Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Service Area Inspection

Health Information and Quality Authority Regulation Directorate monitoring inspection on the progress of the service area's implementation of their foster care services actions.

Name of service area:	Kerry
Name of provider:	Child and Family Agency Tusla
Type of inspection:	Mon-0033745 Follow up Risk based Foster Care Inspection
Date of inspection:	12 – 15 October 2021
Lead inspectors:	Olivia O'Connell
Support inspector(s):	Lorraine O Reilly Susan Geary Leanne Crowe

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 of Kerry Service Area was a follow-up inspection due to the on-going risks within the children in care and fostering services in the area. A risk based service area inspection of the child protection and welfare service and the foster care service in January 2021 identified non-compliances and risks to children in care in the area.

This inspection was a foster care inspection aimed at assessing the progress within the area with respect to agreed actions by the area manager identified to address risks to children in response to previous inspections and significant risk issues identified within the area in 2020 and 2021. In the context of this inspection, the areas inspected related to identified risks and therefore the entire standard was not assessed in all cases.

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interviews with the area manager and principal social workers
- speaking with foster carers and children
- focus groups with social workers, link workers and team leaders
- interview with the chair of the Foster Care Committee
- questionnaires sent to children in care in the area
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of relevant sections of children's case files
- the review of relevant sections of foster carers' files
- the review of other reports and documents as required.

The inspection team issued a request for documentation and data to the service area in relation to each standard of the inspection. The inspection team endeavored to evaluate progress within the area in the management of identified risks and engaged with the social work teams and management with respect to the systems and governance issues which were acknowledged by the area following the previous inspections of the service.

Where an inspector identified a specific issue or systems risk that may present an immediate and or potential serious risk to the health or welfare of children, then, in line with HIQA policy, these risks were escalated to the relevant local Tusla manager during the inspection fieldwork and or following completion of the inspection fieldwork to the Tusla area manager, regional service director and or Tusla's director of services and integration.

Acknowledgements

HIQA wishes to thank children, families and foster carers 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 service area

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 area managers. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the director of services and integration, who is a member of the national management team.

Service area

Kerry is one of Tusla's Child and Family Agency's 17 Areas and forms part of the Southern Region. The 2016 Census recorded a total population 147,707 in Kerry with a child population (0-17 years) of 34,527, representing 23.4% of the Area's total population. The area is under the management of the interim service director for the Tusla South region, and is managed by the area manager who has responsibility for the senior management team. The senior management team consisted of:

- area manager
- principal social worker - duty/ intake team
- principal social worker - child protection and welfare team
- principal social worker - children in care team
- principal social worker - fostering team and aftercare team
- manager - prevention, partnership and family support
- principal social worker - family centre and independent chair for the foster care committee
- principal social worker - child protection case conference chairperson
- business support manager.

At the time of this inspection, the area had a dedicated duty/intake team, child protection team, children in care team, fostering team and aftercare team. The area also had an area support team that provided oversight of retrospective cases of abuse and service development; however the principal social worker who had been providing oversight of the area support team had recently retired and the post remained vacant at the time of this inspection. The child protection and welfare team was providing oversight of retrospective cases since Q2 2021.

Since the previous inspection in January, principal social worker posts were reconfigured to ensure that each team was assigned a dedicated principal social worker post for oversight.

Children in Care and Foster Carers

According to data provided by the area, there were 133 children from the area in foster care at the time of the inspection. The area had one children in care team who provided a social work service to all children in care. There was one principal social worker who had responsibility for the children in care team, and one principal social worker overseeing the fostering team at the time of the inspection. The children in care team was managed by two social work team leaders who reported to the

principal social worker. The two team leaders managed a team of seven social workers, one child care leader and one administration support officer. Two other child in care social worker posts were vacant at the time of the inspection. A senior practitioner social work post had been identified for the children in care team and was in the process of being filled at the time of the inspection. A third social work team leader had a dedicated role of chairing child-in-care reviews; however this post was vacant at the time of the inspection. Principal social workers and team leaders were chairing child-in-care reviews on a rotational basis while awaiting for the post to be filled. The fostering team had one team leader who reported to the principal social worker. The team leader managed a team of three social workers, one senior social work practitioner, one social care worker and one administrator. The fostering team had 2.5 vacant social work posts at the time of the inspection.

Kerry Service Area monitoring and inspection activity

Below is a brief overview of inspection activity and engagement with the Kerry service area relevant to this follow-up inspection of foster care, including the risks identified since the last foster care inspection in 2019 and the risk-based service area inspection in January 2021:

March 2019: Foster care inspection

The key findings were largely related to poor governance. Two standards were non-compliant moderate, two were substantially compliant and two were compliant. The key risks were:

- no system in place to track allegations and child protection concerns
- inadequate management and classification of complaints
- the area had not appropriately informed the Foster Care Committee (FCC) of relevant issues about placements and child protection concerns against foster carers
- lack of documentation about case management and safety planning
- an absence of managerial oversight of care plans and quality of records the validity of the data provided by the area to Tusla national office and HIQA; given that there were differences in what was reported and what inspectors found.

January 2021 – Risk Based inspection

A service area risk based inspection which included the child protection and welfare service and the foster care service was carried out. The focus of the inspection was

to assess progress in relation to the implementation of measures to enhance the capability and capacity of the service. Progress had been required to ensure the delivery of safe and effective child protection and welfare and foster care services in Kerry. The inspection also focussed on the extent to which these measures had addressed the non-compliances found during monitoring inspections in 2019, as well as the concerns throughout 2020. In relation to the three foster care standards which were inspected in January, the overall findings were:

Standard 5 **The Child and Family Social Worker**	**Judgment:** **Non-Compliance Major**
▪ Not all children in care had an allocated social worker ▪ Statutory visits to children in care were not carried out at the frequency required and quality of visits mixed ▪ Some children experienced multiple changes in social workers and not all children had a consistent professional involved in their care. ▪ The recording on children's files required improvement ▪ The recording and quality of case supervision requires improvement.	
Standard 10 **Safeguarding and Child Protection**	**Judgment** **Non-compliant** **Moderate**
▪ Not all child protection allegations of abuse or neglect were categorised correctly and dealt with in a timely manner under child protection procedures that comply with Children First (2017) ▪ Intake and initial assessment records required by standard business processes were not consistently completed in a timely manner ▪ Improvements were required in relation to the management of serious concerns and complaints to ensure that all concerns or complaints were categorised correctly, managed in line with the relevant policies, and dealt with in a timely manner ▪ Notifications to the foster care committee in relation to allegations and serious concerns were not routinely made in a timely manner	

