implemented in the area. (TOR enclosed). This is led and chaired by the Area Manager and attended by key senior management personnel inclusive of PSWs and the area QRSI team.
The central function of the task force is to deliver strengthened senior management governance of children in care. It will also ensure safe management of children's needs particularly during times when children in care do not have an allocated social worker. The Task Force will monitor gaps in metrics, audits, team performance and ensure that teams are supported to meet standards and make improvements in an efficient and timely fashion for children. It will also have a role in developing plans around how to better support children with increased vulnerabilities such as children with disabilities.

This senior management group will forensically review all unallocated CIC cases during the week of 9th Oct 2023. The initial focus will be on children with increased vulnerabilities such as those with disabilities. A forensic review template has been developed to ensure greater clarity on the needs of children both allocated and unallocated. This exercise will assist the area to ensure that children with the greatest need and vulnerability are allocated directly to a social worker.

Timeframe: Week of 9th Oct 2023 for 4 days forensic review of all cases open to CIC
Person Responsible: Area Manager
Monitoring of Action: Task Force for CIC will review the metrics on a weekly basis.

3.2 The Waterford/Wexford area piloted a three-day Reunification Safety Planning in Action Workshop led the by the SofS Practice Lead team on 6th & 7th June, and 26th Sept 2023 with a focus on effective safety planning for children in care. The area has now begun the process of further strengthening safety planning activity and practice within CIC teams. PSWs and SWTLs in conjunction with QA team support will roll out group supervision to build on the progress made in implementing safety planning in action for children in care with reunification cases. A full audit of safety planning standards will be conducted by the area QA team in December 2023 giving time for the practice to be implemented in CIC teams. Learning from this audit will be discussed at the CIC task force forum and disseminated to PSWS which will inform managers on how SofS has been embedded across the CIC teams with a view to capturing learning needs going forward.

Time Frame: Group supervisions starting Oct 2023
Person Responsible: PSW QA
Monitoring of Action: Audit by QA PSW in December 2023 will inform how SofS is being used in practice and what additional support needs the CIC teams have.

3.3 The area has now begun the process of recruiting additional social care leaders for area children in care teams. A further four staff will be added immediately meaning that all unallocated children in care will have dedicated social care worker or leader. Tusla Recruit are currently expressing these posts to panels allowing for onboarding the area would envisage that all unallocated children would have a social care leader secondary allocated to them by Jan 2024. This will ensure that all unallocated children in care have at a minimum an allocated social care worker who is solely focused on supporting the child, their placement and tracking their needs. This will be ensured through regular planned visits that will focus on developing a relationship with the child and hearing their views. This worker will also support tasks as identified within the care planning process as required.

Time Frame: Jan 2024
Person Responsible: HR for recruitment of staff
Monitoring of Action: PSWs for CIC will allocate social care workers to CIC once in position

3.4 There are no dual unallocated cases within children in care and as such a CIC social worker or fostering link social worker will be attached to all children in care.

Time Frame: Completed 13th Sept 2023
Person Responsible: PSW for Fostering
Monitoring of Action: This will be monitored by the Task Force for CIC to ensure there are no dual unallocated cases.

Standard 5: The child and family social worker	**Not Compliant**

Outline how you are going to come into compliance with Standard 5: There is a designated social worker for each child and young person in foster care.

5.1 All unallocated children in care will have an allocated social care worker or social care leader under the guidance of a SWTL, who is solely focused on supporting the child, developing a relationship with them and hearing their views, monitoring their placement and tracking their needs. This worker will also support tasks as identified within the care planning process. If for any reason there is a short period of time whereby the child in care does not have an allocated social worker or social care worker, the PSW will ensure that a letter is sent to the child, foster parents and birth parents advising of the change and advising of contact person/s to raise issues during this time. These foster placements will have a Link Worker assigned to avoid dual unallocation.

Time Frame: Jan 2024
Person Responsible: PSW CIC
Monitoring of Action: Work completed by social care staff will be monitored in supervision with line managers.

5.2 A forensic review by the CIC task force and QRSI team will ensure that all children with moderate to severe disabilities will be allocated to a social worker. Governance around the needs of these children will be strengthened not only through further embedding of the joint protocol with the HSE but also through a specific tracking tool that will ensure children with an identified disability are monitored through level 1 and level 2 meetings and that all their statutory needs are met according to regulations such as care plan reviews and stat visits. The QRSI team will support the development and monitoring of this tracker.

