Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of service area:	Mid - West
Name of provider:	Tusla The Child and Family Agency
Type of inspection:	Thematic
Date of inspection:	15 – 18 August 2022
Fieldwork ID:	MON-0037446

About this inspection

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

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

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

The previous two inspection programmes were as follows:

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

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for Foster Care* (2003).

How we inspect

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

- the analysis of data submitted by the area
- interviews with:
    - the chief regional officer
    - the interim area manager
    - one child-in-care independent reviewing officer
    - two chairpersons of the foster care committees
    - one performance support general manager
    - one general manager for alternative care and the general manager for governance and knowledge management
- focus groups with:
    - three principal social workers for children in care, foster care and aftercare
    - seven social work team leaders
    - nine frontline staff
    - five foster carers
    - four external stakeholder representatives
- observation of:
    - child-in-care review meeting
- the review of:
    - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
    - staff personnel files
    - a sample of 54 children's and foster carer's files
- separate phone conversations with:
    - ten foster carers
    - three children
    - one parent
    - one guardian-ad-litem.

Acknowledgements

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

Profile of the 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 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

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

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

Child and family services are organised into 17 service areas and are managed by interim 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

The Mid-West is one of the six regional areas in Ireland. It was established as a regional area in its own right in March 2022 as part of a national restructuring plan. The area is managed by a regional chief officer and has one interim area manager. The area is noted as having a mix of urban and rural areas which impacts on service accessibility for a significant portion of the population due to the central location of services and lack of rural transport. Based on the 2016 census, the area had a population of 385,000 of which 96,266 are children, representing 25% of the area's total population.

At the time of this inspection, there were 493 Tusla foster care households in the area comprising of 113 relative foster care households and 380 general foster care households. There were 363 children in general foster care and 132 children in relative foster care. There were 10 children in private foster care.

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
15 August 2022	0900hrs – 1700hrs	Lorraine O Reilly	Inspector
		Susan Geary	Inspector
		Sharron Austin	Inspector
		Sue Talbot	Inspector
	0900hrs – 1400hrs	Mary Lillis	Inspector (remote)
16 August 2022	0900hrs – 1715hrs	Lorraine O Reilly	Inspector
		Susan Geary	Inspector
		Sharron Austin	Inspector
		Sue Talbot	Inspector
17 August 2022	0900hrs – 1715hrs	Lorraine O Reilly	Inspector
		Susan Geary	Inspector
		Sharron Austin	Inspector
18 August 2022	0900hrs – 1730hrs	Lorraine O Reilly	Inspector
		Susan Geary	Inspector
		Sharron Austin	Inspector
	1000hrs – 1730hrs	Jane McCarroll	Inspector (remote)
19 August 2022	1000hrs – 1445hrs	Lorraine O Reilly	Inspector (remote)

Background to this inspection

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

- Phase 1 (completed in this area in March 2017) – Assessed the efficacy of recruitment procedures, foster carer supervision, and assessment of foster carers.
- Phase 2 (completed in this area in April 2019) – Reviewed the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children.

Summary of the Findings from Phase 1 and 2

Of the eight standards assessed in phase one:

- three standards were substantially compliant
- five standards were non-compliant, of which two were identified as moderate non-compliances and three major non-compliances.

Allegations were not managed in line with Children First (2011). There was a lack of oversight of how allegations were managed to ensure they were fully assessed and reported to the foster care committee (FCC) in a timely manner.

There was no system in operation to ensure that all foster care household members had been An Garda Síochána (police) vetted, which posed as a risk to children placed in foster care. Foster carers were trained in Children First: National Guidance on the Protection and Welfare of Children (Children First) (2011).

There was a lack of effective recruitment and retention strategies. As a result, there were insufficient foster carers in the area to meet the needs of the service and more foster carers were leaving the service than were being recruited.

Assessments of prospective foster carers were comprehensive and reports were of good quality. However, due to shortages in staffing, assessments were not carried out within required timelines in line with regulations and standards. Relative carers who had not yet been assessed were allocated a link worker in the interim, which was an example of good practice in the area.

Supervision and support was not provided to foster carers in line with standards. While the area maintained a central register of training attended by foster carers, there was limited evidence of training attended maintained on foster carers' files. The majority of reviews were not carried out in line with standards and regulations.

The FCC was guided by but was not fully compliant with the standards and national policy, procedure and best practice guidance.

Of the six standards assessed in phase two:

- two standards were compliant
- one standard was substantially compliant
- three standards were non-compliant, of which two were moderate non-compliant and one was major non-compliant.

There were several examples of good practice in the area, which were driven regionally by a task and finish group set up by the service director for the region. The majority of children in care had an allocated social worker who coordinated the care of children, visited children in their foster homes and ensured that care plans were implemented. Good quality assessments of need were carried out for all children placed in foster care including children placed on an emergency basis. Care planning and review processes were well managed. While there was a matching process in place in the area to ensure that children were matched with foster carers who had the capacity to meet their needs, there was a backlog of long-term matches. Evidence of matching was not available on children's files and the quality of the matching process was mixed.

The quality of case supervision records on children's files was mixed. Some records provided good detail and actions arising while others did not. Deficiencies in statutory visits and child-in-care reviews not being completed within the required timeframes were not consistently discussed or recorded on children's files.

There were gaps in some safeguarding practices, which included delays in scheduling strategy meetings and lack of appropriate safety planning for children in care who required it. The categorisation, management and oversight of complaints, concerns and allegations was good, however, some allegations made by children in care were not always assessed in a timely manner or investigated in line with national guidance.

There was a well-developed aftercare service in the area. Assessments of need undertaken with young people referred to the service were of good quality. Children and young people in foster care were helped to develop the skills and competence necessary for adult living.

Self- Assessment information and what Tusla said about the service

Prior to the announcement of the inspection, a self-assessment questionnaire was submitted to HIQA by the service area's management team. The self-assessment is part of the methodology for this inspection and it required the management team to assess their own performance against the eight standards relating to governance, which in turn identified where improvements were required.

The area completed their self-assessment questionnaire in March 2021. The service rated its performance substantially compliant against seven standards and moderate non-compliant against one standard. In preparation for this inspection, the area updated their self-assessment questionnaire again in August 2022. The service's updated assessment rated its performance as substantially compliant against five standards and non-compliant moderate against three standards. The standards rated as non-compliant were the management of the foster are service, recruitment and retention of foster carers and special foster care.

The findings of this inspection did not match with the area's own judgments against all standards. The area judged standard 22 as moderate non-compliant and this inspection found this standard to be substantially compliant. The area judged standards 18 and 23 as substantially compliant and this inspection judged those standards as moderate non-compliant. This inspection matched the area's judgments for standards 20, 24 and 25 as substantially compliant and standards 19 and 21 as non-compliant moderate.

The area had reviewed and implemented local policies, practice and governance of service delivery in the 12 months prior to the inspection as significant gaps were identified that required ongoing practice improvement. HIQA also requested assurance reports during the 12 months prior to the inspection about the management and oversight of the foster care service. Risks included low staffing levels, children without an allocated social worker and foster carers without a fostering link social worker. Due to improvements made in these areas, the thematic inspection occurred when satisfactory progress had been made.

This inspection took place in the context of what has been a challenging time nationally for fostering services, including children in care and their families, foster carers and local social work teams arising from the COVID-19 pandemic. In this context, HIQA acknowledges that services have had to adapt their service delivery in order to continue delivering the essential service to children in care. This inspection reviewed these arrangements within the overall governance of the service.

Children's experience of the foster care service

Children's experiences were established through speaking with a sample of children, parents, foster carers and external advocates and professionals. The review of case files, complaints and feedback also provided evidence on the experience of children in foster care.

