



**Health
Information
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An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

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

Name of service area:	Wexford Waterford
Name of provider:	Tusla
Type of inspection:	Thematic
Date of inspection:	30 May – 2 June 2022
Fieldwork ID:	MON-0036299

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 region's chief officer
 - the area manager
 - two chairpersons of the foster care committees
 - the quality risk improvement officer
- focus groups with:
 - principal social workers for children in care, foster care, aftercare and child protection and welfare
 - social work team leaders
 - frontline staff
 - seven foster carers
 - four external stakeholder representatives from commissioned services and children's advocates.
- observations of:
 - foster carer committee meeting
 - child-in-care review meeting
 - fostering placement meeting
 - governance 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 52 children's and foster carer files
- separate phone conversations with:
 - a sample of five children, 12 foster carers and two external stakeholders.

Acknowledgements

HIQA wishes to thank 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.

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 six regions, each with a regional manager known as a chief officer. The 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 area comprises of Waterford, Wexford and South Kilkenny and has a population of 280, 260 (Census 2016). According to data published by Tusla in 2018, the service area has a population of children from the ages of 0-17 years of 73,130.

In Waterford, 58% of the population lives within 15km of the City and there is only one other large urban centre in Dungarvan. The rural county area has a deficit of services to meet the needs of the population. In Wexford, the population is more evenly spread across the County and services are delivered from four urban centres, Wexford Town, New Ross, Enniscorthy and Gorey. Wexford and Waterford are the 4th and 5th most deprived local authority areas in the country. There are eight Direct Provision Centres in the area.

At the time of this inspection, there were 279 Tusla foster care households in the area comprising of 80 relative foster care households and 199 general foster care households. There were 290 children in general foster care and 93 children in relative foster care. There were five 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
<p>A judgment of compliant means that no action is required as the service has fully met or has exceeded the standard.</p>	<p>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.</p>	<p>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.</p>	<p>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.</p>

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
30 May 2022	09:30hrs – 17:00hrs	Jane Mc Carroll	Inspector
	09:30hrs – 17:00hrs	Tom Flanagan	Inspector
	10:00hrs – 17:00hrs	Susan Talbot	Inspector
	10:00hrs – 17:00hrs	Sharron Austin	Inspector
	10:00hrs – 15:00hrs (remote)	Pauline Clarke Orohoe	Inspector
31 May 2022	09:00hrs – 17:00hrs	Jane Mc Carroll	Inspector
	09:30hrs – 17:00hrs	Tom Flanagan	Inspector
	09:00hrs – 17:00hrs	Susan Talbot	Inspector
	09:00hrs – 17:00hrs	Sharron Austin	Inspector
1 June 2022	09:00hrs – 17:00hrs	Jane Mc Carroll	Inspector
	09:30hrs – 17:00hrs	Tom Flanagan	Inspector
	09:00hrs – 17:00hrs	Susan Talbot	Inspector
	09:00hrs – 17:00hrs	Sharron Austin	Inspector
	10:00hrs – 12:00hrs (remote)	Pauline Clarke Orohoe	Inspector
2 June 2022	09:00hrs – 16:30hrs	Jane Mc Carroll	Inspector
	09:30hrs – 16:30hrs	Tom Flanagan	Inspector
	09:00hrs – 15:00hrs	Sharron Austin	Inspector
	09:00hrs – 15:00hrs	Susan Geary	Regional manager
	10:00hrs – 12:00hrs (remote)	Erin Byrne	Regional Manager

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 February 2018) – Assessed the efficacy of recruitment procedures, foster carer supervision, and assessment of foster carers.
- Phase 2 (completed in this area in February 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.

Summary of the Findings from Phase 1

Of the seven standards assessed in phase 1;

- one standard was judged compliant,
- one standard (14) was judged partially compliant (14a) and partially non-compliant (14b) in relation to the assessment and approval of non-relative and relative foster carers respectively.
- One standard was judged substantially compliant,
- four standards were judged moderate non-compliant,
- one standard was judged majorly non-compliant.

At time of the phase 1 foster care inspection, the fostering service had undertaken extensive planning and development work in relation to their recruitment strategy for foster carers in the area. The inspection also found that immediate actions were taken to ensure children were safe when allegations were made against foster carers, but monitoring and oversight of complaints, allegations and concerns needed to improve. Fostering assessment were comprehensive and good quality but required evidence of managerial oversight. Safeguarding measures for children living with relatives in emergencies needed to improve. All foster carers had an allocated social worker but improvement was required to ensure that there was a more consistent and timely approach to the support and supervision provided to foster carers from social workers. Interdisciplinary and multidisciplinary working was good and foster carers benefitted from therapeutic supports and relevant training. Reviews of foster carers were not occurring at intervals required by the regulations and standards and the quality of some needed to improve.

Summary of the Findings from Phase 2

Of the six standards assessed in phase 2;

- one standard was judged compliant,
- two standards were judged substantially compliant

- three standards were judged moderate non-compliant.

At the time of the phase 2 inspection, good quality assessments of the needs of children in foster care were undertaken and this supported care planning. There were processes in place to match carers with children based on their assessed needs. However, a shortage of foster carers in the area posed challenges to matching all children with carers in the area. In addition, the number of long term placements awaiting approval was too high and this needed to improve. The frequency of statutory visits to children in care required improvement and there were insufficient recording practices in relation to documenting and recording visits and interventions by social workers. 94% of children in foster care had an allocated social worker. Management oversight of reviews and care planning required improvement. Child-in-care reviews were not taking place within the statutory timeframes and associated records were not always contained in children's files. The voluntary consent of parents was not routinely reviewed.

Self- Assessment information and what Tusla said about the service

Prior to the announcement of the inspection, a self-assessment 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 service rated its performance as compliant against three standards, substantially compliant against four standards and moderate non-compliant against one standard. The information provided described that there was good strategic service planning in the area, led out by an experienced, cohesive senior management team. They described that there was a strong focus on quality improvement and service development, as well as engagement with key stakeholders involved in fostering in the area. They described that a learning and sharing culture was encouraged throughout the service which supported the overall management and monitoring of the service. The service rated its performance as moderate non-compliant against the standard for the management of the placement of children through non-statutory agencies.

While recognising that there were well developed governance structures in the area, coupled with experienced and conscientious leaders and a committed and skilled workforce, this inspection found that management systems, overall, could not ensure the delivery of a consistently high quality foster care service which adhered to relevant policy, procedure, regulations and standards. Four standards were rated as non-compliant moderate by inspectors and these were; effective policies, management and monitoring of the foster care service, the recruitment of an appropriate range of foster carers and the foster care committee. Inspectors agreed with the areas judgement in three of the eight standards and increased the level of compliance for standard 24.