Standard 19 Management and monitoring of foster care services	Judgment **Non-compliant Major**

- Governance in relation to case management required further improvement to ensure that gaps in this area identified were fully addressed
- The Area's capacity to respond to staff remaining on extended leave was a significant factor influencing the service's ability to progress improvements and the quality of service provision
- Actions agreed to address non-compliances identified during the previous inspection of the service in March 2019 had not all been effective in ensuring statutory requirements were met
- There was a lack of oversight in relation to allegations and serious concerns to ensure that all concerns were reported, categorized appropriately and managed in a timely manner.

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	Non-compliant Moderate	Non-compliant Major
The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.	The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.	The service is not compliant with the standard. Where the non-compliance (moderate) does not pose a significant risk to the safety, health and welfare to children using the service, the provider must take action *within a reasonable time frame* to come into compliance.	The service is not compliant with the standard. Where the non-compliance poses a significant risk (major non-compliance) to the safety, health and welfare of children using the service the provider responds to these risks in a timely and comprehensive manner.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
12/10/21	09:30 – 17:00 10:00 – 17:00	Olivia O Connell Lorraine O Reilly Susan Geary Leanne Crowe	Lead inspector Inspector Regional Manager Remote Inspector
13/10/21	09:00 – 17:30	Olivia O Connell Lorraine O Reilly Susan Geary Leanne Crowe	Lead inspector Inspector Regional Manager Remote Inspector
14/10/21	08:15 – 16:30	Olivia O Connell Lorraine O Reilly Susan Geary Leanne Crowe	Lead inspector Inspector Regional Manager Remote Inspector
15/10/21	10:15 – 11:15	Olivia O'Connell Leanne Crowe	Lead inspector Remote Inspector

Views of people who use the service

During the inspection, inspectors spoke with three children living in foster care in the area and with six foster carers. Inspectors also received five completed questionnaires from children who expressed their views on their experiences of the service.

All children reported positively about the quality of care provided by their foster carers. They said that their foster carers were there for them if they needed anything, and would help with important things in their life, like their schooling. They felt cared for and heard by their foster carers.

All children had an allocated social worker and were positive about them. Children said that their social workers met them regularly, both on their own and with their foster carers present. As one child described it – *"my social worker checks to make sure I'm happy."* Another child told inspectors about the difference the social worker made in their lives: *"She organised help for me."*

All children were familiar with their care plan and had either attended their child-in-care review in person or had someone else (such as their foster carer or social worker) speak on their behalf; one advised that they had chosen not to attend but had completed a form for the purpose of their care review. One child said: "*My care plan helps me and makes sure I'm ok."* Another said: "*I talk about how often I want to see my mum and dad and this is included in my care plan*."

All children described feeling safe and supported. They would tell their foster parents or social worker if they were worried or unhappy.

However, the majority had experienced multiple changes in social worker, which they found challenging. One child said they had two different social workers in the past 12 months. One child said *"I haven't met my new social worker yet since my last one left last April."* Another child described having 14 different social workers in 11 years: *"I might have a really good social worker for three months, and then they're gone and you have a new social worker or no social worker. It can be annoying telling your story to people over and over again."*

Foster carers who spoke with inspectors all had an allocated link worker and spoke positively about the support given to them. One foster carer described their link worker as "*being very meticulous in her work".* Another foster carer said that their link worker was *"very good at listening to me."* They described them as available to take phone calls and would regularly visit in person.

Foster carers spoke positively about the support given to children by their social workers. One foster carer described how the social worker had arranged for

permission from the child's parents for a special event. However, foster carers also found changes in link workers and children's social workers challenging. One foster carer described their child's new social worker as *"very off-hand"* and that they would communicate access visit arrangements with the child's family at the *"last minute".*

Summary of inspection findings

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

This report reflects the findings of the follow-up risk-based inspection, which looked at six standards: the role of the social worker, care planning and statutory reviews, safeguarding and child protection, supervision and support of foster carers, the role of the Foster Care Committee (FCC) and the management of the foster care service.

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

- one standard was major non-compliant
- one standard was moderate non-compliant
- two standards were substantially compliant
- two standards were compliant.

This inspection found that the area had put measures in place to address the risks found on the previous inspections. These measures included regular audits of cases, training regarding supervision practice, enhanced oversight of monitoring visits to children in care and a new independent chair for the FCC was in post. The area had reduced the risks, and while not achieving full compliance in all standards assessed, had moved to improved levels of compliance in all other standards.

However, the inspection identified major non-compliance with regards to the support and supervision provided to foster carers. The inspection found that not all foster carers were supervised by a professionally qualified social worker. Twenty-seven foster care households did not have an allocated link social worker. Five unallocated foster carers who had children placed with them, had no supervisory visits completed in 2021. This was despite audits being completed by managers on these cases.

Therefore the service area could not be assured that foster carers were consistently provided with the necessary information, advice and professional support necessary to enable them to provide high quality care. The service's ability to ensure the safety

and care provided to children in foster care was therefore impacted. For this reason, an urgent compliance plan was issued by HIQA further to the inspection. The area submitted a satisfactory response and have provided adequate assurances that these issues will be addressed in an effective and timely manner.

There were improved governance structures in place to support the delivery of services to children in care and foster carers, but these required further implementation. The area had introduced new governance systems to promote practice improvement, however these systems had yet to be fully embedded in order to demonstrate efficacy.

Since the previous inspection, progress had been made to ensure that each child in care had a dedicated social worker who promoted their safety and wellbeing. In the majority of cases reviewed by inspectors, social workers carried out Tusla's statutory duties in order to co-ordinate the care of each child.