Children spoke with inspectors about where they lived. They said things such as:

- 'I love where I live'
- 'it's fun, we do lots of different things'
- 'it's very good where I live'
- (the foster carer's name) 'is a really nice person'
- 'I'm getting on very well'
- It was good 'to stay locally' and 'in the same school'.

Children also spoke about their social workers. They told inspectors:

- I 'can contact my social worker when I need to'
- 'my social worker visits me once per month'
- 'they try to listen and follow up things'
- My social worker 'barely rings or texts'.

Two of the three children who spoke with inspectors attended their child-in-care reviews while the third child chose not to attend. One child described the meeting as 'good' and the second child told inspectors they attended 'all of them'.

While one child told inspectors social workers 'do a great job', the three children also expressed their views about what improvements they would make to the service:

- we 'should be met with on our own if the social worker needs to question anything that is sensitive'
- 'have social workers briefed more on the family'
- 'social workers could check in more to see if everything is ok'.

Although efforts were made to speak with birth parents, inspectors had the opportunity to speak with only one. They spoke very positively about the care provided for their child over a long period of time and said that their own experience of the service was mixed.

The overall feedback from foster carers about the service provided was mixed. One foster carer described the system as 'broken' and said 'there should be greater confidence and trust in the decision-making of experienced foster carers' and that 'foster carers needed to play a stronger part in service developments'. All foster carers told inspectors they were not regularly informed of any change or updates to policies

and procedures and only one foster carer was asked for their feedback about the service. Other foster carers provided positive feedback and described it as 'satisfactory… nothing I would change', another said they were 'happy with the long term plan' and had 'no issues'.

Foster carers told inspectors about their experience of being assessed as foster carers. They told inspectors there were delays in completing the assessments for a variety of reasons including COVID-19 and getting new social workers. One foster carer was hoping to be approved shortly as the child had been residing with them for over two years.

Foster carers spoke with inspectors about their positive experiences with child-in-care social workers. One foster carer described the child's social worker as 'very good' and had 'a great understanding of the child's experience'. Another foster carer described the quality of their work as 'good' and that they 'call regularly enough' and arranged visits for the child with the child's family. They spoke about social workers being strong advocates for children and about them being available to foster carers when they did not have an allocated link worker.

Foster carers also spoke with inspectors about the reduced quality of service provided given the turnover of social workers and the 'burden of their work' meant that they were unable to visit as much as some foster carers and children would like, but they were 'always on the end of the phone'. Another foster carer expressed concern about a child having had four different social workers, which made it very difficult for the child to form a relationship with their social worker.

Foster carers also spoke positively with inspectors about their fostering link social workers. Some of their comments were:

- 'I could not ask for a better link worker. They are very supportive'
- they 'will sit down and listen to what we say'
- 'very nice, very approachable and I could ask her any questions I wanted'
- 'anytime I rang them, they got back to me- they provided a quick response'
- they are 'always available and gets back to us'
- they 'visited every three months and found her support invaluable'
- 'if I need something I can pick up the phone'
- they 'went above and beyond'.

Foster carers spoke about the availability of training to support them in caring for children residing with them. They told inspectors they receive a list of training dates at the start of the year and they chose what they would like to attend. Some foster carers told inspectors they were never asked what training they would need to fulfil their caring role.

Foster carers also spoke about their experience of child-in-care reviews. One foster carer told inspectors that the initial child-in-care review by phone was difficult because they were talking to a room full of strangers. They told inspectors that another review was in person and although it was delayed, it was much better. They told inspectors 'the review process was clear. Everything in relation to the child's needs was discussed'. They said 'we understood the next steps and what we jointly wanted to see happen in the future'. Foster carers told inspectors they received the minutes of meetings and copies of care plans. They said older children attended their reviews and that the 'reviews cover everything that that should be covered'.

Foster carers expressed concern about the delays and wait times in accessing specialised health services and other relevant supports for children with complex needs. One foster carer spoke about an 18-month delay in a child being medically examined by a paediatrician following their admission to care as this was impacted by COVID-19. Another foster carer said a child in their care was on a waitlist for 18 months to access disability services. Concern was also noted with regard to lack of respite being available when caring for a child with complex emotional and behavioural needs. One foster carer said 'there is not enough respite or it is available too late. There should be better access to respite and you should not have to feel you are begging for it'.

External professionals told inspectors that the foster care service had good management and oversight of commissioned services providing direct work and intervention to children and their foster carers. They said that the rights of the child was at the centre of the work undertaken and there was good communication with staff and an openness for discussions.

They told inspectors that there had been a positive change in approach and culture in the past year about how best to support and communicate with all stakeholders. They gave examples of innovative practices such as joint work undertaken between the area and external professionals to promote the participation of children in care with disabilities, which they said would improve the quality of care provided and outcomes for children.

External professionals also said that while the area strived to respond to the needs of foster carers and children in care, there were gaps in the resources available to meet those needs. They said that there had been staffing shortages on social worker teams. They said that there had been a lack of consistency of social workers for children in care and this was destabilising for children. While they said that managers endeavoured to ensure that all children needs were identified, decisions about some children were delayed and this put pressure on children's placements. In addition, they said that there was variation in the level of support and supervision afforded to foster carers by the service. They said expectations about what was required from foster

carers needed to be clearer and there needed to be better tracking of actions when issues are raised.

External professionals told inspectors that the area was taking actions to identify any deficits in the service. For example, given staffing issues which the area had experienced, the area outsourced foster carer assessments to improve the timeframes in which they were completed. They also spoke about the area learning from the management of complaints.

External professionals raised concerns about the lack of foster care placements for children in the area. They said that children could not always be matched to foster carers on the basis of need and suitability. They said that this meant children were placed outside of the area and they acknowledged this was also a national issue. They said that this may still be the best available option for children rather than moving to other alternative care arrangements such as residential care.

Governance and Management

The area had management and governance structures in place to oversee and deliver the foster care service. However, there were significant challenges which impacted upon the quality of the service being provided during the 12 months prior to the inspection. A review of the area's performance data identified operational risks in monthly and quarterly reports in 2021. These risks included high levels of unallocated cases, delays in achieving statutory work within timelines and major staffing deficits, all of which contributed to non-compliance with national standards. This led to a request by HIQA for a provider assurance report in September 2021. Regular updates provided until June 2022 indicated improvements in service performance which also indicated that children and foster carers were receiving a better quality service. The assurance reports provided outlined improved governance and oversight, the development of new local policies and initiatives to address service risks. Inspectors found that although the foster care service had improved governance and oversight at the time of the inspection, further improvements were required to ensure a safe and consistent service was provided to all children and their foster carers.

There was an effective management team in place who were driven to provide a high quality service and take action to address deficits when required. There was a joint ownership across the fostering and children-in-care teams in relation to what gaps in service provision needed to be addressed. This meant there was shared governance of the service and teams showed their commitment through attending various governance meetings and being involved in strategic planning for the service.

Strategic management systems were well developed. The service had a regional plan for 2022, which was aligned to Tusla's own corporate and business plan objectives. The service's business plan set out key actions for service improvement which were measurable and time bound and underpinned by a child-centred approach. Managers monitored the service area's performance and progress through an integrated strategic plan, which connected local targets, standards and service improvement plans with national objectives and targets. The service improvement plan was set out specific to each standard. In addition, findings from HIQA's phase 1 and 2 inspections and from Tusla's own thematic audits were integrated into service plans and development work which overall, was comprehensive and well informed.

Several of the risks in the service area had been recognised by the management team in 2021 and they had taken actions to address these. The area manager acknowledged that while improvements had been made, there was more that the area not only needed to but also wanted to achieve. This required efficient and smart team-working, which was evident through good communication systems which were in place.