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, foster carers and external advocates and professionals. Inspectors did not speak to any parents, as parents may choose to speak to an inspector or not, and in some cases selected by inspectors, it was not possible or appropriate. The review of case files, complaints and feedback also provided evidence on the experience of children in foster care.

Inspectors spoke to five children individually over the phone as part of the inspection. Children said that they were happy where they lived and described many aspects of their lives that were progressing and going well for them, such as their relationships with their families and foster carers, their achievements at school, and the opportunities they had to pursue their hobbies and interests. Some children talked about their social worker who they said had visited them often. Children talked about child-in-care review meetings and they said that they were supported to attend and contribute to these. They said that sometimes they choose not to go and this suited them.

Some of their comments included;

'I am very happy now.'

'I have a care plan and I know what my care plan is, the social worker has talked to me about that.'

'I am going on a holiday soon and it will be a big adventure.'

'They are nice social workers...easy to talk to.'

Some children voiced their views on what needed to improve in the service. Some children said that while they completed their report to the service for their child-in-care review, they did not receive feedback regarding the outcome of their child-in-care review. Some children also said that they would not like to have any more changes of social worker.

Inspectors spoke to seven foster carers through a focus group and 12 foster carers through individual phone calls. Inspectors heard a range of experiences and feedback from foster carers about the service. The majority of foster carers provided overall positive feedback to inspectors and identified areas for improvement.

Foster carers said that they had an opportunity to provide feedback on the delivery of the service through a variety of means including child-in-care reviews, foster care reviews and individual consultations with social workers and their managers. They said that their input and feedback was welcomed by staff. The majority of foster carers who spoke to inspectors were aware of how to make a complaint if they required to do so. Some foster carers wanted more support and better communication from the service when complaints or concerns were being addressed and investigated.

Foster carers who spoke to inspectors spoke positively overall about their access to - and consistency of- fostering social work support provided to them by the service. They said that the support they received was very good and that they felt supported. They spoke highly of the relationships they had with Tusla staff. They said that they had access to supportive events and training both from Tulsa and partner agencies but some more recently approved foster carers wanted more access to training. They made the following positives comments;

'Our link social worker is very available to us...she is very responsive and I can't actually say enough good things about her.'

'The link social worker is very good and very accessible.'

'No problems with Tusla at all. Anytime I needed help, there was someone there.'

'We just need to pick up the phone and the help is there for us.'

'We have never felt we are on our own.'

'We all work really well together and with the children's parents.'

There were mixed views amongst foster carers in relation to the support provided to children in their care who had additional or complex needs. They said that children did not have prompt access to specialist assessments and as a result, they did not have timely access to specialist health or education services either through public or private referral pathways. They gave examples of the impact of these delays for children. One foster carer talked about 'the spiralling of issues' experienced by a child, which may have been prevented if the support was available from the beginning of the placement. Another foster carer said that the service did not provide adequate resources to social workers to enable them to communicate with a child with complex needs. Some foster carers also said that the availability of respite needed to improve.

The turnover of social workers for children in their care was a concern for foster carers. They said that the children in their care did not always have good access to social work support that promoted continuity and consistency due to frequent changes of social worker and periods of time when children in their care were not allocated to a social worker. They said that;

'It was very difficult for children to build trust. Repeating their stories and getting to know new people was very challenging.'

'We just get to know them and they are gone. It is hard for the children to get used to a new social worker'.

'It was a couple of months after the child's social worker had left that we found out the child was unallocated.'

Some foster carers said, that although the children placed with them had not had an allocated social worker for periods of time, they managed as the link social worker was there for them as a family.

Other areas for improvement identified by foster carers included greater levels of information sharing from the service to inform them of outcomes of child-in-care reviews and changes to children's care plans. While the majority of foster carers said the voice of children in their care was respectfully acknowledged and managed, some said that children needed greater opportunity to say what they are feeling at meetings.

External professional told inspectors that there were elements of the service which were working well, which was a testament to the hard work and commitment of staff and managers, given the staffing challenges in the service. They said that the service had effective measures in place to respond to safeguarding and child protection concerns for children which meant that they were safe.

Representatives from commissioned services also identified that there were good management and monitoring systems in place to review the effectiveness of their

interventions with children in foster care, to ensure that their service being provided was meeting the child's needs, and providing outcomes effectively. However, they said that professional relationships between them and staff were challenged by high turnover. They said that greater levels of engagement and communication from social workers was an area for improvement, in order to improve the quality of joint working.

The turnover of staff was also identified as a factor which impacted the quality of service being provided to some children. External professionals said that in some cases, it meant that there were delays in work being undertaken with children to progress their plans and delays in decisions being made about children.

External professionals raised concerns about the lack of foster care placements for children in the area which they said was a challenge. They had concerns about the impact of placement moves for children, and this required greater focus and understanding by the service. Matching was a concern and while there were services provided to support placements with the potential for breakdown, there was a lack of alternatives for children when things went wrong. Some external professionals said that children did not always know what was going on due to, in some cases, protracted court proceedings relating to their care, the use of language which was inaccessible to them, and uncertainty about their future plans. In addition, they said that the use of respite as a supportive mechanism for foster carers needed development.

Case records reviewed on inspection demonstrated mixed quality in relation to overall service being provided to children and foster carers. Capacity and pressures on frontline staff and managers had impacted on the quality of recording and this meant that the progress of the service in meeting the needs of children and creating better outcomes was difficult to track. Positively, children's records indicated that their safety was proactively monitored in most cases. Equally, in most cases, social workers and managers paid good attention to identifying children's needs to inform dynamic child-centred care planning and there was a strong multi-disciplinary team approach. However, the extent to which written records, care plans and reviews clearly identified desired outcomes and the changes that subsequently occurred for children was variable and there was evidence of some drift and delay in a minority of children's cases. For example, delays in the arrangements for access, delays in a child obtaining a passport and delays in voluntary consent of parents being reviewed.

Social workers allocated to children got to know them well and this was evidenced in the recording of children views and their unique profiles and needs. However, turnover and gaps in social work allocation, impacted on some children's capacity to get to know and build relationship with their social workers and not all children had up-to-date care plans.

Foster carer records demonstrated overall mixed quality in relation the support and supervision provided to them. In most cases, there was evidence of frequent contact and support for foster carers and a strong multi-disciplinary team approach. Fostering link workers were responsive to the increased support needs of foster carers associated with the complexity of children's needs and or the recency of foster carers' approval for example. Records showed that fostering teams knew their foster carers well, and their support was valued by foster carers. There were aspects of the support and supervision for foster carers that required greater focus, such as training and the renewal of garda vetting.

The lack of foster care placements was evident and some foster carers were caring for children outside of their approval status and exceeding numbers of children in placement which placed excessive demands on them.