Time frame: Complete
Person Responsible: Professional Services Manager
Monitoring of action: Children with disabilities tracker will be monitored and updated by Professional support manager following each JWP Level 1 and Level 2 meeting.

5.3 The area has now further developed and strengthened its regulatory tracking system. This will ensure all statutory functions will be tracked more robustly in conjunction with the stable cases team as previously referenced. The area QA team will take a greater role in tracking and improving linkages with CIC PSWs to ensure that the metrics are analysed more efficiently, and actions occur quickly when overdue statutory functions are noted. The team will report to the Task Force so that challenges and improvement can be overseen.

This approach will further decrease the risk of case drift. The area will be adding increased business support to the QRSI team to assist in achieving these improvements.

Time frame: December 2023
Person Responsible: PSW QA
Monitoring of Action: QA team provide into the Task Force to ensure oversight and governance of activity on the CIC teams across the area.

5.4 The Stable Cases team is an approach that the area expects will achieve immediate improvements for children, this approach will be subject to review within the CIC task force to ensure that improvements are tangible and measurable. For example, by evidencing progress with agreed actions arising from audit and greater levels of compliance with standards relating to visits, care plans and child in care reviews. It will also allow for oversight of, and response to, new information for any children in care without an allocated social worker, so that priority levels can be revised and required actions completed within specified
timeframes.

Time frame: Stable cases team in operation in Waterford – first rotation Oct 2023. Stable cases team to be developed in Wexford in October 2023
Person Responsible: PSW for CIC
Monitoring of Action: Task force for CIC forum will review the metrics from Stable cases team. PSW and SWTL from Waterford to complete an audit to determine the benefits of the Stable cases team first rotation and to inform actions for the second rotation in terms of improvements that can be made to the structure of the team.

5.5 An Active on Duty system is in place across children in care in Wexford and in development in Waterford. In both areas the system ensures that all new referrals that are received by Tusla are screened by the PSW or SWTL for CIC within 24 hours. Both areas have duty phone support for any calls that come in on unallocated children. Referrals received are categorized and prioritised for allocation based on need. If a child is unallocated there is a duty social worker or SWTL in place who will complete the Standard Business process such as IR / IA. All children that require immediate attention are allocated on day of receipt and immediate action taken with support from social care worker if required. Area-wide SOPs are currently being developed to ensure there is a consistent response to duty cases in Waterford and Wexford.

Timeframe: Development of area-wide SOPS – 13th Oct 2023
Person responsible: PSW CIC
Monitoring of Action: Task Force for CIC is reviewing SOPS for active on duty cases to ensure the practice is consistent across the area.

5.6 Permanency planning for children is a key target for the area under our change program. All children that fall into this category have been clearly identified and the tasks required to progress these cases are known. These tasks will be allocated to appropriate staff in order to ensure that there are minimal blockages to permanency plans. The area has initiated ongoing engagement with our colleagues in adoption for example and have established a joint approach to assist this process. A full review of all children in this cohort will occur and will be led with the QRSI team and CIC PSWS. All children in care whose permanency plan is formalized as working towards adoption have been identified and are currently being tracked by both the Children in Care & Adoption Services. Governance meetings for the purpose of tracking & reviewing progress on adoption cases, and to strengthen systems & processes across both teams have occurred in March & September 2023. This forum will continue to convene twice yearly to ensure cases identified for adoption are progressing in a timely manner. In 2023, four children in care have been adopted. There is a schedule of anticipated adoptions in place for the remainder of 2023 to 2025.

Time frame: In place and operational.
Person responsible: PSW CIC
Monitoring of Action: Meeting twice a year March 2024 and Sept 2024 with PSW adoption and CIC will continue to track fostering to adoption cases and will identify any blockages in progressing the cases through to adoption.

5.7 The region has recruited a workforce retention officer to assist improve recruitment and retention rates and to work towards children in care having a consistent allocated social worker. A regional retention forum has also been developed. The Retention Team continue to place a focus on learning from employees' experiences to make improvement or change to provide a positive experience for all. This in turn should result in improved retention. To this end, the Southeast Retention Officer continues to support new graduate starters, new joiners, and people resigning, retiring, or transferring teams, and offer support to individuals who seek assistance or guidance.

Time Frame: In place – quarterly updates
Person responsible: Retention Officer
Monitoring of Action: The Retention Officer updates the HR Manager and RCO on these initiatives and through the regional Staff Retention working Group meeting quarterly.