Child-in-care reviews were well managed and of good quality; however there were ongoing issues with regards to timeliness of reviews. Care plans were comprehensive and reflected the needs and wishes of children, their parents and foster carers. There had been improvements made in the area regarding ensuring that actions recommended and decisions made at review meetings were carried out in a timely manner, and the oversight of this had improved. There remained however an element of drift and delay in progressing some actions, in particular actions relating to accessing additional services.

Complaints, concerns, and allegations against foster carers and other allegations made by children in care were assessed and investigated in line with Children First (2017). This inspection found that the area had made significant improvements since the previous inspection in this regard.

The area had a well-functioning foster care committee with an independent chairperson. The membership of the committee demonstrated the requisite knowledge and experience to successfully perform its duties. The foster care committee was guided by the standards and the national policy, procedure and best practice guidance on FCCs. There were appropriate procedures, including an appeals process in place.

This report reflects the findings of the inspection, which are set out below. The provider is required to address a number of recommendations in a compliance plan which is published separately to this report.

Findings and judgments

Standard 5: The child and family social worker

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

Summary of inspection findings under Standard 5

This inspection found that, since the previous inspection, progress had been made to ensure that each child in care had a dedicated social worker who promoted their safety and wellbeing. In the majority of cases reviewed by inspectors, social workers carried out Tusla's statutory duties in order to co-ordinate the care of each child.

At the time of the inspection all 133 children in foster care in Kerry had an allocated social worker. Data provided prior to the inspection indicated that of the total number of children in care in the area, only six (4%) did not have an allocated social worker, but these were allocated by the start date of the inspection. There were no dual unallocated cases, that is, there were no cases where both the foster carer and the child in placement with them did not have an allocated social worker.

Inspectors reviewed 19 children's files to ensure that Tusla's statutory obligations around children in care were being met. Eleven files were reviewed specifically around the frequency and quality of statutory visits by children's social workers. Eight cases showed that children in care were being visited in line with national standards. However, in three files reviewed, the frequency of statutory visits to children in care was not in line with foster care regulations, as the time elapsed between visits exceeded six months for children in long term care; although at the time of the inspection all children in care had been visited by their social worker.

Of the eight files where social work practice met statutory requirements, four exceeded the frequency required by the regulations. In one case for example, the social worker had visited the child four times in the previous five months. Since the previous inspection where the service gap in meeting statutory visits to children was found to be a major risk to children in care, this was an improvement in practice. However, inspectors found that in two cases, children with additional needs, or children whose placements were at risk of disruption, did not receive increased visits to address their care challenges in a timely and effective manner. This meant that although there was no immediate safety risk to these children in care, the service provided could not be described as a quality service to these children.

Regarding the quality of recording, which was found to be poor on the previous inspection, a new statutory visit template had been introduced by the area management team. This was found to be effective in ensuring that key aspects of a statutory visit to a child in care were addressed. Inspectors saw evidence of this form being used to record the social worker meeting with the child alone; visiting their bedrooms; and discussing their needs, such as education, contact with their birth family and health.

In six out of 19 files, inspectors found that children experienced multiple changes in social worker. In one case for example, the child's social worker changed three times over a two year period. In another case, a child's social worker changed five times in as many years. Multiple changes in social workers impacts on a child's ability to build a meaningful relationship with their social worker, and to enable the social worker to assure themselves that children in care are receiving a quality and safe service.

In summary, further improvements are required for the service to move from meeting minimum standards to delivering a quality service to all of its children in care; for example regarding children with complex needs. Overall however, this inspection found that progress had been made in addressing the risks identified in the previous inspection. For these reasons the area is judged to be compliant with this standard.

Judgment: Compliant

Standard 7: Care planning and review
Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

Summary of inspection findings under Standard 7

Child-in-care reviews were well managed and of good quality; however there were ongoing issues with regards to timeliness of reviews. Data provided by the area in advance of the inspection indicated that two child-in-care reviews were overdue. However, at the time of inspection there were 17 child-in-care reviews overdue, which the area had not identified in the data returned to HIQA. This discrepancy was due to how the area determined the timeliness of a child-in-care review. Any child-in-care review which was scheduled to take place in 2021, was not considered by the area to be out-of-date until the end of 2021. This practice is not in compliance with the regulations, nor does it promote child-centred best practice.

The area had a dedicated chair for child-in-care reviews, however at the time of the inspection this post was vacant. Principal social workers and team leaders were rotating chairing child-in-care reviews between them, on top of their normal duties. Inspectors found that this had an impact on the timeliness of some of the child-in-care reviews.

Inspectors reviewed ten children's files around their care planning and review. In six cases sampled, the frequency of child-in-care reviews were in line with statutory requirements. In four cases sampled, children's child-in-care reviews were not up to date; in three cases there were delays of between one to six months to be in line with regulations.

As stated previously, inspectors found that there were 17 child-in-care reviews overdue. Eight child-in-care reviews were overdue by one month, six between two to three months, and three between four to six months. For example, one child's child-in-care review was overdue since April 2021.

Inspectors found that care plan reviews had considered all the needs of the child in line with statutory requirements. The child's educational and health needs were discussed and relevant people including external professionals were consulted in the process. These reviews considered whether all supports were in place as appropriate to each child's needs and the plans for the child's contact with their family were included. The continuing suitability of the placement was discussed and actions were identified with associated timeframes for their completion.

Good care plans comprehensively addressed all areas of the child's care and identified the supports necessary to meet the child's individual needs. Inspectors noted that one care plan in particular was very family orientated in promoting family contact, and another gave a lovely description of a child which clearly demonstrated the social worker's knowledge of the child and their interests. Several care plans reflected the views of children whether through their attendance, completion of a form in preparation for the care plan review meeting or through the social workers account of their discussions with the child.