Governance and Management

There were clear and established governance systems in place to manage the foster care service and to provide assurance of the safety and quality of the service being provided to children, their foster carers and families. However, the effectiveness of these arrangements varied due to significant organisational risks in the service. This meant that the foster care service did not have the capacity to provide a responsive and consistent service to all children, foster carers and families. The allocation of social workers to all children is critical in driving improvements in service quality. In addition, the recruitment and timely assessment and approval of a range of foster carers to best serve children's needs in the area was required. Case file auditing and better record management systems were areas for significant development in order to provide better oversight and understanding of the children's journey through the service and the impact of support on improving outcomes for them.

The service area benefitted from having experienced and conscientious leaders 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 almost all of the deficits found on this inspection. However, over the past 12 months, the capacity of frontline teams and their managers had been impacted by vacancies and absences. Staff turnover was significant in the last 12 months (12.11%) and this had an impact on the overall pace of service improvement and the lack of progress in levels of compliance with some standards

assessed on this inspection. It is acknowledged that there are aspects of the service which have continued to develop and improve but significant challenges since the last HIQA inspection have remained, and the service was not yet providing a responsive and consistent service to all children, foster carers and families.

Strategic management systems were well developed. The service had a business plan for 2022 which was aligned to Tusla's own corporate and business plan objectives. The service's business plan set out key deliverables for service improvement which were measurable and time bound and underpinned by a strong ethos and vision for improving outcomes for children in foster care. Managers monitored the service area's performance and progress through an integrated strategic plan which connected local targets, practice standards and service improvement plans with national objectives and targets. 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.

The issues and risks in the service area had been well-recognised by the management team. A core focus of the business plan for 2022, is a systemic review and reconfiguration of the service's structures, processes and outputs. The area manager acknowledged deficits in the efficiency and efficacy of workflow processes across the service and capacity challenges, which required analysis and review, to drive an increase in the activity of the service, in order to meet service improvement targets and national corporate objectives. The area manager sought to ensure this progress through an external improvement board, which was approved by Tusla's national office. This systems review or 'change management project' was due to commence in July 2022.

Communication systems were strong which supported oversight of the service across all grades. Senior management meetings, governance meetings and quality forums included representation from each service pillar. These provided mechanisms for management assurance and continuous review of performance trends, progress made and areas of identified risk. Inspectors observed a governance meeting for the review of unallocated cases of children in foster care in the area and found good practice. There was robust review of outcomes to actions taken to reduce the number of children in foster care without an allocated social worker across teams. Standard operating procedures and other tools to enhance the quality of service delivery to children without an allocated social worker were reviewed and shared. Individual case management plans for children were collectively reviewed in situations of increased risks, such as placement instability, as an example.

Managers actively monitored the service's area performance in its service review, improvement plans and individual supervision activity. Systems to support the

collection of data to inform analysis of organisational risk and performance were developed, but the consistency of recording practices across the service needed to develop in order to improve the efficiency and accuracy of data analysis. This had been identified by managers and was a core service development focus for 2022.

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 prevent the drift and delay in the completion of key markers of quality and performance in the service being provided to children, foster carers and families, such as reviews, statutory visits, and recruitment and assessments of foster carers for example. But at the time of this inspection, the current situation in the service area meant that a significant focus was on managing risks and quality assurance activity was not yet consistently leading to better practice, due to pressures in capacity across the workforce.

There was evidence of improvement in some tracking and monitoring systems since the previous HIQA inspection, such as the management of allegations and serious concerns for children in foster care, for example. But 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 absence of 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.

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 stress within the team due to complex and challenging caseloads and the lack of capacity in child in care teams in the last 12 months. It also mapped out the challenges in providing suitable placements for children requiring alternative care and finding placements for children with complex needs. Concerns were also highlighted about insufficient access to psychology, psychiatry and child and adolescent mental health services to meet the needs of the children in care in the area.

Systems and accountabilities for escalation of risk to the area manager, service and national director were clearly defined. There was evidence of timely and supportive responses from senior managers in seeking to devise effective mitigating actions to reduce risks. 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 ensured that situations of increasing risk or placement instability for children were prioritised for allocation. In addition, a tiered system of support for foster carers

was introduced in one team which aligned the frequency of social work visits to foster carers with the level of their support and supervision needs, whilst maintaining compliance with the regulations and standards.

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 and lack of staffing capacity regarding child in care teams.

The availability of foster carers to best serve children's needs in the area was inadequate. This posed risks to children due to increasing potential for placement instability, placement endings and further disruption in their lives. Poor matching had resulted in foster carers taking a break from fostering or leaving altogether, and in other cases, there was increased pressures in foster care households who were asked to facilitate additional placements causing the numbers of children placed to exceed the standards. The main challenges for the service were in finding suitable and sustainable placements for children over time following their admission to care in an emergency and matching the complexity of children's needs to the skills and long term availability of foster carers. In addition, respite support or short breaks for children and foster carers did not meet current levels of demand. These organisational gaps had been recognised by the service with evidence of development work to create a service strategy for the assessment, approval and recruitment of foster carers.

Staff turnover and workload pressures continued to affect the capacity of the service and children's experiences. The lack of a resourced workforce posed risks to the service due to delays in foster care reviews, delays in statutory visits to children and supervisory visits to foster carers and delays in child-in-care reviews and care planning. At the time of this inspection, there were 122 children in foster care without an allocated social worker and this represented 33% of children in foster care. At the time of this inspection, the stability of the workforce had started to increase and morale amongst staff who met inspectors was good.

Staffing deficits also compromised the capacity and quality of monitoring and oversight by social work team leaders and principal social workers of the service being provided. There was insufficient monitoring of records. The extent to which written records, care plans and reviews clearly identified desired outcomes and the changes that subsequently occurred for children was variable and there was evidence of some drift

and delay in a minority of children's cases. Few case records did justice to the quality of critical analysis and reflection that inspectors observed and heard from staff and managers during the inspection. Some documents were missing, incomplete and unsigned by managers which meant that they could not be authenticated. This caused difficulty for staff. In addition, it weakened the reliability of data to measure adherence to key quality indicators, such as statutory visits and care plans and reviews. These shortfalls obscured the record of children's journeys through the agency. This required improvement to ensure better oversight and understanding of the impact of support on outcomes for children and to ensure that information was clearly available for children 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 and opportunities for reflective practice and learning. Staff valued the level of mutual support provided by their teams. This contributed to their motivation and enjoyment of the work. Staff were aware of their roles and responsibilities. They had good understanding of the policies and procedures in place relevant to their roles but challenges associated with high caseloads, high staff turnover and 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 'change management' plans for 2022 and they were committed and trusting of the direction of managers' leadership in this regard.