Communication systems were strong which supported oversight of the service. Senior management meetings, governance meetings and quality forums included representation from each pillar and were well attended. These forums for discussion provided mechanisms for management assurance and continuous review of performance trends, progress made and areas of identified risk. This was evident in a review of documentation spanning over the previous twelve months. For example, there was significant work undertaken to reduce the risk of unallocated cases of children in foster care in the area, which resulted in 19 unallocated children in care at the time of the inspection. There was also a comprehensive review of foster carers who did not have an allocated link worker. A plan was put in place to ensure unallocated foster carers would be visited within the month following the inspection.

Managers routinely monitored the service's area performance in its service review of data at monthly meetings, through updating service improvement plans and individual supervision activity. Systems to support the collection of data to inform analysis of organisational risk and performance were developed but required some improvement.

Management trackers, registers and logs were used in the service as a mechanism to provide business intelligence about the quality of the service. These mechanisms would ordinarily alert management to delays in the completion of key tasks to ensure the quality and performance in the service being provided to children, foster carers and families, such as the management of allegations and serious concerns, for example. Inspectors found that the system in place for tracking the management of allegations and serious concerns did not accurately reflect up-to-date information and this was brought to the attention of the general manager of alternative care who took

immediate action to rectify this. The consistency of recording practices across the service needed to develop in order to improve the efficiency and accuracy of data analysis. This issue had been identified by managers and they recognised the need to make information governance a priority for the service to maximise the use of information intelligence to assist with service improvement and being compliant with national standards.

Improvement was required to develop other tracking mechanisms to capture the training and development of foster carers and trends associated with unplanned endings of placements for children in foster care, as well as those at risk of disruption. The lack of consistency in holding disruption meetings or reviews following placement breakdowns was a missed opportunity for managers to learn from these situations and inform the future plans for children. The area had identified this as a gap in service provision and action had been taken prior to the inspection to address this.

Systems for managing and reviewing organisational risk, overall, were well-developed. Risks were clearly identified, recorded and reviewed by the area's management team. The risk register had flagged staffing deficits and lack of placements as being high-risk among other issues. Concerns were also highlighted about insufficient access to specialist services such as disability services and psychology services. The area again had taken action with disability services and progress had been made due to action being taken. The area also had a special team who undertook work with children with complex needs and further action was taken to recruit a multi-disciplinary team to undertake assessments with children in care.

Systems and accountabilities for escalation of risk to the area manager, regional chief officer and national director were clearly defined. The area was proactive in attempting to resolve risks associated with the service. For the majority of risks, mitigating controls put in place by the service had been effective at reducing and or stabilising the impact of risk on service delivery. For example, governance arrangements in place for the management of unallocated cases had been effective and all staff described this as providing a safer service to children and foster carers.

There were regional and national structures to review and monitor high rated risks in the area which required a national or regional response. Controls put in place to mitigate against risks to the service from a regional and national level were tracked through a live and dynamic risk management system for the service. However, the risk management response from a regional and national level had not been effective in reducing all risks. There remained areas of ongoing organisational risk and challenge that were impacting on the service area's capabilities to provide a consistently high standard of safe, effective and child-centred foster care service, such as lack of placements for children.

The availability of foster carers to best serve children's needs in the area required improvement. The lack of placements had the potential to expose children to placement instability, multiple placements or being placed in residential care. The area did an analysis of placement requests which highlighted this vulnerability as some children were being placed in residential care as a result of no foster care placements being available. There were also additional pressures in foster care households who were asked to facilitate additional placements causing the numbers of children placed to exceed the standards or provide care for children outside of their approval status. Organisational gaps had been recognised by the service with evidence of outsourcing of foster care assessments to non-statutory agencies to assist with timely completion and approval of foster carers. Furthermore, the area had recently appointed a social care leader who would be dedicated to the recruitment and retention of foster carers.

The quality of monitoring and oversight by social work team leaders and principal social workers required improvement as there was insufficient monitoring of records. The extent to which written records, foster care assessments and reviews were adequately completed and on file was poor in the fostering service. Records did not reflect the good pieces of work undertaken by link workers who foster carers spoke very highly about in terms of the level of support being provided. It was evident from inspectors interactions with staff through interviews and various discussions during the inspection that the level of work undertaken was not reflected on foster care records.

Documents were missing, incomplete and unsigned by managers. This weakened the reliability of information to measure adherence to key quality indicators, such as missing supervision records, supervisory visits records and foster care assessments, some of which were missing pages when presented to inspectors. This area required improvement to ensure better oversight and understanding of outcomes for children and their foster carers and to ensure that information was clearly available for them if they wished to access their files either now or in the future.

There was a supportive and open working culture in the service. Managers worked hard to retain their staff. Staff who met inspectors described good mechanisms of support such as informal and formal supervision, as well as well-being initiatives being planned and opportunities for reflective practice and learning. Staff placed value on the support of one another's teams and this led to greater service provision.

Many staff had joined the service throughout the last year and with new policies, procedures and service improvement occurring, it was hoped by managers that staff would remain with the service, gain experience through their practice and remain to provide a safe, steady and consistent service to children and foster carers. They had good understanding of the policies and procedures in place relevant to their roles but

gaps in frontline oversight meant that there were gaps in practice and in adherence to policy and procedure. Staff were optimistic about the service's recent service improvements and were well aware of the impact of staff turnover on children and foster carers but also on the social workers themselves given additional work was assigned to them. This highlighted the importance of not only having regular supervision with staff but good quality to support staff through challenging times.

The response to incidents, complaints and representations was good but there were delays in some instances. The area maintained a register of compliments and complaints which was subject to review by managers through governance meetings and management team meeting and supervision. This supported ongoing learning and improvement. Mechanisms to enable children, families and foster carers to provide feedback to the service required improvement as there was poor evidence of this on files. Some improvements were required to broaden the scope and scale of learning from complaints such as broadening the capturing complaints which were not made through Tusla's national system given they were not recorded on the complaints register.

The Mid-West Foster Care Committees (FCCs) had governance structures in place to support their functions in line with the standards and the national policy, procedure and best practice guidance on FCCs but these were not all effective. Inspectors found that there were good records of member's personnel files.

Inspectors found that improvements were required to ensure that the FCC's discharged their accountabilities in line with Tusla's FCC's policies, procedures and best practice guidance (2017), standards and regulations. Due to significant work pressures last year with regards to outstanding foster carer reviews, not all foster carer reviews were presented to the FCC in the previous twelve months. The FCC's were not all routinely checking if foster carers had completed mandatory safeguarding training prior to approving them as foster carers.

This issue, among other identified risks arising from the inspection were escalated to the area manager and are judged under standard 19. Satisfactory assurances were provided in addressing the risk issues going forward.

Of the eight standards assessed for this inspection, four were judged as substantially compliant and four were judged as moderate non-compliant.

Standard 18 : Effective Policies

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

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

In general, policies, procedures and plans were in place to promote the effective and safe delivery of foster care services. These were informed by the relevant legislation, regulations and standards. However, not all the systems to monitor the implementation of policies were effective. Some key policies were not fully embedded in practice and this had not been appropriately addressed through effective management and oversight.

Managers who spoke to inspectors were satisfied that staff had a good understanding of policies and practice requirements. It was evident that policies were discussed at team meetings with staff. All staff who spoke with inspectors had an awareness about national policies and they had good knowledge about the local policies and procedures that guided their work. Local guidance documents were developed to support them in their work in relation to areas such as the management of unallocated cases, the independent child-in-care reviews and foster carer reviews. Policies were reviewed in a timely way as required and the area reflected on what had worked well and what required improvement. The fostering service in the Mid-West were proud of their learning culture and this ethos underpinned the service's value on partnership working.