There had been improvements made in the area regarding ensuring that actions recommended and decisions made at review meetings were carried out in a timely manner, and the oversight of this had improved. There remained however an element of drift and delay in progressing some actions, in particular actions relating to accessing services such as occupational therapy and therapeutic services. In June 2021, the area introduced new procedures around the care planning and review for children in care. This included that the child-in-care review chairs make a record of the key actions agreed at the child-in-care review in respect of the child on a "priority action sheet". Each action sheet would be shared and discussed at the area's Priority

Action Meeting which convened every six weeks to review all 'Priority Action sheets' and to agree a plan for completion of the actions identified. The form would remain under review until all actions were completed. At the time of this inspection, one Priority Action meeting had taken place in September 2021 and inspectors reviewed the minutes of that meeting; six children's care plans were discussed; however the record did not clearly reflect agreed actions, persons responsible and timelines for completion.

All ten children's files sampled for care planning had completed care plans on file, but four of them were out of date. Nine out of ten reviewed by inspectors had good quality child-in-care review records and care plans in place for children. In one case however, there were no records of the most recent child-in-care review, despite it having taken place in August 2021. This meant that there was no written record of actions and decisions from the child-in-care review, separate to what was recorded in the child's care plan.

Inspectors reviewed files for evidence of appropriate management oversight of the care planning and review process and found that there was good management oversight in most of the cases sampled. Three care plans (30%) however, were either not signed off by the team leader, or had been signed off several months after the child-in-care review took place. Furthermore, inspectors noted that actions agreed at a child-in-care review and outlined in the child's care plan were not always progressed in a timely way by the social worker. Inspectors reviewed case supervision records where the actions from the child-in-care review were recorded in the notes, but did not appear to progress from one case supervision record to the next. For example in one case, which had been unallocated for several months in 2021, actions from the care plan included therapeutic work with the child and this had not been progressed since the previous review in July 2020. In another case, the supervision records in February 2021 noted that actions from previous care plan in 2020 should be completed before next child-in-care review due in April 2021; at the time of the inspection these actions were still pending. In a further example, multiple child-in-care reviews of one child had requested that the child be referred to a specialist service. Inspectors sought assurances from the area manager as to why this had not progressed and why no referral was made to this specialist service. This was subsequently followed up by the team leader and social worker and inspectors were assured by the area manager that this action had been prioritised. The commencement of the Priority Action meetings should address this and lead to an improvement in practice.

In summary, care plans and care plan reviews were well managed and the majority of care plans were up-to-date. Good quality care plans were in place. The decisions of care plan reviews were communicated to children and foster carers. Further improvements were required regarding the timeliness of child-in-care reviews and

ensuring that actions agreed were followed through. For these reasons the area is judged to be substantially compliant with this standard.

Judgment: Substantially compliant

Standard 10: Safeguarding and child protection
Children and young people in foster care are protected from abuse and neglect.

Summary of inspection findings under Standard 10

Complaints, concerns, and allegations against foster carers and other allegations made by children in care were assessed and investigated in line with Children First (2017). This inspection found that the area had made significant improvements since the previous inspection.

The safety of children was a priority in the area. The previous inspection had found significant gaps in the management of allegations, complaints and serious concerns; primarily around the correct categorisation of these and providing a timely response. The area manager told inspectors that the service improvement plan for the service had focused on addressing these gaps to ensure a safe and effective service for children in care. To that end, in July 2021, management led a policy implementation workshop for all staff around responding to allegations, complaints and serious concerns by children in care. Managers told inspectors that they were confident that staff now understood the different processes in order to be in line with Tusla's national policies around the management of allegations, complaints and serious concerns.

Staff described to inspectors the processes in place for the management of allegations against foster carers and third parties and were clear on the distinct actions to be taken in investigating these. Link workers gave examples of allegations made against foster carers and how these were responded to by the child protection team to assess and determine if any protective actions were required. Managers were assured of social workers ability to identify safeguarding issues.

Information provided for the inspection indicated that there were no dual unallocated cases, that is, there were no families where both the child and the foster carer did not have an allocated social worker.

In interviews and questionnaires returned by children, all answered the question on safety and said that a social worker had told them who to talk to if they felt unsafe. All seven children said they knew how to keep safe.

Data provided for the inspection showed that there were 43 child protection referrals made in relation to children in care since the previous inspection; of these, three were allegations made against foster carers. Forty-one of these were concluded and two were ongoing. There were two serious concerns about foster carers, all of which had been concluded at the time of the inspection.

Inspectors reviewed three allegations against foster carers. These allegations were managed in line with Children First (2017) and Tusla's Interim Protocol for managing concerns and allegations of abuse and neglect against Foster Carers and Section 36 (relative) Foster Carers (Tusla, 2017) but they were not always timely. Strategy meetings were held on all three allegations and Intake Records were on their National Child Care Information System (NCCIS). In two cases the initial assessment was not completed in line with the timeframe of 40 days as outlined in Tusla's standard business processes. This was impacted by the child protection duty social worker being on sick leave. In two cases, the allegations were appropriately re-categorised; in one case to a complaint, in another to a serious concern. When re-categorised, the serious concern was managed appropriately and had been concluded prior to the inspection. The complaint however, was still unresolved after five months, although there was no risk to the child. All three cases had been notified to the Foster Care Committee (FCC). The third allegation met the threshold for an allegation, and was correctly classified as such. Appropriate actions were taken to ensure the child's immediate safety and address concerns with foster carers.

The chair of the FCC was informed about any allegations against foster carers within five days in line with Tusla's Interim Protocol. There was a clear pathway for the management of appeals with appropriate follow-up review of foster carers' suitability and approval status having been informed of the outcome of the investigation into the allegation.

Inspectors reviewed child protection concerns made by three children in care against people other than their foster carers. In all three cases, the allegations were referred after the children had come into care, and related to prior events. The referrals were screened and closed in a timely manner by the child protection duty team.

The area manager held overall responsibility for the oversight and management of all allegations against foster carers and child protection concerns made by children in care. The two principal social workers who managed teams with responsibility for children in care and foster carers maintained trackers to facilitate their management of these allegations and concerns. Inspectors reviewed these trackers which contained details of the date the report was received, the category of the report, the names of the professionals involved, a summary of the report, dates of strategy meetings held and the final outcome of the investigation. The principal social workers

told inspectors that they also had oversight of these reports through supervision with team leaders.