The response to incidents, complaints and representations was good. 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 organisational learning, quality improvement, and appropriate identification and reflection on what was working well. There were well developed mechanisms in place to enable children, families and foster carers to provide feedback to the service. Some improvements were required to broaden the scope and scale of learning from complaints and the reasons for foster carer's leaving the service.

The Wexford Waterford 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. However, inspectors found that improvements were required to ensure that the FCCs discharged their accountabilities in line with Tusla's FCC's policies, procedures and best practice guidance (2017), standards and regulations. Inspectors found that membership of the committee was not in line with regulations and Tusla's own policy

guidance, and governance of committee member's personnel records needed to improve.

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 compliant with this standard. Inspectors did not agree and judged the area as non-compliant moderate.

Service planning was comprehensive and at the time of this inspection, the fostering service was on the cusp of a transformational change management project at an operational level. There were policies in place to guide the management and provision of foster care services at organisational and local level and these were informed by relevant child care legislation, regulations and standards. Managers sought to ensure consistent application of organisational policies and procedures but ongoing organisational risk challenged the service area's capacity to review, implement and monitor the implementation of policies and procedures.

The service area's annual plan provided a clear focus on priorities for service improvement and was aligned to wider regional and national objectives and targets. Service planning and development was underpinned by comprehensive analysis of the service's performance, risks and areas for improvement as well as changing needs of the community and the service, inspection findings, research and practice developments. Service plans aimed to build on families' strengths, utilising families' extended support networks in the community to keep children safe and provide care for children where appropriate. There was a focus on establishing 'reconciliation teams' who would provide interventions and supports to families to enable children to return home if it was safe to do so. This would enable the service to have a paralleled approach to permanency planning for children, with considerations, at all stages of care planning, to a wider range of options for children.

The area followed the national transfer policy in relation to children placed outside the Wexford Waterford area. There were some delays in the transfer of responsibility for these children to the service area where they were living but there was a consistency of service being provided to them which was comparable to cases of children living in foster care in the area.

Inspectors reviewed files of children placed outside the area, and found good quality care planning had taken place. While the children had been visited by their social workers, statutory visits had not taken place in line with the regulations, and were not consistently recorded on the child's file. In addition, records of supervision and managerial oversight were significantly lacking on these files.

The area maintained a register of the panel of persons approved to act as foster carers in each county in order to comply with the Child Care (Placement of Children in Foster Care) Regulations 1995. The register included approved foster carers working for private non-statutory foster care agencies. The register in the Wexford Waterford service area was kept up to date. It included a list of approved foster carers, their address, contact details, their assessment type, their allocated fostering social worker, the date of their approval and whether they were active, inactive, on hold or exiting the service. However, inspectors found that the details relating to one foster carer were not accurate as it was not recorded that they were also providing care for other children and young people placed by another team outside of the area.

There were effective arrangements in place to support partnership working with other agencies, to facilitate the management of specific cases as needed. There was a joint Garda/Tusla forum also aligned to national protocols to facilitate on-going case management liaison and information sharing in relation to allegations of abuse of children. There was a joint HSE/Tusla governance forum, aligned to national protocols, which was assisting in joint working in the delivery of care for some children as required. Gaps in access to some specialist services had been identified by staff, management and foster carers. This was being followed up in line with the joint working protocol, and in some cases had resulted in Tusla funding additional specialist services. This risk was escalated and reviewed at a regional management level.

Systems to review, implement and monitor the implementation of policies and procedures needed to strengthen. There were areas of good practice found for example, in the management of preliminary assessments of relative carers. Inspectors found prompt follow up in response to emergency placements with relatives. Initial screening assessments were good quality with relevant checks undertaken of foster carers in a timely manner. Case work was well-managed with appropriate involvement of child protection social workers recognising the impact of children's earlier experience of abuse or neglect.

There was good practice found with regard to the structures in place for the management of placement requests by the service. Operating procedures for placement requests were detailed. There was a weekly fostering placement meeting which provided a clear structure for identifying children newly admitted to care;

placements under stress; and for tracking changes in children's needs and circumstances, as well as the availability and capacity of the wider foster carer panel. Inspectors observed a fostering placement meeting and found that case discussion was informed by clear and agreed next steps for promoting stability or permanence for children and denoted strong joint working with the child in care social work teams. Discussions were child-centred and good attention was paid to matching children to the most suitable placement and additional support provided to children in crisis or placements under pressure. Good attention was paid to managing risks for children transitioning to new placements and efforts were made to sustain children's links with their school and home community.

Foster carers told inspectors that they felt informed about policies and procedures, such as those regarding the support and supervision provided to them by the service. Correspondence to foster carers included policy updates which ensured that there were aware of changes in the service. The youth participation group in the area were making an effective contribution to policy and practice development through providing feedback on services and undertaking initiatives to improve their experiences, such as developing information cards to inform teachers of the contact details of their foster carers and social worker.

Children and foster carer records indicated appropriate systems were in place for investigating concerns and allegations of abuse by foster carers. Allegations and serious concerns were taken seriously and managed in line with the Interim Protocol although there were some delays in notifying the FCC. There was evidence of regular support and supervision visits by fostering social workers, with joint visits undertaken with the child's social worker where safeguarding risks increased. When there was a requirement to take immediate action, such as interviewing the children and foster carers, this was done in a timely way. Foster carers were informed of the allegations and concerns and provided with information. There was good cooperation between the child protection and welfare teams, children in care teams and fostering teams. Where a case was held by child protection and welfare teams, the case supervision records were excellent and detailed effective monitoring and review of safety plans. Inspectors found that serious concerns and allegations about foster carer's were sensitively and effectively managed, and safety plans were in place when required.

Some aspects of the service's policy management systems needed to improve. For example, there were standard operating procedures provided to HIQA which were undated. In addition, some policies, procedures and guidelines were too brief. For example, the procedure for statutory visits by social workers to children in care was and they did not fully aligned to the template used for such visits. The long-term matching guidance did not adequately explore the complexity and diversity of children's needs and the key aptitudes, knowledge and skills required by foster carers to ensure appropriate matching. In addition, inspectors found that records did not always provide evidence that foster careers had been sent or informed of policies and procedures relevant to them. While recognising that the senior management team had established governance structures and systems in the area, inspectors did not find evidence of regular review and monitoring of local policies and procedures as described in the areas SAQ in March 2021.

Foster carer training records were poor and not kept up to date. Inspectors found that not all foster carers had received training in safeguarding, child protection and associated mandated responsibilities in line with *Children First: National Guidance for the Protection and Welfare of Children (2017)*. Training logs were not maintained on foster carers' files and records, overall, denoted low attendance levels at training including relative specific support and training. One foster carer told the inspector that they were fostering for a year and a half before there was any training offered to them and they were not familiar with Children First.