There were policies and procedures to promote a partnership approach to the care of children including other stakeholders in the development and delivery of services. There were formal arrangements between the service and stakeholders to support this. Forums were in place for the service to engage and collaborate with external stakeholders, to develop joint working and to advocate for the needs of children in foster care where appropriate. Such meetings included joint working with the Health Service Executive (HSE), Garda liaison meetings, meetings with disability services amongst others. In addition, external stakeholders were included in the development and delivery of the service through the commissioning processes, which included additional funding to support foster carers and children through community-based events.

The area had recently updated their local guidance relating to notifications to An Garda Síochána when there is suspected or confirmed abuse has occurred as there had been a recent change in national policy. This showed good planning for the delivery of local procedures. It was noted that the guidance had been developed within a context of an ongoing national review of protocols and policies. The area therefore recommended that this new local guidance be reviewed by the end of this year.

In the previous 12 months, gaps in accessing specialist services, such as disability services, had been identified and placed on the area's risk register. When required, individual cases were escalated for involvement of the senior management team and Tusla's national office. At the time of this inspection, senior management were assured that good progress had been made in ensuring good collaboration in terms of joint protocol meetings with disability services. Terms of reference had been agreed and an implementation plan was being developed at the time of the inspection.

An initiative called Creative Community Alternatives (CCA) had provided dynamic and practical support to placements at risk of breakdown in the service area. There was a clear referral pathway for access to commissioned services through the CCA project and a project lead with delegated responsibility for oversight, review and approval of all referrals. This will be discussed further under standard 24 regarding special care arrangements.

While there was good partnerships in place with external stakeholders, the participation of children and foster carers in the development and review of policies required improvement. There was poor evidence on children's and foster care records of them being consulted and involved in the development or the delivery of the service. There was evidence of newly-approved foster carers being provided with copies of the standards and policies and two other foster carers had been involved in presenting at training to new foster carers.

The area was found to be operating in line with the inter-area transfer policy. Data provided by the area indicated two foster carers had transferred from other areas. Inspectors reviewed one of these records and found processes were followed by the area. All relevant documents were provided and presented to the FCC and the area formally wrote to the foster carers. Although there was some delay with the transfer, this was due to delays by the area transferring in, rather than the Mid-West region. The service also followed the national transfer policy in relation to children placed outside the Mid-West service area.

Inspectors found examples of poor practice which did not adhere to national standards and regulations. Inspectors reviewed a list of 95 unallocated foster carers who had recently been allocated a link worker to complete support and supervisory visits. Of those 95 foster carers, at least 26 did not receive a support and supervisory

visit during the twelve months prior to the inspection. This meant that while there was a plan in place to address this issue, a number of supervisory and support visits had not occurred in line with policy and regulations.

A new local policy had been put in place to address the significant number of foster carers who had not received support and supervisory visits in line with national standards and regulations. Overall, the new policy for the management of unallocated cases was working well. Staff and managers all reported that the service felt safer and they were confident that the policy assisted in providing good quality social work practice.

Inspectors found inconsistent practice in managerial oversight and supervision provided to social workers and it was not in line with national policy. The oversight of case management was judged under standard 19.

Inspectors found inconsistent practice in the implementation of Tusla's standard business processes for the management of allegations made by children. Inspectors looked at three child protection and welfare concerns for children in foster care and found that two were significantly delayed and did not adhere to Tusla's own timelines within standard business processes.

The area had implemented local measures which did not adhere to the Foster Care Committees – Policy, Procedures and Best Practice Guidance. The area had narrowed the criteria for when foster carer reviews should be presented to the FCC and this was not in line with national policy. This was done as a temporary measure due to staffing shortages and a significant backlog in foster care reviews which were required to be completed. The region had reverted to all foster care reviews being presented to the FCC at the time of the inspection.

All complaints and representations made to the service were not managed in line with Tusla's national complaints policy. There were delays in the processing of complaints and this is further discussed under standard 25.

There were inconsistencies with the adherence to several key policies. This meant areas of practice within the service required improvement as this impacted on the service provided to children and their families. For these reasons, the area has been judged as moderate non-compliant.

Judgment:
Moderate non-compliant

Standard 19 : Management and monitoring of foster care services

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

The area judged themselves to be non-compliant moderate with this standard. Inspectors agreed with this judgment.

Overall, there were established governance arrangements and structures in place, but improvements were required to ensure their effectiveness. Since the last inspection, progress was made to address various challenges but further oversight was required at the time of the inspection. The capacity of frontline teams and their managers had been impacted by vacancies and absences in the previous 12 months. This had been a significant organisational risk which challenged the service area's capabilities to effectively monitor the operations of the service and to drive improvement in line with the vision of the service held by managers. Some but not all posts had been filled at the time of the inspection, which led to a reduction in risk, and an improvement in the quality of the service provided to children and foster carers. However, the monitoring and oversight of the service required significant improvement.

Management structures and reporting systems were established in the service area at the time of the inspection. The area was under the direction of the regional officer for the Mid-West region. The interim area manager assumed their post twelve months prior to the inspection and told inspectors that they identified risks within the foster care service after commencing in the role. In the 12 months prior to the inspection, there were two general managers for alternative care providing governance and oversight at different times. The full-time general manager for alternative care resumed their post four months prior to this inspection. There was one principal social worker for fostering and two principal social workers for children in care. The area had secured a further principal social worker position with responsibility for quality, risk and service improvement and they had yet to commence their role. The regional chief officer told inspectors the area of priority would be the fostering service.

There was evidence of good collaborative working relationships between managers and their teams. There were clear accountabilities, with staff at all levels, understanding where and by whom decisions should be made. Managers and staff reported a reflective and open culture across the service. Staff said that they were supported in the delivery of care to children and families, and although the stability of staffing had improved, the past year had been challenging as they were assisting and supporting other teams to limit the impact of staffing shortages. Principal social workers who spoke with inspectors said that despite the challenges, they were more

assured of the service being provided. Staff at all levels told inspectors they felt that they were providing a safer service and spoke about working more closely across teams to provide a more cohesive service.

The area was committed to continuous improvement and this was evident through conversations with staff at all levels. There was openness in exploring how to do things better to provide the best possible service to children and foster carers. When non-compliances with standards was evident, senior managers set up a 'task and finish' group which identified all tasks requiring completion and assigned members of the teams to complete these tasks within a specified timeframe. Inspectors reviewed the meeting minutes and found the discussions to be comprehensive when deciding on smart, achievable tasks. The team also reflected on the process in terms of providing assurance reports and about their experience of developing their service improvement plan. This showed the area's drive to learn from what had happened and to progress service provision moving forward.

The service area benefitted from having experienced, attentive and receptive managers who provided good strategic leadership. They knew the area and community well and had clear vision for service improvement. They knew the strengths and weaknesses of their service, having already identified many of the deficits found on this inspection and already had plans in place to address these deficits.

The service area's strategic direction and service plans were appropriately aligned with Tusla's national service development and improvement plans. The interim area manager told inspectors that regional priorities were developed from the national plans and then in turn, local priorities were developed from regional priorities and decided with the local social work teams. Service led auditing, external monitoring and service plans were incorporated into an overarching service improvement plan which was reviewed and updated at senior management and governance meetings against performance and activity data and reports.

The area reported on all aspects of their foster care service as part of their annual Adequacy of the Child Care and Family Support Services report which was published nationally. The 2020 Mid-West annual report as well as the FCC's annual report informed the wider alternative care planning and service development activity.

Tusla's National Child Care Information System (NCCIS) was used to monitor service provision and allowed the management team to gather data to support service delivery. In addition, the service maintained a child-in-care register in compliance with statutory requirements and there were arrangements in place to ensure it was

updated and accurate. The register was reviewed monthly by the general manager for alternative care at the alternative care meetings.