There was a system in place to manage complaints. Complaints were notified to the principal social worker and were investigated by a social worker or team leader. The principal social worker for children in care kept a tracker to log complaints made. Inspectors reviewed the tracker of complaints made by children in 2021. Four complaints were listed (two in relation to the same child) and whether they were open or closed. The tracker did not indicate any actions, whether the child was advised and/or satisfied with the outcome. The principal social worker advised inspectors however, that further information on the complaints could be reviewed by her through NCCIS.

Inspectors reviewed one file where foster carers had made a complaint to the service. The complaint was classified as a 'local resolution complaint'. The foster child in their care had changed social workers five times in as many years, and little progress had been made on actions formulated in their care plan. Inspectors queried the outcome of this complaint and were advised that local resolution complaints are not logged as complaints, and are therefore not tracked as such. In this particular case, it meant that the child did not receive the right service at the right time and there were significant delays in getting required supports. This situation could potentially put a foster placement at risk of disruption.

Data provided by the area indicated that five children had gone missing from care since the previous inspection. Inspectors reviewed two cases where children had multiple instances of absconding from care. Case records evidenced that foster carers responded appropriately and contacted An Garda Síochána (the police) where appropriate. However, there were no missing from care risk assessments on file. This was not in line with Tusla's Missing from Care Protocol, as there should be a clearly defined risk assessment around unplanned absences to keep these children safe. Children that were missing in care were also notified, as appropriate, to the national office through a reporting procedure called the Need to Know (NTK) procedure.

The NTK reporting mechanism is Tusla's national incident management system and was used to notify Tusla's national office of serious incidents and adverse events in relation to children in care. There were three such notifications in total made to the national office since the previous inspection. Inspectors reviewed the area's NTK log and found it to be effective. This inspection did not review the individual issues raised on the NTKs in children's files as they did not pertain to the remit of the inspection.

The area focused on the safety of children as a priority and there were some good practices in relation to safeguarding in place. However, there were some delays in

the processing of allegations made by children against both foster carers and other persons. Whilst the reasons for some of these delays were due to staff shortages and were recorded, there were still issues with regards to classification of information. There were delays in the commencement and completion of initial assessments for children who had made allegations. Management oversight and tracking of child protection concerns made by children in care required improvement to ensure they were completed in a timely manner. This inspection would also query the effectiveness of the governance systems regarding both formal and 'local resolution' complaints. Patterns of dissatisfaction were not centrally tracked to assist with improving the service for families.

Overall, this inspection found that progress had been made in addressing the risks identified in the previous inspection regarding the management of allegations, serious concerns and complaints. Further improvements were required in relation to absence management plans and oversight of the timeliness of the management of allegations, serious concerns and complaints. For these reasons the area is judged to be substantially compliant with this standard.

Judgment: Substantially compliant

Standard 15: Supervision and support
Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.

Summary of inspection findings under Standard 15

Not all foster carers were supervised by a professorially qualified social worker. Of the 96 foster care households currently providing placements for children in care, 27 (28%) foster carers did not have an allocated link social worker. Furthermore, support and supervision visits to foster carers were not adequate, both in frequency and quality. The area was issued with an urgent compliance plan following the inspection to address the deficits identified as regards supervision of foster carers, and a satisfactory response was subsequently received.

This inspection found that not all foster carers were supervised by a professionally qualified social worker. As outlined above, of the 96 foster care households currently providing placements for children in care, 27 (28%) foster carers did not have an allocated link social worker. Fourteen foster carers' files were sampled on this inspection, seven of which were unallocated foster carers who currently have children placed with them. Five of the unallocated foster carers sampled had no

supervisory visits completed in 2021. This was despite audits being completed by managers on these files.

Not having an allocated link worker could put the success of a child's placement at risk, as well as a potential safeguarding issue; Tusla could not be assured of the quality or safety of care being provided. Inspectors reviewed files where there were gaps in the effective and timely sharing of information relating to the child's care; and additional supports for foster carers were not consistently identified and addressed in a timely manner. There were also ineffective support systems in place when a placement was at risk of disruption.

In order to provide a minimum level of oversight and support to unallocated foster carers, the fostering department had set up a "check-in" system through their duty system. Link workers would take turns providing on-call duty to source available foster carers as soon as when requests for a placement came in from the children in care/child protection teams. Link workers would also contact unallocated foster carers to monitor their foster placements. Inspectors found this system to be ineffective in providing support and supervision to foster carers. Both managers and staff also told inspectors that this system was ineffective, as link workers were very busy while on duty trying to source foster care placement requests, and therefore lacked the capacity to address the needs of unallocated foster carers. Some staff told inspectors that when they did make contact with unallocated foster carers, the check-ins would take time as foster carers might not have spoken to a member of staff for a period of time. Further to the inspection, the area identified further actions to address the deficit; such as assigning a social care leader to link in with unallocated foster carers. The area also provided assurances that all foster carers would be allocated by November 2021, when a further 1.5 social work post would be allocated to the fostering team.

This inspection also looked at the frequency and quality of support given to allocated foster carers. From a review of seven allocated foster carer files, children's files and interviews with staff, there was evidence that the majority of link workers were in telephone contact with the foster carers but did not visit their homes regularly enough. When home visits did occur the quality of the support provided varied, and in some cases was poor. In one case for example, a recently approved foster carer who was providing a placement for a young child with disabilities since July 2021, had a link worker who had yet to complete a health and safety check in the foster carer's home at the time of the inspection. The foster carer's assessment home visit in December 2020 had identified safety risks in the household which would have required follow-up by the link worker to ensure this child's safety and wellbeing prior to being approved as a foster carer in April 2021. Foster carers' supervision records in general did not routinely include regular health and safety checks. In a further example, although there was evidence of regular visits by the link worker, four in six

months, actions agreed were not progressed until the foster carer made an informal complaint. In another foster carers' file, inspectors found that there were only two visits completed over 10 months; the renewal of the foster carer's Garda vetting was overdue by three months and there was no evidence on file that this had been progressed by the link worker or discussed at a supervision visit. In another case reviewed by inspectors, a child's foster placement was at risk of disruption; yet the link worker did not attend the foster carer's review nor the child-in-care review, both in 2020.