Practice and procedures to ensure oversight by the FCC and the manager of the service area of fostering households caring for children and young adults from other teams outside the area were not strong enough. This meant that any potential risks could not be identified, assessed and mitigated against. In addition, improvement was required to ensure that procedures for matching and determining placement suitability were implemented fully. Inspectors found one case which did not provide sufficient analysis and assessment of the needs of all children and young people living in the foster care household including the needs of children due to move to the foster care household. Equally, the capacity of the foster carer to meet the range of needs of children and young people in this placement was not subject to sufficient assessment and analysis in line with the service's procedure.

Inspectors found that priority action was required to mitigate the non-compliance associated with this standard and ensure the safety and welfare of children using the service. Following this inspection, HIQA requested the area to submit a provider assurance report to provide assurances against this standard in relation to identified gaps in practice and policy, and implementation of procedures. These gaps related to the following inspection findings;

- The service could not ensure that all foster carers had received appropriate training in safeguarding, child protection and associated mandated responsibilities in line with *Children First: National Guidance for the Protection and Welfare of Children (2017)*.
- Practice and procedures to ensure oversight by the FCC and the Manager of the Fostering Service of fostering households in the service area caring for other children and young people from other teams outside of the area were not strong enough.
- Procedures for matching and determining placement suitability were not implemented fully. The needs of all children living in one foster care household including the needs of children due to move to the foster care household had not been adequately assessed and analysed in line with procedures.

The area provided HIQA with satisfactory assurances in relation to how they would address these deficits.

Judgment: Non - Compliant Moderate

Standard 19 : Management and monitoring of foster care services

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

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

Overall, there were established governance arrangements and structures in place, but improvements were required to ensure their effectiveness. Since the last inspection, improvement and progress to address critical weaknesses in the service has been slow. The capacity of frontline teams and their managers had been impacted by vacancies and absences in the previous 12 months. This was an ongoing 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.

Management structures and reporting systems were established in the service area at the time of this inspection. The area was under the direction of the regional chief officer for the south Tusla region. Following significant changes in senior management within the fostering service, the service area had recently strengthened management structures in the service by reconfiguring the senior management team. In May 2022, there were two principal social worker posts, one for the area's fostering service, and the second for quality risk and service improvement. There was also a new area manager appointed in August 2021. Positively, transition planning, at a management level, had been effective in establishing clear reporting lines to the area manager from newly appointed and established managers and from newly appointed principal social workers to their direct reports.

Since the area manager's promotion within the service, there were gaps in the quality improvement of the service, as he had previously held this role. There had also been a reduction in management capacity over the last 12 months which had affected management oversight and the implementation of quality improvement actions. For example, there were vacant social work team leader posts which curtailed the level of operational quality improvement work intended by the service and described in the area's SAQ in March 2021. This meant that management capacity to provide regular audit of children's and foster care records had been limited.

In May 2022, the appointment of the principal social worker for quality risk and service improvement to the service area facilitated a renewed focus and increased capacity on improving service led auditing. Priority areas of focus for her for the coming months included developing audit programmes, developing and standardising naming conventions, improving supervision and support of staff and developing recruitment and retention strategies for both staff and foster carers, which were welcomed developments for the service.

There was evidence of good collaborative working relationships between managers and teams. There were clear accountabilities, with staff at all levels, understanding where and by whom decisions should be made. Managers and staff reported a positive 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 recently improved, they said that they had a very difficult previous 12 months, whereby they were considerably stretched as individuals and as teams.

Managers monitored the service area's performance through its service review, service improvements plans and individual supervision activity but the pace of improvement had not been enough to improve levels of compliance with the standards overall. The senior management team persistently balanced competing demands of managing significant and serious risks to the service as well as driving improvement. Management reporting systems provided the area manager and principal social workers with oversight of service delivery and there was appropriate identification of most risks and challenges to the service. But this meant that quality assurance activity was not consistently leading to better practice at the time of this inspection due to pressures in capacity across the workforce. Inspectors found that oversight and monitoring of some aspects of the service required strengthening in order to provide a high quality and safe fostering service.

Although supervision took place, it was not yet effective enough to ensure consistency of practice. There were gaps in individual case supervision records on children's files for periods of time up to 23 months and these were linked to periods of case un-allocation and staff absences. When individual case supervision records were available on children's files, they were a mix of typed records on standardised templates and records filed as case notes. Some were comprehensive while others gave limited information as to case discussion and decisions agreed. There was no record of chronologies on file which would be a useful tool for social workers and managers to monitor and analyse the impact, both immediate and cumulative, of events and changes on children and to strengthen the systems already in place for matching resources and interventions with levels of need.

Equally, the quality and regularity of formal supervision of staff was variable. Inspectors saw examples of good practice such as good case discussion including the effective identification of risks for children and evidence of clear decision making and direction of appropriate next steps. Some records tracked levels of compliance with regulations and standards, such as care plans and statutory visits but others did not. 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. In addition, some supervision records were poor, for example, they were undated and or incomplete and case management actions were not always time bound or

recorded and evidenced as being complete. Inspectors found that senior manager's oversight and support in some supervision had not always been sufficient to address issues arising for staff, such as unmanageable caseloads.

Tusla's National Child in 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 register of all children in care in line with statutory regulations and the service area used NCCIS to inform the management and updating of this register.

While there were was appropriate identification of risks and challenges to the service by the senior management team, inspectors found that oversight and monitoring of some aspects of the service required improvement, such as the monitoring of completion of mandatory training for foster carers *in Children First: National Guidance for the Protection and Welfare of Children (2017)*, monitoring of records and administrative management of records and the delegation of duties to secondary workers assigned to working with children in care.

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 for considerable lengths of time. Some of these records was stored in filing cabinets and others were with business support personnel for typing and filing. Other documents which should be held securely on foster carer's files were absent such as contact details for foster carers and support and supervision visits to foster carers.

Similar gaps were found on children in care files. Statutory visits were not always recorded as such but referenced in other records and reports which made it difficult to evidence and track compliance with standards, regulations, policies and procedures and pull accurate metrics for monitoring and oversight. It also meant that there was a lack of descriptive analysis of the progress children were making and a lack of measurement of impact of the support they received on improving outcomes. There was also a delay in uploading records into children's files.

In addition, at the time of the inspection, inspectors were informed that records relating to case work, supervision, and team meetings in one social work office were not accessible to staff or managers. These records were saved solely against a staff member's individual network account and as they were now absent from their role, the records were not accessible. These gaps posed risks to the management and monitoring of the fostering service.

Inspectors also found that the roles and responsibilities of social care staff undertaking direct work with children and families were not clearly defined across the service, and the service area could not ensure that all statutory work, such as renewing voluntary consent with parents, was undertaken by social workers.