The service area had a risk register which was well-maintained, monitored and up to date. There was good oversight of the risk register which was held electronically. This was provided by the interim area manager and general manager for performance support. The identification and classification of risk was comprehensive but the service did not have the capacity to implement all existing controls to mitigate against certain risks and some risks to the service persisted. Risks in relation to lack of placements to meet the needs of children in the area were regularly risk escalated but the risk management response from a regional and national level, had not been effective.

There was a 'need to know' (NTK) reporting mechanism in line with Tusla's national incident management system and this was used to notify Tusla's national office of serious incidents and adverse events in relation to children in care. There were six such notifications in total made to the national office in the 12 months prior to this inspection. Inspectors reviewed two of the NTK's and found there was appropriate follow up and further review that provided assurances to the safety of children or staff.

There were senior management meetings at which risk management was discussed. For example, the alternative care management team consisting of principal social workers and general managers met with the interim area manager on a quarterly basis. Meetings consisted of an analysis of how the service was performing and identified actions which were required to be taken. The Mid-West fostering governance group was attended by general managers, principal social worker for fostering and social work team leaders. They reviewed monthly performance metrics, resources, the panel of approved foster carers as well as other standing item agenda items such as foster care assessments, visits and reviews. The minutes of these meetings were comprehensive, actions were clear and reviewed at subsequent meetings.

In addition to senior management meetings, individual team meetings were regularly held to ensure ongoing monitoring of performance against policies, procedures, statutory requirements and standards, but inspectors found that oversight and monitoring of aspects of service delivery by social work teams required improvement.

Overall, the regularity of formal supervision reviewed was good but the quality was variable. Inspectors found that senior manager's oversight and support in supervision was good, with discussions clearly documented and plans put in place for any issues arising. Inspectors saw some examples of good practice such as good case discussion

including clear decision-making and direction of appropriate next steps. Some records showed little focus on the quality of children's lived experiences which compromised the tracking of outcomes for children through the supervision process. Some records were poor, for example, they were incomplete, handwritten and illegible. Case management actions were not always evidenced as being completed in subsequent sessions.

Whilst social workers and link workers reported that children and foster carers were being well supported, there were significant gaps in supervision and case management on children's and foster carer records. Supervision and case management records were not consistently being recorded across all teams and at times, they were absent from foster carer files. This required improvement to ensure consistent and effective management oversight of these cases. The area provided assurances following the inspection that this would be addressed.

The auditing of case records was an area for significant development. Inspectors found poor use and implementation of information management systems on this inspection. In some foster care files reviewed, substantial amounts of information which should have been held securely on foster care files, were not on file or were incomplete. Although there was a plan in place for social work team leaders to audit one file per month and senior managers were of the view this was happening, when inspectors requested the audits it was established that they had not been completed.

In their SAQ, the following issues were identified by the alternative care manager as areas requiring improvement and plans were put in place to address these gaps.

- There were legacy fostering reviews as the area had a number of reviews outstanding. A system was put in place to ensure the backlog could not occur again. A fostering governance group was set up to track these reviews and had its remit extended to track all performance data relating to the fostering service on a monthly basis. Other actions included a more refined tracker being develop to flag all reviews when they were due and all completed fostering reviews were being presented to the FCC
- Deficits in the management of disruptions in foster care was identified as a significant gap. Disruption meetings were not routinely happening or being jointly presented to the FCC by the children in care team and fostering team. A local policy was being developed at the time of the inspection to guide staff on the management of disruptions.
- Long-term matching was outstanding across the region. Specific FCC's to address this were scheduled for September 2022. Monthly business meetings between fostering and children in care teams had commenced and matching was an agenda item to ensure future tracking.

Inspectors identified additional areas requiring improvement during this inspection. These were brought to the attention of the general manager for alternative care and the interim area manager during the inspection. These issues, while referred to under other standards, the monitoring and oversight of them to ensure they did not occur required improvement, and therefore were judged under this standard.

During this inspection, priority action was required to mitigate one urgent non-compliance. From a review of files and records, inspectors identified seven foster care households whereby both children and their foster carers had not been visited in the six months prior to the inspection. Inspectors reviewed the tracker that the area had developed to monitor the supervisory and support visits to foster carers who did not have a link worker. Inspectors requested further information with regard to the most recent social worker visits to children residing in those foster care households. From this information, it became apparent that neither a social worker from the children in care team nor fostering team had visited these seven foster care households for at least six months prior to the inspection. This was not in line with national standards and regulations and demonstrated poor oversight of information available to managers. The interim area manager provided satisfactory assurances that these children had statutory visits organised within one week. They advised that the social work team leaders and principal social workers would maintain oversight of statutory requirements to plan for their completion.

Following this inspection, HIQA also requested the area to complete an urgent compliance plan to provide assurances against this standard in relation to other identified gaps in the management and monitoring of the foster care service. These gaps related to the following inspection findings;

- Not all foster carers received mandatory training in Children First and not all were updated in line with requirements. Upon review of foster carer files, lack of mandatory training records was evident. Inspectors also reviewed the area's records with regard to Children First. Managers could not provide assurances that all foster carers had up-to-date training in Children First as required by national standards and regulations.

Following the inspection the area provided satisfactory assurances. Upon managers reviewing the register of foster carers, for 127 foster carers their mandatory training in Children First was out of date. Measures were put in place to ensure this would be addressed and improved oversight would be in place going forward, such as completion of this mandatory training prior to approving foster carers and ensuring link workers fulfil their responsibilities for ensuring this as part of their support and supervisory role of foster carers.

Furthermore following this inspection, HIQA also requested the area to complete a provider assurance report to provide assurances against this standard in relation to further identified gaps in the management and monitoring of the foster care service relating to children's records. These gaps related to the following inspection findings;

- Case management and oversight by managers was not evident on all children's files reviewed by inspectors. This meant that decisions made about what actions were required were not routinely documented on children's records. Inspectors obtained assurances from the interim area manager about this issue. The region acknowledged that improvements were needed regarding consistently filing supervision records on children's files and the oversight of children's files. The area put a plan in place to ensure improved oversight.
- The quality and recording of support and supervisory visits to foster carers was poor, and not consistently on their file. Foster carer records demonstrated overall poor quality in relation the support and supervision provided to them. There was little up-to-date recording on the majority of foster carer records which was a poor reflection of any of the work undertaken by the fostering link workers. This meant that decisions made about what actions were required were not routinely documented on foster care records.
- Systems with regard to information governance was poor. For example, the poor quality of foster carer files, handwritten records on some files, and lack of audits on files by social work managers.

The area provided HIQA with satisfactory assurances in relation to how the service would address these issues. This included;

- improvements were needed regarding consistently filing supervision records on children's files and the oversight of children's files
- all staff would read and comply with the staff supervision policy and confirm same with their line managers
- supervision training to be completed by supervisees and supervisors
- social work team leader audits of children's files and these would be placed correctly on the children's records and presented to senior management at monthly meetings
- senior managers would audit compliance with the supervision policy
- Practice Assurance and Service Monitoring (PASM) to conduct a verification of service improvement with the staff supervision policy.

The area acknowledged that the quality and recording for support and supervision visits to foster carers and that the governance of information in the fostering service required improvement, and provided the following assurances:

- A local Standard Operating Procedure (SOP) was being developed to support staff to conduct and record good quality support and supervisory visits
- The storage of fostering records was reviewed and updated

- Training for all fostering staff in areas such as NCCIS and supervisory and support visits
- A full audit of all fostering files will be conducted by senior managers of the service.
- Social work team leaders and link workers will also audit files.
- Findings from audits would reviewed by senior management during the monthly alternative care meeting.