Inspectors found evidence of case supervision of link workers for the purpose of oversight of the frequency of home visits, however there remained gaps around the quality of support being provided to foster carers. Audits of files did take place, however inspectors still found that the quality of record keeping and case notes required improvement. Staff told inspectors that their caseloads were at full capacity. Due to staff shortages, they couldn't always offer the level of support and supervision required, particularly to unallocated foster carers.

Inspectors also found evidence of good practice. In one case for example, the link worker provided good quality support and supervision to foster carers through regular contact, visits and also advocated for the child in care who did not have an allocated social worker. The link worker also supported the foster carers in obtaining enhanced legal rights so as to be better able to provide a long term stable placement to the child in their care. In a further case example, inspectors found the quality of engagement with foster carers and the recording of visits to be excellent. Such variance indicates a gap in management oversight to promote good practice examples, in order to successfully implement service improvement. Despite this however, the template used by the fostering team to record supervisory visits lacked key information, such as Garda vetting status; health and safety checks completed; and updates on foster carers' mandated training.

Overall, inspectors found that inadequate frequency and poor quality of supervisory visits meant that the service provided was not consistently safe and effective for children in care. For these reasons the area is judged to be major non-compliant with this standard.

Judgment: Major 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.

Summary of inspection findings under Standard 19

This inspection found that the services for children in care in Kerry had improved. Since the previous inspection in January 2021, the area had introduced various mechanisms to improve its governance and oversight and were in the process of embedding these into practice. However, the need for further improvements were required and gaps in service provision remained. Therefore, the governance and oversight of services provided to foster carers remained inadequate. The area could not be assured that foster carers were consistently provided with the necessary information, advice and professional support necessary to enable them to provide high quality care. Vacant posts and movement of staff continued to impact the delivery of services to children and families. The service's ability to ensure the safety and care provided to children in foster care was therefore impacted.

The service was managed by an experienced and well established area manager, who showed good leadership and gave good direction to the service and staff. At interview, she described the progress made since the previous risk based inspection in January 2021, as well as the challenges to implementing some of the improvement initiatives. Inspectors were satisfied that the service area was being led in the right direction by the area manager who was well informed of the risks in her service, and was open and transparent about any other identified issues during the course of the inspection.

Inspectors reviewed the minutes of senior management meetings. The senior management team met on nine occasions since the previous inspection. Membership of the senior management team represented each service pillar, and included the area manager, business support manager, FCC chair, principal social workers for fostering, child protection and children in care services, among others. The principal social worker for children in care was newly appointed in July 2021. The area manager received updates from fostering and children in care services at each meeting. The agenda included discussion of governance, strategic planning, recruitment, and organisational risk. In the third quarter of 2021, the area manager requested written updates from each service pillar to be presented at senior management meetings. The area manager told inspectors that this ensured clarity around the distinct pillars and strengthened lines of accountability. However, this inspection identified gaps in performance which had not been noted, such as the numbers of unallocated foster carers who had not been visited by a link worker in 2021.

In the third quarter of 2021, the senior management team implemented two new governance mechanisms for alternative care: an alternative care management group and children in care priority action meetings. The alternative care management group aimed to provide governance and oversight across all relevant pillars: children in care, foster care and aftercare. Its main function was to ensure effective communication around alternative care case management so that any issues identified were managed and processed in a timely manner. The purpose of the children in care priority action meeting, one of which had been held by the time of the inspection, was to ensure that all actions agreed at a child-in-care review were addressed in a responsive and timely manner to meet children's needs. Inspectors welcomed both of these initiatives, although their effectiveness will be measured over time.

The area had a complex case forum in place to provide senior managerial oversight of cases that presented as a significant risk to children, families and to Tusla as an agency. In one case inspectors reviewed, the foster carers did not have an allocated link worker and the child's social worker had identified issues with the foster carers and the child wished to move placement. There was no link worker to discuss these issues with the foster carers and the case was referred to the complex case forum for review. As per the area's local policy, the function of the complex case forum is to support front line managers in decision-making to provide the appropriate service for high risk category cases; however had there been an allocated link worker this case might not have met the threshold for referral to the complex case forum.

Principal social workers used trackers to oversee that staff were meeting statutory requirements, such as: supervisory visits to foster carers; statutory visits to children in care, child-in-care reviews; and allegations and complaints by children in care. Managers told inspectors that these trackers enabled them to identify any gaps and address them as required. Inspectors found that the efficacy of these trackers was mixed. In one case, it helped identify staff performance shortcomings, which had subsequently been addressed by their manager. In another example, a tracker identified unallocated foster carers who had no supervisory visits in 2021. The principal social worker had put in place measures to address this gap. A social care worker was allocated to undertake home visits to foster carers. Furthermore, a student social worker was tasked with contacting unallocated foster carers by phone to ascertain if there were any issues or concerns that needed to be brought to the team leader's attention for a further response. However, this inspection found that the measures put in place were inadequate, as no link worker had visited these foster carers to conduct a supervisory visit and to ensure the placement was safe. Since the inspection, HIQA have been assured by the area manager that all foster carers will be allocated to a link worker by November 2021 and that all pending supervisory visits would be completed by the end of the year.

Inspectors saw evidence of good communication in the area. There were established working relationships between staff and managers. Clear lines of communication allowed information to be shared efficiently and effectively. This was confirmed by staff members, and they said that they felt supported and were kept up to date by managers. Team meetings were held within the different pillars. The area also introduced learning and service improvement opportunities for managers through local initiatives, to ensure policies and procedures were consistently implemented. These included a principal social worker forum and a team leader forum. There was also evidence of policy implementation workshops being provided to staff by their managers.

Fostering team meetings took place regularly throughout 2021. They were chaired by the principal social worker or team leader and were generally held monthly. The agendas included policies and procedures, training, updates on foster carer issues, staffing shortages and a range of business issues that included time management and meeting statutory requirements by some link workers.