While it was acknowledged that the staffing stability had increased slightly in the service area and new management structures would improve the oversight and monitoring of the quality of the service in the coming months, this inspection found that the service could not ensure that there were sufficient numbers of social workers employed to undertake duties in compliance with statutory regulations. This posed risks to the safety and quality of the service due to delays in foster carer reviews, delays in statutory visits to children and supervisory visits to foster carers, delays in child-in-care reviews and care planning. Staffing deficits also compromised the capacity and quality of monitoring and oversight by social work team leaders and principal social workers of the service being provided. At the time of this inspection, there were three vacant social work team leader posts for children in care teams, one vacant social work team leader post for fostering, seven vacant social work posts across both teams and one vacant social care worker post.

Inspectors found that priority action was required to mitigate the non-compliance to ensure the capacity and capability of the service to effectively monitor the quality and safety of care provided to children. Following this inspection, HIQA requested the area to complete a provider assurance report to provide assurances against this standard in relation to the identified gaps as follows;

- Gaps in information management systems (outlined above) posed risks to the management and monitoring of the fostering service.
- The roles and responsibilities of social care staff undertaking direct work with children and families were not clearly defined across the service, and the area could not ensure that all statutory work, such as renewing voluntary consent with parents, was undertaken by social workers.
- The service could not ensure that there were sufficient numbers of social workers employed to undertake duties in compliance with statutory regulations. This posed risks to the safety and quality of the service.

At the time of writing this report, the area provided HIQA with satisfactory assurances in relation to how the service would address these issues and strengthen levels of compliance with the standards. These actions will continue to be monitored by HIQA through the authorities monitoring approach for children's services.

Judgment: Non-compliant Moderate

Standard 20 : Training and qualifications

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.

There was a range of knowledge and experience amongst practitioners employed by the service ranging from newly qualified social workers, social care workers to social work managers with extensive experience and expertise. From observations of meetings during the inspection, reviews of records and interviews with staff, inspectors found that there was a high level of knowledge of children, families and foster carers amongst staff. Inspectors observed and found evidence of good quality critical analysis and reflection of casework which demonstrated the capabilities and competence of staff working with children, young people, their families and foster carers. Staff were committed to the service being provided and to improving outcomes for children.

Recruitment practices supported the employment of staff who had the qualifications and skills to work with children, their families and foster carers. As part of the recruitment process and the on boarding of staff to the service, garda vetting disclosures and professional registration were monitored and tracked in the service to ensure timely renewal. However, not all of the required documentation was available to inspectors during the review of staff files. Inspectors sampled 10 staff files held centrally, and found gaps in the records such as missing CORU registration certificates in five out of 10 files sampled, no record of qualifications in two out of 10 files sampled and one file which contained no staff records including garda vetting. Following the inspection, the area provided assurances that all documents were available to the agency, some of which were held with Tusla recruit and others had been scanned from paper archives. One staff member without garda vetting was not working at the time of the inspection and inspectors were provided with an assurance that the required vetting disclosure had been processed.

There was a culture of open communication and support in the service which was observed from interviews with staff and from review of records such as meeting minutes, supervision records and internal correspondence. Newly recruited social workers who spoke to inspectors said that they received good levels of support and guidance from staff and managers which helped them in their new positions. Social workers provided examples of good processes and systems in place which facilitated feedback across all grades and shared learning and development amongst staff, such as, for example, team meetings, complex case forums and placement meetings, amongst others. Staff were issued with local guidance and procedures to assist them in their work. There were established working relationships between teams. While staff acknowledged that collaborative working had helped to reduce gaps associated with unfilled and vacant posts, the absence of permanent social work managers for children in care teams needed to be addressed to ensure the delivery of consistent line management structures and supports.

Staff were supported informally and formally by managers through their detailed knowledge and understanding of the case work, their direct involvement with children, families, parents, formal supervision of staff and open door policy to facilitate regular informal supervision and support.

There were systems in place to identify the developmental and training needs for all those involved in delivering the foster care service. A training needs analysis was undertaken on a three yearly basis by the area to inform the regional workforce learning and development plan. In the previous 12 months, staff said that they had access to a range of training such as trauma and attachment training, permanency planning workshops, health and safety training, amongst others. Managers were responsive to individual and collective training needs of the service and sourced additional specialist training for staff when relevant and required. Continued professional development of staff required greater focus. The development of comprehensive professional development plans and performance plans as set out in the areas SAQ in March 2021 had not been reached.

Social workers attended joint training programmes with foster carers, such as legal training provided by an external advocacy group, and training on therapeutic approaches to parenting.

Staff retention was a key priority for the service in response to the challenges of the pandemic which exacerbated existing capacity challenges, staffing and workforce deficits. Staff said they met with Tusla's national management team to contribute their views and ideas in relation to staff retention and increased recruitment. Staff in this service availed of protected time to participate support and development programmes, such as wellbeing initiatives and reflective practice group meetings once per month and undertook training on burnout prevention. Staff had access to a complex case forum which helped them to identify specific actions to be taken in relation to children with increased levels of need. These provided additional support and guidance to social workers from managers.

The service area had clear systems and processes in place to ensure safe recruitment and continued growth in the competencies of its workforce. Continued professional development of staff required greater focus. The development of comprehensive professional development plans and performance plans as set out in the areas SAQ in March 2021 had not been reached.

Judgment: Substantially Compliant

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

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

The area judged themselves to be substantially compliant with this standard in their SAQ in March 2021. Inspectors did not agree with this judgement and assessed the service area as moderate non-compliant with this standard.

Recruitment and retention strategies needed to strengthen in order to attract and retain a sufficient number of foster carers to meet the varied placement needs of children in the service area. There were not enough foster carers to meet demand. The main challenges for the service were; finding suitable and sustainable placements for children over time following their admission to care in an emergency, matching the complexity of children's needs to the skills and long term availability of foster carers. In addition, respite support and short breaks for children and foster carers also did not meet levels of demand. These gaps posed risks to children due to increasing the potential for placement breakdown and placement moves causing further disruption in their lives. It also led to some children being placed outside of their own community, and in households exceeding the number of children that could be placed there in line with the standards.

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

The lack of placements to meet the needs of children in the area was regularly risk escalated and considered at the highest risk level for the area, but risk management structures and processes were not effective in the reduction of this risk for the service in the previous 12 months. Due to the demand for foster placements, the area had 14 foster placements where the number of unrelated children exceeded the standards, 21 children placed with non-statutory foster care agencies and 13 children waiting for a suitable foster care placement.

Gaps in the capacity and sufficiency of foster care placements available to the service were known. There were effective systems in place to assess and understand the placement needs for the children living in foster care or requiring foster care. For example, there was regular review of the service's position in respect of the current panel of foster carers and level of capacity to meet the service's need. There were weekly fostering placement meetings which provided a clear structure for identifying children newly admitted to care and for tracking changes in children's needs and circumstances and the availability and capacity of the wider foster carer panel.