In addition to the above actions outlined to address the gaps identified, the area had 19 actions in their service improvement plan to attain compliance with this standard. The area manager and senior managers told inspectors that with the findings of this inspection report, they would review their service improvement plan to ensure it remains focussed on the risks identified and a re-prioritisation of actions may be required based on addressing the more immediate risks in a timely manner.

Overall, management and oversight of several aspects of service delivery required improvement. It is acknowledged that the area had already commenced actions to address some of these deficits at the time of the inspection. To achieve full compliance with this standard, more effective structures were required to be in place for the management and monitoring of the foster care service. Therefore, the judgment was moderate non-compliant.

Judgment:
Moderate non-compliant

Standard 20 : Training and qualification

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

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

Staff were experienced and competent and had the required skills and knowledge to efficiently perform their duties However, further training was required in the areas of information management, supervision and statutory duties to ensure all staff members were fulfilling their respective roles. All appointees were selected under competency frameworks to ensure they met the required competencies in terms of professional knowledge and standards required to fulfil the role. Turnover in the area

had greatly reduced from 2020 when it was 104% compared to 2021 when it was 19%.

A sample of 10 staff personnel files were reviewed for safe recruitment practices. Evidence of professional registration and renewal of registration were available on all staff files who were professionally qualified social workers. There were gaps in staff personnel files held centrally. Five staff files were missing information such as references, qualifications and date of appointment. Inspectors brought this to the area's manager attention who took action and liaised with the regional human resources team. Assurances were provided that the required missing documentation were held by the regional human resources office. Vetting and professional registration was monitored locally by the area to ensure action was taken when they were due for renewal. Inspectors observed this tracker and noted it was up to date.

The service maintained clear job descriptions for all staff and members of the fostering teams and ensured each staff member and foster carer were aware of their roles and responsibilities. Newly qualified staff availed of corporate induction and regional induction. General managers gave a presentation to new staff as part of the induction program.

Retention and wellbeing initiatives were in place to support staff. Staff wellbeing was addressed at team meetings and within individual supervision. Formal wellbeing initiatives included the employee assistance programme and access to occupational health. Senior management encouraged continuous professional development (CPD) and bespoke training opportunities. For example, it was evident in supervision files that some staff had availed of trauma-informed training to support them in their work.

A training needs analysis had been completed by management and the workforce development unit. There were nine areas identified for fostering and these included refresher training on assessments, undertaking foster carer reviews, managing disruptions in foster care and the management of serious concerns and allegations against foster carers. Management training was also identified as a priority for the area and was being completed at the time of the inspection.

Joint training of social workers and foster carers was an area for improvement. The training needs analysis noted that there was a significant gap identified in the area regarding joint training opportunities with foster carers and staff. This gap was also evident from foster carer file reviews and staff supervision records. The area's SAQ noted that a training schedule was sent to foster carers and fostering link workers who were encouraged to attend. Data provided by the area noted that there had

been one joint training throughout 2022 and this was attended by one fostering staff member.

Management had poor oversight of training completed by social workers. Managers advised that staff training information was held with the workforce development unit and although requested, it could not be shared with managers. Managers told inspectors training was discussed in supervision and each worker was responsible to produce their training certificates to be held on their supervision records.

Supervision records were of mixed quality and the majority required improvement. Some records contained very little or no evidence of training completed by staff. The use of training and development plans was inconsistent across the teams. The interim area manager was aware of this and told inspectors about plans to focus on the quality of supervision and training plans moving forward. Despite the lack of evidence of formal supervision, social workers told inspectors they felt very supported by their line managers. Staff told inspectors that informal supervision occurred on a regular basis and this was not always recorded.

The Mid-West region was in the process of rolling out a staff well-being and retention initiative as part of a national strategy. It focussed on all aspects of work, the workplace, careers, psychological and physical wellbeing. Tasks due for completion by the end of the year included a staff engagement forum to coordinate activities, the delivery of a leadership development programme and other training workshops.

External professionals reported good working relationships with social workers to improve the outcomes for children. They spoke about good communication with social workers and that there had been positive changes in the last 12 months. They told inspectors that the area was open to working with external services and there was an openness in terms of how to best support children's placements. They said the area place value and priority on children's rights and participation and the best interests of children were promoted by staff.

Judgment:
Substantially compliant

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

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

The area judged themselves to be non-compliant moderate with this standard. Inspectors agreed with this judgment.

The area acknowledged in its SAQ that it had insufficient carers to meet demand and would benefit from a greater pool of foster carers. Senior management told inspectors based on experience and needs analysis, that word of mouth and positive experiences of existing carers was the most successful recruitment and retention tool. Existing carers support staff in recruitment campaigns. For example, foster carers who attended coffee mornings were encouraged to bring along someone who was interested in fostering. While a number of coffee mornings occurred, information provided by the area indicated that attendance was poor and alternatives needed to be explored.

The service area had a recruitment and retention strategy for 2021-2022. The aims were to improve local placement choice and stability for children and to continue to work on ensuring that foster carers felt valued and supported in their role. This included a bespoke recruitment campaign with the ROMA and Traveller population.

There were 90 enquiries regarding becoming general foster carers in the service area in the 12 months prior to the inspection. From these enquiries, 43 progressed to application stage and 15 foster carers were approved in 2021.

Enquiries and placement requests were reviewed on a weekly basis at placement planning meetings. The meeting records were updated to reflect subsequent discussions and progression of actions assigned to the fostering team members. From information provided by the area, the timeframe to respond to initial inquiries from prospective foster carers was 3 to 5 working days.

The area had completed an analysis of placement requests for 2021 to determine how many placement requests were met. The analysis showed that there were seven instances where residential care was sought as a last resort for children where lack of placement was the primary consideration. The analysis noted that children deemed suitable for foster care could not avail of it because placements could not be sourced through Tusla or private foster care agencies.

Relatives were always the first option considered for any child placed in care. This was supported by the signs of safety assessment and safety networks that were

generally in place before a child was placed in care. In this area, 27% of children in foster care were placed with their relatives.

The area maintained panels of approved persons who were willing to act as foster carers in order to comply with the Child Care (Placement of Children in Foster Care) Regulations 1995. The alternative care manager maintained oversight of the panel, and had a system in place to ensure it was updated on a monthly basis at the foster care governance meeting. The panel contained all necessary information in relation to the foster carer.

Inspectors reviewed a sample of foster carer records who had been approved as foster carers in the twelve months prior to the inspection. The sample of files demonstrated significant delays in completing foster care assessments. One assessment commenced one year after the application was received. Not all foster care assessments were on foster carer files. When inspectors requested two assessments, there were pages missing from both reports. The area had identified that there were significant delays in completing foster care assessments and had outsourced a number of these to non-statutory agencies to complete.

There were mixed findings in terms of matching foster carers with children. While there was evidence in some files, there was no evidence on others and some foster carers had children placed in their care outside their approval status. For example, one child was placed with foster carers on a long-term basis although their foster carers were approved to care for children on a short-term basis. This meant that foster carers may not be the best match for that child or may need additional support if caring for a child on a long term rather than a short-term basis. For example, another foster carer requested regular respite to provide them with additional supports to fulfil their caring role on a longer-term basis. Another example was foster carers were approved to take a child of a certain age but a child not in line with that age was placed there

Efforts to retain foster carers was not evident in most of the foster carer files sampled by inspectors and this required improvement. There was a lack of evidence of retention initiatives, well-being initiatives or of foster carers being encouraged to attend any local support groups.