5.8 Area Manager has approved and supported the establishment of a Health and Wellbeing Group. Terms of Reference are drafted, membership has been identified and the first meeting took place in September '23 and will continue monthly.

Time Frame: In place
Person responsible: Retention Officer

Monitoring of action: Health and Wellbeing Group will feedback to Senior management Team about initiatives that are being progressed to support staff.

5.9 National and Regional Recruitment initiatives from which the area will benefit:

National:

- Tusla People and Change Strategy launched.
- Development of sponsorship programme to train as Social Care Worker and Prof Qual SW
- Ongoing international recruitment of overseas SWs and returners
- Promotion of Tusla as a career opportunity at Transition year events.
- Leadership academy in UCD Smurfit commenced in Aug 23.
- Mediation training, coaching and mentoring programmes complete and ongoing.
- Visible Values Programme developed, and Values Champions identified to promote values in regions/areas.

Regional:

- Southeast regional Staff appreciation event on 19th Oct 2023
- Regional Staff retention group commenced 21st September 2023
- Regional Staff induction event every quarter commencing Q4 2023.

Time Frame: In place
Person responsible: People and Change
Monitoring of action: Executive Management Team and RCO.

5.10 The area will target a reduction in unallocated CIC cases of 10%
This will be achieved through following actions being conducted:

- Case load management review of all cases open to CIC in Oct 2023 will give a clear indication of capacity to allocate cases across CIC.
- The forensic review of cases the week of 9th Oct 2023 will identify the cases that need to be prioritised for allocation.
- 12 new social workers onboarded since June 2023 – 5 have been allocated to CIC, 6th is currently on boarding. 6 have joined other teams in the area.
- Social worker returning to CIC following maternity leave in Nov 2023
- Implementation of business pod system will provide additional administrative support to CIC social workers.
- An increase in social care staff who will offer ongoing support to children in placement.

These initiatives will support social workers in completing tasks in a timelier manner thus increasing capacity for new cases to be allocated.

Time Frame: December 2023
Person Responsible: Area Manager
Monitoring of Action: Careful monitoring of allocated cases is a standard metric review

at Task Force CIC meetings.

5.11 Actions to support further reduction of unallocated CIC into 2024

The following initiatives are in place:

- Regrading positions to offer additional support to social workers through business support and social care workers into 2024 will continue to increase social work capacity to take on new cases.
- Task force will continue to monitor caseloads, taking into consideration children aging out, one worker returning from maternity leave in Feb '24, children who are on reunification plans going home and a steady increase of case loads to new workers the area would project a further 20% reduction in case loads by Feb 2024
- The area remains committed to ensuring that all unallocated children will have a social care worker/leader allocated to them to offer ongoing support
- Stable case team rotation will support all unallocated CIC having their statutory responsibilities met until such time as they can be allocated
- The area continue to actively recruit social workers through rolling social work panels and international recruitment campaigns
- Engage with colleges around new graduates to encourage social workers to come to work in the area
- The area has 8 students in placement who have expressed an interest in returning to work as new graduates in June 2024. 3 of these positions will be allocated to children in care thus increasing capacity to allocate cases and reduce the waiting list by a projected 30% by Jun '24 – this projection is dependent on retaining the staff currently in place. See 5.12 for initiatives in place to retain staff

The compliance plan response from the provider does not adequately assure HIQA that the action will result in compliance with standard 5.

5.12 Initiatives to retain current staffing level

- Monthly reflective practice is offered to all grades across the area and provides an invaluable support to staff who undertake very demanding work within CIC through regular sessions with clinical psychologists.
- Debriefings sessions are available through clinical psychologists both on an individual and group basis to support staff following a significant event. This support acknowledges the emotional impact the work can have on workers and provides a basis to process these events and support their wellbeing.
- Blended working is in place to ensure staff are afforded a better work life balance.
- Health and Wellness group is in place and offers initiatives to support staffs physical and mental wellbeing.
- Leadership and management training has been rolled out across the area and is an additional support to help leaders become more proficient in managing the challenges facing their teams.
- Peer support groups led out at all social work grades to provide the opportunity for

enhanced learning and increased support across the teams.

Time Frame: Actions in place and ongoing
Responsible: Area Manager
Monitoring of Action: Senior management team

5.13 Auditing programme in place whereby SWTL will audit one file per supervision session with staff. The focus of this is to review recording on TCM and file management. Monthly Audit reports will be provided by the PSW for CIC to the Task Force for CIC which will provide data on the quality of the work provided and note recommendation for improving the service.