As part of their 2020/2021 service improvement plan, the area had strengthened their auditing mechanisms. Inspectors reviewed evidence of audits completed by principal social workers and found their effectiveness to be mixed. There were two audits in 2021 in relation to the support and supervision of foster carers, and three audits in relation to children in care completed in April, July and September 2021. The most recent foster care audit in September 2021 had identified six unallocated foster carers who had not been visited in 2021, out of a sample of sixteen foster carer files. Actions identified further to audits included safety plans which directed unallocated foster carers to the fostering duty system. As mentioned previously in this report, this system to manage unallocated foster carers was inadequate.

Unallocated foster carers' case file audits were present on files sampled by inspectors which evidenced the managers' awareness of service provision gaps. However, despite audits identifying some unallocated cases as being a priority over a number of months, and foster carers requiring supervisory visits which were overdue, this awareness did not always lead to supervisory visits being undertaken by a link social worker. Therefore, the auditing process was ineffective with regards to driving improvements in service provision for foster carers who remained unallocated.

Inspectors reviewed the children in care file audit completed in April 2021; findings from the audit identified gaps in relation to the frequency and quality of statutory visits to children in care. Further to the audit, a template for statutory visits was introduced to the children in care team. The purpose of the template was to provide consistent quality recording of statutory visits to children in care, with clear actions identified. The completed templates were regularly reviewed by team leaders and

used in supervision to track progress. Inspectors saw evidence of this template on children's files and found it to be an improvement on case recording since the previous inspection.

Inspectors also saw evidence of case file audits for children in care and found the quality of these to be mixed. In some cases key information, such as foster care placement details, were left blank.

Inspectors reviewed the area's risk register. Since the previous inspection, there were two new items relating to the remit of this inspection. One outlined the risk posed by a lack of services provided to foster carers due to staff shortages on the fostering team (2.5 vacant posts due to sick leave). This was then further escalated by the area manager to the regional risk register. The risk assessment identified additional control measure such as duty system in fostering team to provide cover for unallocated foster carers; however an audit in August 2021 identified that this control measure was not working. The second item identified staffing shortages across all pillars, including foster care and children in care due to sick leave.

Overall, this inspection found that managerial oversight had improved since the previous inspection. However, vacant posts and movement of staff remained a significant factor influencing the service's ability to progress improvements and quality of service provision. Governance arrangements put in place to ensure compliance with care planning and the support and supervision of foster carers had not achieved sufficient progress and systems for oversight of these processes were not yet fully effective. For these reasons the area is judged to be moderate non-compliant with this standard.

Judgment: Moderate non-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.

Summary of inspection findings under Standard 23

The foster care committee (FCC) was guided by the standards and the national policy, procedure and best practice guidance on FCCs.

The FCC was made up of a recently appointed independent chairperson, a coordinator, and several other members including a foster carer, a former foster carer, a medical advisor, a psychologist, an independent representative and Tusla employees. Inspectors found that the FCC members included people with appropriate experience and qualifications in the area of child protection, child welfare, and foster care. Inspectors reviewed minutes of committee meetings and found that the committee met on six occasions in 2021 up to the time of the inspection. One meeting in March could not proceed as the independent representative was not in attendance; this decision was in line with national policy and meeting quorum requirements. The committee aimed to meet on a monthly basis at a minimum, however meetings in May and June were deferred due to the cyber-attack on HSE/Tusla services. The chairperson told inspectors that the committee met frequently enough to carry out its business and could hold an emergency meeting if this was required.

The national policy required that the committee meetings should be attended by at least six members to meet the quorum requirement. Inspectors sampled minutes from the 2021 meetings and found that the quorum was met on all occasions where the meeting proceeded. The chair of the committee told inspectors that the meeting attendance was high. Minutes of committee meetings were of good quality, detailed and reflected discussions on assessments, reviews and allegations and complaints. Decisions and recommendations were clearly recorded and included timely follow-up actions and who was responsible for the follow up.

The chair of the FCC was also the service manager of an assessment unit for Tusla Cork and Kerry. The chair had over 20 years' experience in the area of child protection and social work. The chair had been in the role of FCC chair since the second quarter of 2021 and was supervised in her capacity as a service manager on a monthly basis by the Kerry area manager. The management and oversight of the FCC was further enhanced by monthly activity data submitted by the FCC chair to the area manager. The monthly reports ensured that the area manager was aware of any issues and a corresponding plan to address same. For example, analysed activity data by the FCC chair had identified a need for greater governance and oversight within the fostering and children in care departments so that documentation

submitted to the FCC was fully completed and appropriately signed off. This impacted on the FCC's ability to complete its functions. The FCC chair subsequently designed a guidance template to support teams in providing all necessary information to the FCC in an effective and timely manner. At the time of the inspection, the template was being reviewed by the operational teams prior to implementation. The FCC chair told inspectors that it can be challenging introducing changes within teams, particularly in avoiding adding any unnecessary burden to social workers' workload. However, she described her experience of engaging with social work departments as positive and responsive to her requests.

The FCC had developed a quality improvement plan in May 2021. At the time of the inspection, many of the proposed actions were still ongoing: expanding the membership of the FCC to include more non-statutory organisations; strengthening the autonomy of the FCC from the fostering department by appointing an independent secretary for the FCC; improving the quality of FCC submissions by the social work teams and providing training for existing and new FCC members.

The chair of the FCC told inspectors that there was no formally recognised national induction programme in place for new committee members; however training for existing and new members had been co-ordinated at regional level which included: the function of the committee; information on the organisational structure of Tusla; what the foster carer assessment would entail; children's experience of being in care; and what happens following receipt of an allegation. Training dates had been set for November and December 2021, with further dates to be agreed for 2022.

Inspectors found that the foster care committee was effective and made clear decisions that were in line with the standards. The committee prioritised assessments of prospective foster carers, reviewed reports of allegations and complaints, considered requests for changes to approval status and reviews of foster carers. The foster care committee also considered disruption reports and long term matching of children.