There were planned initiatives aimed at supporting foster carers and improving wellbeing through parallel support groups, training events and days out organised by both a national advocacy group and the fostering service. Liaison meetings had commenced with an external stakeholder to discuss working together to provide support services for foster carers such as a helpline, advocacy, counselling services and training. Liaison meetings were scheduled to occur every six months.

The area was aware there had been significant challenges to retain foster carers. In the 12 months prior to the inspection, the area had to end some placements, as the

level of care being provided was not to a good enough standard. It was noted in their SAQ that while the area considered this to be a measure of good practice, it was also challenging when there was a shortage of foster carers available. A further 28 foster carers voluntarily left the panel in the 12 months prior to the inspection.

Exit interviews were completed in a timely manner and outcomes were discussed with the foster care committee. Inspectors sampled some of the 13 exit interviews completed in the 12 months prior to the inspection to review the reasons why foster carers made the decision to no longer foster. Reasons included children ageing out of care and personal family-related issues. Their fostering experience was mixed with some foster carers reporting good support from social workers while others reported communication difficulties with social workers. Learnings differed according to their respective experiences, such as consideration of the impact on carer's own children and the need to decrease delays in completing assessments.

An area of good practice was the region had recently recruited a dedicated social care leader to oversee and manage the recruitment and retention of foster carers. Given the specificity of this role, it was planned that further improvements would be made in both the recruiting of foster carers, a greater emphasis and drive could be placed into retaining foster carers and continued collaborative work with external agencies could further support this.

Judgment:
Moderate non-compliant

Standard 22: Special Foster Care

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

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

There was no national policy in relation to special foster care service for children whose behaviour posed real and substantive risks in line with the criteria set out in national standards. The Mid-West did not have a formal special foster care scheme and did not denote special foster carers on the panel of approved carers. There was a local briefing note in place with regard to identifying, recognising and supporting children with complex needs. Inspectors assessed this standard against the

arrangements in place to provide additional supports and resources to children with complex needs and their foster carers.

Data returned by the area indicated there were 47 foster care households in receipt of enhanced supports who provided care for 63 children in the area. The area had a number of fostering placements where there were individually designed support packages in place as well as an enhanced fostering allowance for foster carers depending on the child's complex or therapeutic needs. This meant that children were provided with the level of care required to meet their individual, additional needs.

The area also used their own community-based support services which allowed social workers to develop creative packages of care to assist children in foster care. This meant that placements could be maintained and placement breakdowns could be avoided, where possible. A total of 38 children in foster care placements received supports through these services within their own community.

A number of criteria had to be met for children and foster carers to avail of these additional resources and supports. The social worker was required to complete a comprehensive assessment of need which was reflected in the child's care plan. The package of support was clear in the child's care plan and included multi-agency input when required. The proposal was presented to the principal social worker and if financial support was required, this was approved by the interim area manager. The enhanced payments were to be reviewed every six months at the monthly county-based forums.

From a sample of foster care households file reviews, the level of social work support provided to foster carers and children with complex needs was mixed. In some cases there was evidence of good support provided by fostering link workers and children's social workers to ensure children's needs were met. For example, a social worker transported the foster carer and child to various appointments. There were gaps in visits for the majority of these foster carers and children and the recording of visits required improvement.

Manager's oversight of the foster carer files who were caring for children with complex needs was an area for improvement for the area. Given these foster carers and children have additional needs and were receiving additional resources, there was a lack of oversight on the files. This led to some key actions not being addressed in a timely way.

Inspectors found that foster carers received enhanced payments and children received additional supports depending on their needs. Children were referred to services such as the area's aftercare team and the therapeutic team for support. The area also provided respite for children. This was recorded on foster carer files and assisted in maintaining children's placements over a sustained period of time. However, the lack of respite placements for children meant that some children and

foster carers who required this support were not always provided with it in a timely manner.

There were appropriate external professionals involved in supporting foster carers and children such as mental health services, disability services and other commissioned services. These professionals also attended child-in-care reviews and were involved with children's care plans.

Care plans for children with complex needs were child-centred and of good quality. Child-in-care reviews showed participation of a range of professionals involved with children and good levels of information sharing to ensure accountabilities for practice and monitoring of the impact of interventions in addressing children's additional needs.

There were slight delays in some reviews occurring which did not impact on children's safety. The relevant professionals involved with children contributed at the reviews and to care plans. The various needs of the children were discussed, actions were identified and the most appropriate person was assigned to complete the actions.

According to the regional chief officer, there was a drive to further promote a comprehensive multidisciplinary assessment of need for children in foster care. Recruitment was occurring at the time of the inspection to fill positions in a therapeutic multidisciplinary team. This could potentially mitigate against the delays experienced when children were referred to external professionals for specialised assessments such as occupational therapy and psychology.

Judgment:
Substantially compliant

Standard 23: The Foster Care Committee

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

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

In the Mid-West Area, there were three Foster Care Committees (FCC), one in each of the counties of Limerick, Clare and North Tipperary. The three committees were chaired by three separate chairpersons and the three FCC's met separately on a monthly basis. The FCC chairpersons provided cross-cover for each other as required

to ensure that FCC meetings could continue to occur. There was one secretary designated to support the chairpersons and the functions of the three FCC's in the area. The committees also had a part-time administrative officer.

The membership of the committees was in accordance with Tusla's Foster Care Committees, Policy, Procedures and Best Practice Guidance (2017). Committee members consisted of a broad range of members with appropriate experience and qualifications. It also included representation from public health nursing, medical health officers, foster carers and experienced social workers. Committee members offered specialist advice and the FCC had access to other relevant specialist advice externally if required.

A review of ten FCC member's files showed that they contained the relevant documentation regarding their qualifications, police vetting and professional registration where required. Member's files were well-maintained and it was easy to retrieve the required information. Appropriate arrangements were in place to track Garda vetting and renewal. When there were delays in renewing vetting, members were advised they could not attend committee meetings until this was in place.

Member's files also had induction records indicating that all members had received an appropriate induction which enabled them to carry out the FCC's functions effectively. New members received briefings on FCC policies and procedures as part of their induction. Members received a letter of appointment and an information pack which included relevant legislation and policies.

Training provided to committee members required improvement. The area's draft 2021 FCC annual report noted two online training events were offered to committee members that year. It also noted that there had been agreement that a formal training plan would be put together for FCC members and a training log would be kept on each member's file. These actions had yet to occur.

There were four FCC governance meetings scheduled each year. These were chaired by the general manager for alternative care and attended by FCC chairpersons, principal social worker for fostering and the FCC secretary. These meetings reviewed the work of all three committees and agreed any actions required. The interim area manager had delegated the oversight of the FCC to the general manager for alternative care. This meant that the interim area manager did not meet directly with the FCC chairs but rather met with the general manager to review the overall work of the FCC's.

Inspectors found that the minutes from FCC meetings were detailed and ensured that the FCC met their responsibilities in line with the relevant standards and policies. Inspectors found good evidence of the FCC requesting additional information when required, in order to support them to make appropriate decisions. Minutes included consideration of disruption reports, notifications of serious concerns and allegations

and outcome reports, notification of placements over numbers, matching long-term approvals, consideration of assessment reports of foster carers and reviews of foster carers. The minutes were comprehensive and well structured, with clear recommendations and decisions recorded.

Due to capacity issues within the service over the 12 months prior to the inspection, foster carer reviews were not always presented to the FCC and when they were, they were not presented in a timely manner. Inspectors found evidence of this in foster carer's files and it was an area for improvement which management were aware of. Foster carer reviews were not routinely being presented to FCC's except for those where there was a change in approval status or there was an allegation of abuse or a serious concern about a foster carer. While this practice had changed by the time of the inspection and all reviews should be presented to the FCC going forward, this practice was not in line with national guidance and standards.