Time Frame: Oct 2023
Person Responsible: SWTL for CIC
Monitoring of Action: Supervision and Auditing

5.14 Monthly review of TCM activity will be highlighted by User Liaison Support (ULS) and send to PSWs on a monthly basis for review. This will help to flag caseloads where recording activity is low and will trigger a file audit review by SWTL / PSW.

Time Frame: In place
Person responsible: ULS Support
Monitoring of action: Task Force for CIC

Standard 6: assessment of children and young people	**Not Compliant**

Outline how you are going to come into compliance with Standard 6: An assessment of the child's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

6.1 The area fostering team is in the process of developing a Placement Committee –a Matching forum for ensuring the needs of a child is known, discussed, and analysed in a multidisciplinary setting prior to placement. This Committee will further ensure that social work assessments of the child's needs are fully considered and matched with suitable foster care options.

Time Frame: November 2023 when assessment team leader is in position
Person responsible: PSW for Fostering
Monitoring of Action: Area Manager will review the effectiveness of the placement committee with the PSW for fostering. Task Force for CIC will review metrics on placement requests as a standard metric being monitored.

6.2 Emergency placement requests will continue to be provided outside of Placement Committee Forum. Placements provided will then be brought to the next Committee Meeting and will be minuted and record of placement and decisions placed on children's files.

Time Frame: In place and further developing re link to placement committee
Person responsible: PSW Fostering
Monitoring of Action: The PSW for Fostering serving as Chairperson of the Placement Committee will oversee the governance and performance of the Placement Committee.

6.2 Foster care reviews are ongoing and program to complete same has been agreed with strict timeframes. An agreed schedule is in place to address same and reviews have begun. Thirteen fostering reviews have been presented to the FCC from July to Sept 2023. The area Foster Care Committees have agreed to meet more regularly to accommodate the turnover of additional fostering reviews that must be presented. Already in place are two additional Foster Care Committee meetings in Oct'23 and Nov '23.

Time Frame: Ongoing and on target. Expected completion of foster care reviews in Waterford Jan 2024. Expected completion of reviews in Wexford Jun 2024.
Person responsible: PSW Fostering
Monitoring of Action: The Foster Care Committee are monitoring the schedule.

6.3 An additional SWTL has been recruited by the area to lead out on the area's dedicated fostering assessment team as part of the change program and will begin work November 2023. This additional post will further assist the area in reaching on foster care review targets by affording a dedicated supervision and support team to concentrate fully on reviews. A more robust tracking system is now in place and led by a PSW – a dedicated area fostering PSW was recruited in 2023 to ensure improvements in processes, structures, recruitment, and assessment practices. This is another example of how the area are actively implementing its change program.

Time Frame: November 2023
Person responsible: Fostering PSW
Monitoring of Action: PSW program of audits

6.4 All foster carers are allocated a fostering link social worker and their link workers are strong advocates of proposing the capabilities of foster carers in terms of matching and supporting children's placements.

Time Frame: Completed 13th Sept 2023
Person responsible: PSW for Fostering

Monitoring of Action: Task force for CIC

6.5 The area has continued to develop a therapeutic team that specialises in providing direct specialised services for children particularly those with increased vulnerabilities and disabilities. This includes area play therapists, area psychotherapist, social care leaders and commissioned services which are routinely approved by the area manager to ensure children have swift access to service provision – these services range from ASD assessment to occupational therapy assessments. The area has now also replaced its senior clinical psychology post within this team which will be a key component in improving our support of children – start date 31/10/23

Time Frame: Clinical Psychologist post will be filled on 31/10/23. Therapeutic team in place and operational.
Person responsible: Therapeutic Team manager
Monitoring of Action: The TT team manager is directly supervised by the regional therapeutic manager who provides regular updates to the AM who also has a direct governance role in approving commissioned therapies for children and families.

Standard 8: Matching carers with children and young people	**Substantially Compliant**

Outline how you are going to come into compliance with Standard 8: Children and young people are placed with carers who are chosen for their capacity to meet assessed needs of the children and young people

8.1 The area fully recognises the need for further foster carers and is actively engaged with National and area fostering recruitment campaigns. The area held various recruitment events during 2023 with a further two scheduled for remainder of the year.