The chair told inspectors that the FCC was notified of all allegations and complaints made against foster carers. Allegations and complaints were a standing item on the meeting agenda and inspectors found that allegations were kept on the agenda until they had been investigated and recommendations had been made. The FCC chair told inspectors that she used a variety of trackers (allegations and serious concerns, actions following FCC meetings) to review progress and to provide informed activity reports up to the area manager. Inspectors reviewed the trackers and found that this process ensured that the FCC chair maintained oversight of progress with processes and could identify any delays Furthermore, the chair set up a tracker for breaches of regulations.

The national policy, procedures and best practice guidelines requires the FCC to produce an annual report of its activities. As the chair was newly appointed in 2021,

she had yet to submit an annual report. However she provided inspectors with copies of monthly activity reports detailed above. The FCC chair told inspectors that this information would be used to provide an annual report to the area manager and contribute to the strategic planning of the foster care service.

Inspectors were advised that all members of the FCC were Garda vetted in relation to their specific roles as members of the FCC.

In summary, the membership of the Foster Care Committee demonstrated the requisite knowledge and experience to successfully perform its functions. The foster care committee was guided by the standards and the national policy, procedure and best practice guidance on FCCs. There were appropriate procedures, including an appeals process in place. For these reasons, the area is judged to be compliant with this standard.

Judgment: Compliant

Compliance Plan

This Compliance Plan has been completed by the Provider and HIQA has not made any amendments to the returned Compliance Plan.

Provider's response to Inspection Report No:	MON_0033745
Name of Service Area:	Kerry
Date of inspection:	12 – 15 October 2021
Date of response:	03 December 2021

These requirements set out the actions that should be taken to meet the *National Standards for Foster care* (2003).

Theme 2: Safe and Effective services
Standard 15 **Non-compliant major**
The provider is failing to meet the National Standards in the following respect: 1. Not all foster carers had an allocated link worker. 2. Not all foster carers had supervisory visits by a professionally qualified social worker in line with the requirements of the standard. 3. Foster carers' supervision records required improvement as they did not include all the link worker's areas of responsibilities under the standards. They also did not routinely include regular health and safety checks. 4. The quality of record keeping and case notes on foster carers' files required improvement. **Action required:** Under **Standard 15** you are required to ensure that: Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high quality care. **Please state the actions you have taken or are planning to take:**

Actions Taken/Planned	Person Responsible	Completion Date
1. Since the Inspection, 1.5 of the 2.5 vacant posts have been filled. Therefore, all cases are currently allocated to a Link Worker.	Senior Management Team	01.11.2021
2. As all cases are now allocated. Supervisory Visits will be undertaken by the allocated Link Workers who are Professionally Qualified Social Workers.	Allocated Social Worker Social Work Team Leader Principal Social Worker	31.12.2021

3. A new template for Supervisory Visits to Foster Carers is being devised by the Fostering Resource Unit which will include standard items such as Health and Safety Checks, Garda Vetting status and mandated training. This is to ensure that there is good governance and good quality case recording of the areas covered by Link Workers against the standards being monitored.	FRU Team	31.12.2021
4. A New template for Supervisory Visits is being developed by the Fostering Department. A review of at least one recent supervisory visit will take place at each supervision session to ensure managerial oversight of good quality recording.	PQSW & SWTL	31.12.2021
5. The Principal Social Worker will undertake an Audit every quarter on a sample of cases. The purpose of this audit activity will include reviews of the quality and frequency of Supervisory Visits to Foster Carers. These audits are currently in place and will continue. The findings of this audit activity will be brought to FRU Team Meetings where findings will be discussed and shared with Team Members, the function of which will be to implement changes where negative results are an issue.	PSW	Ongoing every Quarter
6. Where issues exist in regard to Practice or quality of recording, these will be addressed in Supervision with the individual worker by the SWTL.	SWTL	Ongoing from Q4 2021
Proposed timescale: **Timeframe: 31.12.2021**		**Person responsible:** **Senior Management Team**

Standard 19
Non-compliant moderate

The provider is failing to meet the National Standards in the following respect:

1. Vacant posts and movement of staff continued to impact the delivery of services to children and families.

2. Governance in relation to the quality of practice as identified under standard 15 required further improvement.

3. Audits did not always lead to timely action being taken to address the gaps found.

4. Management reports required further development to ensure that key performance metrics, such as gaps in supervisory visits to foster carers are known and reported on.

Action required:
Under **Standard 19** you are required to ensure that:
Health boards have effective structures in place for the management and monitoring of foster care services.

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

Actions Taken/Planned	Person Responsible	Completion Date
1. Tusla National have a recruitment strategy in place to address the issue of vacant post.	National HR	Ongoing
2. The Template for the Pillar update at Senior Management Team Meeting is to be updated to include a section on the following; • *Any identified Gaps in service* • *Are all statutory requirements being adhered to?* • *Any gaps identified in Audits and the action plan to address same* This will ensure governance and oversight at senior management level. • The PSW will discuss the Pillar report with the SWTL at supervision • In addition, where issues exist in regard to Practice or quality of recording, these will be	Senior Management Team PSW	31.12.2021 & Ongoing 31.12.21 & Ongoing

addressed in Supervision with the individual worker by the SWTL.	SWTL	31.12.2021 & Ongoing
3. Audit Reports to be brought to SMT on a quarterly basis with action plans to address any gaps identified. In, addition, audit activity will be brought to FRU Team Meetings where findings will be discussed and shared with Team Members, the function of which will be to implement changes where gaps are identified.	PSW & SMT	31.03.2022 & Ongoing
4. The area manager will be assured of governance and oversight through the revised pillar report which will be presented at each monthly SMT. The revised Pillar report includes the following: • *Assurance that all Statutory Obligations are being met.* • *Audit Findings and action plan.* • *Identified Gaps in service.*	PSW & SMT	31.03.2022 & Ongoing
5. The Area Service Implementation Plan which the Senior Management Team will agree at the beginning of each calendar year will be a live document and reviewed quarterly at a Social Work management meeting.	PSW & SMT	28.02.2022 & Ongoing
6. The Area Manager will continue to engage with the Regional Quality Assurance Monitor to assist the area.	Area Manager & PASM	31.03.2022
Proposed timescale: **Timeline: 31.03.2022**		**Person Responsible:** **Senior Management Team**