Current provisions in place to drive recruitment were not effective. The fostering service had a recruitment policy and strategy aimed at recruiting a range of carers to meet the needs of the children for whom it aimed to provide a service. However, capacity challenges in the service meant that this recruitment was not sufficiently prioritised in the previous 12 months. There were two recruitments campaigns and one information session provided to prospective foster carers which resulted in three applicants for fostering. Positively, foster carers told inspectors that they were involved in recruitment campaigns such as radio interviews to raise the profile of the service through publicity and to give foster care applicants a realistic view of what is expected of them.

There were standard operating procedures for the recruitment of foster carers from initial enquiry stage right through to the assessment and approval of foster carers in the area. There was evidence of ongoing development work by the service to devise a bespoke recruitment plan to meet the needs of increasing numbers of children from a range of cultural and ethnic backgrounds who require care. Publicity events were being planned for the second half of the year to raise the profile of the service and attract potential interest in fostering from minority ethnic, cultural and religious groups. In addition, the placement request process ensured that social workers considered all options for a relative foster care placement, in order to maintain the child within the family unit and within their community were possible.

While existing recruitment methods had been evaluated in respect of the number of enquiries generated and subsequent applications made at the time of this inspection, provisions in place to drive recruitment in the area lacked strategic management planning. The area manager and senior management team acknowledged that changes to the management structure of the fostering service and additional social work staff were required to increase the capacity of the service to evaluate, plan and deliver a more robust recruitment strategy for the area. The fostering service had been managed by two principal social workers (one in Wexford and one in Waterford) who also had management responsibility for children in care. The recent appointment of one principal social worker for oversight and management of the fostering service was intended to facilitate a more targeted and focused approach to the recruitment of foster carers.

The area manager acknowledged that the fostering service needed to build capacity to complete assessments for prospective foster carers amongst the social work teams. There were 16 assessments completed by the service and presented to the FCC for approval in the previous 12 months. There were 14 assessments ongoing at the time of this inspection, ranging in timeframes from 9 to 96 weeks from the time the assessment commenced. It was intended that the change management project would help to streamline these processes and build capacity for greater encouragement of foster carer applicants and for more timely assessment of applicants.

There were strategies in place for the retention of foster carers in the area with some improvements identified. There were coffee mornings for foster carers which facilitated peer support and speakers on topics which were relevant to foster carers. There was training and joint training initiatives for foster carers and their families and additional supports through the area's therapeutic team and creative community alternatives for foster carers and their families. Through the COVID-19 pandemic, the area utilised different technologies to engage with foster carers to ensure that they received adequate support and supervision when home visits were not possible and supports groups ran online in 2021. One team set up a duty system to make sure that there was a social worker available to speak to foster carers if their allocated social worker was not available due to the pandemic, another team developed a system whereby every child in foster care had a social care worker assigned to them as an additional support in times of need. At the time of the inspection, all foster carers had an allocated link social worker who provided support and supervision.

Improvements needed to strengthen retention strategies were acknowledged by the service and learning from disruptions and foster carers leaving was a focus for the area for the remainder of 2022 and 2023. Exit interviews were offered to all foster carers leaving the service to gather information about their experiences of the service and to identify learning for service improvement. In the previous 12 months, 16 approved foster carers left the service but just four agreed to an exit interview. Equally, learnings from placement disruptions were also under developed because of the low take up and attendance at disruption meetings. Improvement was required to expand the ways in which the service captured the individual views of children and foster carers and to understand why placements ended and from foster carers to understand their reasons for leaving. Furthermore, the area had not completed a training needs analysis of foster carers since 2018 and the methods of tracking and monitoring training completed by foster carers required improvement.

Judgment: Non-Compliant Moderate

Standard 22: Special Foster Care

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

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

There was no national strategy in relation to the provision of a special foster care service for children whose behaviour posed real and substantive risks in line with the criteria set out in the national standards. The service did not have any special foster carers approved as such on their local area panel. 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 provided to HIQA from the service prior to this inspection, showed that there were 19 foster care households which received additional supports to meet a range of complex needs of children placed there. Although the service area did not have special foster carers in terms of a designated category, overall, the additional needs of children were recognised, with some areas for improvement identified in relation to the requirement for a more timely response by the fostering service to facilitate children's access to specialist services.

The identification and response to complex needs from the service was dynamic and fluid. Complex needs were identified well through multi-disciplinary working, care planning processes, direct interventions and visits to children and foster families, line management supervision, complex case forums and partnership working with other external services and commissioned services.

Inspectors found examples of good practice in the service's response to the complex needs of children in foster care. There were examples of effective multi-agency working with the HSE disability services for children with additional needs. There was evidence of additional funding provided for specialist services for children such as equine therapy. Additional supports, such as weekly therapeutic consultation for foster carers and play therapy for children for example, were provided to support children in foster care who had experienced previous placement breakdown and had complex needs. Where appropriate, packages of support set up by the service also recognised the need for direct work with foster carers' own children when needed. This was good practice.

From a sample of foster care households, who received additional supports to meet a range of complex needs for children, inspectors found that records demonstrated good practice in the levels of multidisciplinary and partnership working in care planning processes and reviews. Care plans detailed a range of care and support needs including treatment and interventions from other services. 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 was a therapeutic team in the area which focused on the delivery of a therapeutic service to children, their families and foster carers, to enable children to be safe and achieve their full potential. The team worked with children in foster care in a supportive and preventative way to reduce unplanned endings of placements and to provide therapeutic interventions to meet their longer term needs.

There was some evidence of drift and delay in the assessment and interventions for children who required specialist supports for complex needs and this was mostly linked to periods of unallocated status. Poor quality plans and records for some children and a lack of timeliness in response to complex need had led to some drift and delay in a minority of children's cases reviewed on inspection.

The assessment of children's needs was an area for development in the service and region. According to the chief officer for the region, plans were being developed to facilitate a full multidisciplinary assessment of need for children on admission to care. This will support a more timely response to unmet need from the service and identify appropriate referral pathways for children in a more timely way.

As identified in the area's SAQ in March 2021, the area's respite service continues to provide children with complex behavioural issues a safe and structured environment to deescalate and begin examining triggers. 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.

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 compliant with this standard. Inspectors did not agree and judged the service area as moderate non-compliant.

The Wexford Waterford Foster Care Committees (FCCs) had governance structures in place to support their functions in line with Tusla's FCC's policies, procedures and best practice guidance (2017), standards and regulations. However, inspectors found that improvements were required to ensure that the FCCs discharged their accountabilities in adherence to these. The FCCs considered the suitability of applicants to act as foster carers and made recommendations in terms of their approval. Wexford and Waterford each had their own foster care committees due to the geographical size of the service area. The FCCs were led by two suitably experienced independent chairpersons.