Time Frame: Ongoing – 2 events planned in Q4 2023
Person responsible: PSW fostering
Monitoring of Action: The area recruitment campaign is a rolling agenda item at monthly team meetings

8.2 The area fostering recruitment and assessment team is already in part operation with a new team leader post to commence in October 2023. This will assist bring an increased focus to improved and measurable assessment metrics

Time Frame: October 2023
Person responsible: PSW Fostering
Monitoring of Action: PSW conducts fostering assessment audits every four months in line with national timeframes for completion of relative and general fostering

assessments.

8.3 Seven private fostering assessments have been commissioned by the area and will be presented to respective foster care committees in October and November 2023. Foundations Training is scheduled for November 2023 for twenty applicants.

Time Frame: November 2023
Person responsible: Fostering PSW
Monitoring of Action: Task Force for CIC will Monitor the number of assessments brought to committee as part of metrics review.

8.4 Improvements to matching processes – While the fostering team holds records of matching centrally, PSW and SWTL fostering to develop a SOP on recording responsibilities of fostering link workers for addition to a child's file on TCM. Monitoring of this practice will be incorporated into existing scheduled fostering audits -November 23, January 24, April 24 and every three months thereafter.

Time Frame: July 2024
Person responsible: PSW for Fostering
Monitoring of Action: Task force for CIC

8.5 Stronger linkages with area Foster Care Committees is an ongoing target for the area – the area manager has increased meetings with the committee from quarterly to every 8 weeks and has requested an audit of processes by the area QRSI team. This will include governance roles such as review of cases moving toward adoption and permanency planning.

Time Frame: Jan 2024
Person responsible: QA PSW

Monitoring of Plan: Task Force for CIC form the basis for additional service improvement plans linked to the foster care committee

8.6 A grade 5 has been approved under the new Pod system allocation to the fostering team. This position will provide consistent and expertise administrative support to both foster committees and placement committee, as well as ensuring that one person has the oversight and governance of the tracker in Fostering.

Time Frame: Feb 2024
Person Responsible: HR for recruitment of Grade 5 from existing panel
Monitoring of Action: Fostering PSW

8.7 To ensure foster carers are fully supported prior to making a decision to care for a

child, all information on children available to the area fostering team is shared with foster carers in advance of and during placement. The area will further provide a copy of the second schedule document. The fostering teams use the second schedule as a means to gather information for emergency placements. The fostering team will also engage with a cross section of our foster carers to ascertain what would assist in making further improvements.

Time Frame: Dec 2023
Person responsible: PSW for Fostering
Monitoring of Action: PSW for Fostering to report to Task Force for CIC

Standard 19: Management and monitoring of foster care services	**Not Compliant**

Outline how you are going to come into compliance with Standard 19: Health boards have effective structures in place for the management and monitoring of foster care services.

The area has developed a significant change program which is the foundation and building block of improvements identified as necessary to further improve services. That said the area are also acutely aware of the need for immediate change to better meet the needs of children now. The area is fully aware that any change program takes time however immediate steps are planned to further improve services for children. Via the QRSI Team, the area is actively engaging with other areas where allocation of social workers for children in care is a challenge, so that new ideas and initiatives can be considered and actioned as appropriate.

19.1 The area has on-boarded five new CIC social workers in this quarter improving capacity to allocate, a 6th social worker is currently onboarding to CIC. PSWs carrying out case load management review Oct 2023.This review will capture where there is additional capacity to allocate cases thus reducing the waiting list.

Time Frame: Oct 2023
Person responsible: PSW CIC
Monitoring of Action: Task Force for CIC

19.2 The Regional Chief Officer has developed a forum with quarterly meetings to review performance indicators. This forum will also seek to strategically address national blockages such as recruitment and retention.

Time Frame: Quarterly meetings in operation

Person responsible: RCO
Monitoring of Action: Quarterly meetings provide the mechanism to review performance indicators.

19.3 The area continues to strengthen its own strategic approach to recruitment by conducting regular meetings with regional HR teams. This is with a view to using creative recruitment practices such as regrading opportunities to ensure support staff are employed when social work vacancies exist.

Time Frame: Ongoing
Person responsible: Area Manager
Monitoring of Action: Monthly meetings with SMT and Local and regional HR team

19.4 A full review of the area risk register has occurred and scoring metrics adapted to reflect the assessed risk and mitigating actions to reduce risk. This will better inform Tusla National Office around of the level of risk and priority responses required.

Time Frame: Complete Sept 2023
Person Responsible: Professional Services Manager
Monitoring Plans: Risk Register meetings take place every 2 months. Task Force monitors risk on the register.