The FCC wrote to all social workers, applicants, and foster carers to inform them of the FCCs decision in relation to their case. Where applicants had been approved to become foster carers, the FCC sent them the decision in writing with copies of the national standards and information in relation to foster care support services.

During the inspection, it became evident that foster carers were being approved by the FCC without mandatory Children First training being completed. Inspectors escalated this issue during the inspection, as foster carers are mandated person under Schedule 2 of the Children First Act 2015, and issued an urgent compliance plan. Immediate action was taken by senior management to address the issue, and a satisfactory compliance plan was received. The monitoring and oversight of this issue is discussed further under standard 19.

The presenting of disruption reports to the FCC required improvement and this was being addressed in their service improvement plan. The area were in the process of developing a draft procedure to guide social workers about placement at risk disruption strategy meetings and how to evidence the implementation of national policy.

Allegations and serious welfare concerns were not notified to the committee in a timely or consistent manner. Inspectors reviewed three serious concerns and allegations. Two were notified in a timely manner and a third had not yet been notified, twelve months after the allegation had been made. One of the two notification reports was not accepted as there were gaps in the information provided. Although the FCC requested a subsequent update, there were significant delays in case management and this remained outstanding at the time of the inspection, ten months after the request was due before the FCC. This showed poor oversight of processes to ensure national policies and guidance were being adhered to.

The committee's work was underpinned by their annual report and service improvement plan that had been informed by the committee's activities and learning over the previous year. This informed the wider alternative care planning and service development activity and information about the FCC was included in their annual Adequacy of the Child Care and Family Support Services report which was published nationally. The 2021 FCC Annual Report, which was in draft form at the time of the inspection, outlined areas such as reviewing membership of the FCC to increase diversity, developing a formal training log, tracking of foster carer reviews and improved information governance.

Not all foster care reviews had been presented to the FCC and there were also delays in those that were. Improvements were required to ensure disruption reports were presented to the FCC and with regards to Children First training for foster carers at approval stage. There was an immediate escalation with regard to this standard, given the legal requirement under the Children First Act 2015, and therefore it has been judged as non-compliant moderate.

Judgment:
Moderate non-compliant

Standard 24: Placement of children through non-statutory agencies

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

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

There were service level agreements in place with non-statutory agencies used by the area. The oversight and governance of non-statutory agencies formed one of the business plan priorities in 2021, which resulted in agreed national procedures being implemented. The area accessed emergency placements when required through the private service as this was contracted on a national basis.

There were six non-statutory agencies commissioned by Tusla and five had service level agreements in place, and the remaining one was being progressed. Tusla had a delegated national manager who provided governance of each of the non-statutory agencies. The national manager met with the non-statutory services four times per year to discuss items such as performance data, governance and finance. Inspectors

were told that the national manager then communicated with the regional chief officer and interim area manager about any issues arising.

In the SAQ, the area stated compliance was measured through care plans, child-in-care reviews and statutory visits. Social workers and managers also told inspectors that children placed in non-statutory agencies should be visited and supported in line with standards and regulations. Inspectors sampled the files of children residing in non-statutory agencies for compliance against this standard.

Improvements were required to ensure good monitoring and oversight of the placements provided by non-statutory agencies. All four children's records had gaps in statutory visits to children and poor evidence of case supervision. Some records lacked evidence of joint-working with non-statutory agencies. Inspectors sought assurances from social workers who advised that this did happen but had not been recorded on children's files. Although care plans were detailed and child-centred, there were delays in them being reviewed and signed off by managers. Monitoring and oversight of the service has been judged under standard 19.

Good practice was seen on files for additional supports being provided for some children and foster carers and a child-in-care review occurred when a child moved placement. This meant that the child's needs and change in living arrangements were discussed to ensure people involved in the child's care were aware of impact for the child.

The area's service improvement plan detailed how the area aimed to reach compliance with this standard. Local actions included care plan reviews as well as monitoring of statutory requirements through supervision with social work team leaders.

There were delays in statutory visits and child-in-care reviews. There was poor evidence of oversight of the cases as well as delays in managers signing off documents. Therefore this standard was judged as substantially compliant.

Judgment:
Substantially compliant

Standard 25: Representation and complaints

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

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

There were some delays in managing all representations and complaints but these did not pose a risk to children's safety. Effective oversight was in place which demonstrated a response and satisfactory resolution to the complaints. The area maintained a tracker of representations and complaints and they were standing agenda items on the quarterly management meetings chaired by the performance support general manager. Staff at all levels had been trained in relation to the management of complaints. All 14 principal social workers were complaints officers for the area.

The tracker recorded complaints made through the national system only which meant that complaints made outside of this system were not captured. This meant that potential trends or possible learnings may have been missed. Data provided by the area indicated that no children had made a complaint in the twelve months prior to the inspection and this may have been the case as only formal complaints were being recorded. A review of the complaints tracker demonstrated an efficient response to all complaints. There were 13 entries recorded in the twelve months prior to the inspection. Two remained open at the time of the inspection.

It was not evident from a review of case files if complainants were advised of the outcome of their complaint. It was noted on the tracker that two complaints were closed by way of local resolution. However, there was no record on case files of the final responses being sent to the parent and foster carers.

There was a delay in resolving two of the three complaints reviewed by inspectors. While complaints were acknowledged in a timely way, there was no evidence on files to show that complainants were updated and advised of delays every 20 days, as required by national policy. An internal audit dated February 2022 had also identified this issue. A more recent complaint reviewed by inspectors was completed in a timely manner.

Children in care were advised of how to make a complaint. Social workers told inspectors that they talk with children and foster carers about complaints and some parts of service delivery they may not be happy with. Social workers told inspectors

they provide children and foster carers with written information about how to make a complaint. Inspectors sampled children's files to see if they had been informed about the complaints process. There was evidence of this on some files but not all. Inspectors did see good practice on one child's file who had a disability. An advocacy worker had been assigned to the child to ensure their needs were being met.

Information in relation to external independent advocacy services was available to children, foster carers and parents if required. External advocates reported an open culture, where children's rights and advocacy were strongly promoted. They reported strong joint working with all front line teams in shared efforts to manage risk and improve outcomes for children.

Inspectors found poor evidence of foster carers being informed about how to make a complaint. A review of foster carer files showed that although the supervision and support template for visits to foster carers prompts this discussion, the section about informing foster carers about the complaints process was blank on the majority foster carer files reviewed by inspectors.

For those complaints recorded, the service area actively sought to use them to support organisational learning and quality improvement. The area had completed a review and analysis report of complaints made in 2021. The main finding was that most (30 out of 33) complaints related to communication issues perceived by the complainant. Senior managers told inspectors that from this, training for staff had been approvedabout usingplain English when communicating with children, parents and foster carers.

The area reported they had received 20 compliments from a variety of sources in the 12 months prior to the inspection. These included compliments from foster carers, parents, judges and other external stakeholders. A review of a sample of the compliments noted positive feedback about the support provided by children in care social workers and social work team leaders. The interim area manager wrote to the respective individuals to let them know she had been informed and thanked the staff member for their service delivery. This was an example of good practice in the area.

The area's service improvement plan detailed how the area aimed to reach compliance with this standard. It involved planned actions such as monitoring through quality, risk and service improvement (QRSI) meetings, how to record on files that children understand how to make a complaint, ensuring staff understand the complaints procedure and developing a participation plan to assist children with disabilities to fully participate in their reviews and have their voices heard.

There was poor evidence on files of children and foster carers being informed about how to make a complaint. There were delays in managing some complaints in line with Tusla's policy. There was no record on foster care records of final responses

being sent to the parent and foster carers and it was not recorded if they had been informed of the appeals process.
Judgment: **Substantially compliant**

Appendix 1: National Standards for Foster Care (2003)

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

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