19.5 A National Tusla PASM audit on CIC case management in Waterford Wexford has just concluded. Learning from same has been discussed at the CIC task force forum and learning will be disseminated to teams and agreed actions and timeframes will be monitored and reviewed via the QRSI team. This will strengthen the solution focussed approach to audit outcomes across the team. PASM will conduct further review of all unallocated CIC in Nov 23.

Time Frame: November 2023
Person Responsible: PASM
Monitoring of Action: Task Force for CIC

19.6 To address the risk of drift, and to maintain oversight of changes in circumstances for a child in care that may influence their priority for allocation to a social worker or the need for further follow up actions, monthly governance meetings within Stable cases team to take place attended by PSW, SWTLs, CICR Chairperson, Stable Case Worker & Support Visit Social Care Team. These governance meetings review the effectiveness of systems in place, track & monitor completion of statutory functions and support visits, and review cases for priority allocation or stable case rotation. They also inform fortnightly CIC management meetings, and Task Force in terms of review of progress,

metrics & trends in practice, oversight & management of Children in Care.

Time Frame: In place
Person responsible: PSW CIC
Monitoring of Action: Monthly governance meeting in place which inform fortnightly CIC management meetings and weekly Task Force meetings

Standard 21: Recruitment and retention of appropriate range of foster carers.	**Substantially Compliant**

Outline how you are going to come into compliance with Standard 19: Health boards have effective structures in place for the management and monitoring of foster care services.

21.1 The Waterford Wexford area had fourteen children in foster placements where numbers exceeded the Standards. This is a direct result of placement demands that exceed availability. Standards are exceeded where two or more unrelated children are in placement together. The area acknowledges the position and prioritises notification to the FCC. The area will ensure additional safeguards are in place for these placements: The Fostering PSW in conjunction with CIC PSWs are developing a SOP on these placements to include the minimum level of support visits to be provided by Fostering Link Workers to exceed statutory obligations. Additional Support visits by fostering link workers will increase the support available to carers and help to identify any additional supports required for the child and/or foster carers to help maintain the placements.

Time Frame: October 2023
Person responsible: PSW for Fostering
Monitoring of Action: Task Force for CIC

21.2 The fourteen placements affected shall form part of a rolling agenda item at the area's two Placement at Risk Forums in place three times per year. This will ensure more support and governance of these placements is in place. Record of discussion at the Placement at Risk forum will be held on child's and foster carers file to demonstrate the oversight of these placements.

Time Frame: In place
Person responsible: PSW Fostering
Monitoring of Action: Placement at Risk Forums will review the children in placements that exceed the standards. This forum meets three times a year.

21.3 The area had fourteen unallocated foster carers at the time of the inspection. The

fourteen carers are now allocated to a fostering link worker

Time Frame: Completed 13th Sept 2023
Person responsible: PSW Fostering
Monitoring of Action: Task Force for CIC.

21.4 The Area acknowledges the numbers of children awaiting foster placements and continues with its recruitment and retention efforts of foster carers.
An area Fostering Recruitment Champion is in Place and leads out on targeted recruitment campaigns and works other fostering champions nationally. Since inspection two further recruitment campaigns have occurred in the area with a further one scheduled before year end. The campaigns aim to generate new enquiries and applications from a wider demographic.
This will expand our panel of foster carers and assist in reducing the number of foster placements exceeding the standards. It will allow for strengthened matching of children with placements. From July 2023 to September 2023 a further eight fostering assessments have been approved by the area FCCs.

Time Frame: December 2023
Person responsible: PSW Fostering
Monitoring of Action: Foster care committee review all new assessments and make decisions regarding approval status. Fostering team will continue to strive to increase the number of assessments through the development of the assessment team in Nov '23.

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider has failed to comply with the following regulation(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 1	Children and young people are provided with foster care services that promote a positive sense of identity.	Substantially Compliant		Jan 2024
Standard 2	Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.	Substantially Compliant		Feb 2024
Standard 3	Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and have their views, including complaints, heard when decisions are made which affect them or the care they receive.	Not Compliant		Jan 2024
Standard 5	There is a designated social worker for each child and young person in foster care.	Not Compliant		29 Feb 2024
Standard 6	An assessment of the child's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.	Not Compliant		31 October 2023
Standard 8	Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children and young people.	Substantially Compliant		July 2024
Standard 19	Health boards have effective structures in place for the management and	Not Compliant		31 October 2023

	monitoring of foster care services.			
Standard 21	Recruitment and retention of appropriate range of foster carers.	Substantially Compliant		Sept 2024