Committee members had a broad range of knowledge and expertise to contribute to the FCC meetings and enhance the quality of the committees' collective oversight and decision making in relation to children's placements in foster care. Inspectors observed part of a FCC meeting during the inspection which demonstrated good collective discussion and information sharing. The FCC chairperson sought input from all committee members. There was appropriate challenge, suggestion and scrutiny of information to ensure that placements were suitable to meet children's needs, and that the best interests of children were central to decision making. Minutes of the committee meetings were detailed and reflected comprehensive discussion and a strong focus on permanency planning for children. Tracking of priority items such as serious concerns was also evident. The quality of foster carer assessments was carefully considered to ensure all relevant factors were clearly explored. On occasion, approval decisions were deferred until sufficient assurance was received.

The FCC carries the responsibility to makes decisions to change or terminate the approval status of foster carers. These decisions require formal approval from the manager of the fostering service to come into effect. However, inspectors found that when a significant change in circumstances affected the ability and capacity of a person to foster, decisions by the FCC regarding changes or termination of their approval were deferred due to the lack of an alternative placement for a child. This meant that the FCC's could not reconsider foster carers' approval status based on information provided by the social work department in line with the standards and this narrowed the scope of the FCC's function for independent decision making and quality assurance. Positively, the FCC maintained strong oversight and review of the foster care placement in this instance. However, the service was not compliant with

regulations for the placement of children with relatives due to delays in terminating the placement when it was no longer considered the most appropriate way of providing care to the child.

Inspectors found that membership of the committee was not in line with regulations and Tusla's own policy guidance. Both committees comprised of a chairperson, secretary, foster carer, social work team leaders and principals, as well as additional membership such as a representative from the voluntary sector, a general practitioner and clinical psychologist. Gaps in membership across the two FCCs included a care experienced representative and relative foster carer. This had been identified and a target for action for the FCCs in 2022. Positively, membership included professionals who offered specialist advice and the committee had access to other relevant specialist advice externally, if required.

The FCC and foster care service maintained a joint register of foster carers in the area which was updated at each FCC meeting to ensure it was maintained and accurate. The register was monitored and reviewed by the senior management team and foster care committee chairperson and secretary. Key data and information was tracked and analysed as a quality assurance measure, such as the expiry of garda vetting for foster carers, the tracking of assessments of relative carers and the monitoring of serious concerns against foster carers. However, inspectors found that the details relating to one foster carer were not accurate as it was not recorded that they were also providing foster care for children and young people from another area.

Joint development work with other FCC chairs and access to training and peer review with other service areas in the region supported access to additional advice and expertise as required. FCC meetings had been held on a regular monthly basis over the past year. Meetings had been conducted virtually during times of restrictions associated with the pandemic. Face-to-face meetings had been reconvened earlier in the year, with additional facilities for a blended model to include video conferencing options for members and attendees including foster carers and social workers. This had worked well for the FCCs and facilitated greater flexibility and time efficiency.

Inspectors found that the systems in place to maintain the required documentation on individual FCC members was not effective, which in turn did not support good governance of committee member's personal data. Absence of professional registration, qualifications and garda vetting were found and a full review of personnel files was required.

The area manager had sufficient oversight of the FCCs in the area. Management meetings, supervision and good communication systems allowed the area manager to maintain oversight of the operations and activities of the committee. The FCCs chairpersons contributed to service improvement in the area and completed a FCC annual report in line with national standards and best practice guidance which

contributed to the annual review of services in line with the Child Care Act 1991. However, gaps found on this inspection, such as the limited take up of training by foster carers in recent years and the governance of committee member's personal data for example, were not identified or evidenced in records of reports or oversight systems between the FCCs chairpersons and the area manager.

Judgment: Non-Compliant Moderate

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 non-compliant moderate with this standard. Inspectors did not agree and judged the area as compliant.

The service had clear policies and procedures regarding the contracting out of fostering service to non-statutory agencies. There were service level agreements in line with standards with non-statutory agencies (private providers). There were national arrangements in place for governance and oversight and local managers were supported by governance structures for monitoring and benchmarking their performance.

There were five children placed in private foster care placements from the area and all of these children were allocated to social workers or social work team leaders. There was examples of due diligence in the oversight of the service to ensure safe and secure placements for children in private foster care. There was evidence of reports requested by social workers regarding the support and supervision provided to foster carers and these provided good quality and oversight mechanisms to the service. There was evidence of good communication between the child in care social worker and the private fostering link worker and this facilitated good collaborative working between both services in order to promote the quality of care provided to children. Statutory visits were completed in line with requirements. In one case the social work team leader, who recently took over the case, contacted the private provider to ensure that a link work was allocated to the case as the foster carer was

without an allocated link worker for six weeks. A new link worker was allocated as a result.

The area had other review and analysis systems in place to satisfy themselves of the quality and safety of care provided to children in private foster care. Private foster carers in Wexford Waterford were approved through the FCCs processes. This ensured that assessments and reviews for non-statutory foster care agencies complied with policy, procedure and guidance and the foster carers were listed on the area's foster care register. In addition, all non-statutory service providers were subject to Tusla's monitoring and inspection arrangements through the Alternative Care Monitoring and Inspection Service.

In addition, annual and bi-annual improvement meetings were conducted with private providers to review successes and areas for improvement. The service had implemented good measures to ensure oversight and governance of private foster care placements.

Judgment: 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 systems in place to enable children, young people, their families and foster carers and others, to make representations, including feedback, compliments and complaints about the service provided to them. Inspectors found that managers were responsive to these representations, and valued this process as an opportunity for acknowledging good practice but also for learning, development and service improvement. However, while all complaints reviewed by inspectors were responded to, inspectors found that not all complaints were processed in line with policies and

procedures and this required improved monitoring. Some foster carers told inspectors that they wanted more support and better communication from the service when complaints were being managed.

Inspectors found that the service placed significant emphasis on consulting with children. There were several ways that the service let children know how to make a complaint or provide feedback. Children were provided with an information pack which included information about providing feedback and making representations or complaints to the service. Children had regular visits from social workers and social care workers. They were met with alone and they were supported and encouraged to voice their wishes, concerns and worries. Children had access to advocates to support them to make representations to the service. They had opportunity to share their views at review meetings. Individual children's records did not always document discussions between social workers and children about the ways in which they can access advocacy support and or use feedback processes to raise a complaint or compliment to the service. This required improvement.

In addition, there was a youth participation group in the area which was established in 2016, to provide children and young people with an opportunity to influence the development of the service through a range of activities such as fun days, feedback sessions and peer support. For example, children from the area had contributed to a book entitled 'My life during Covid 19' which included their views of what was important for people to know. Their views were expressed through artwork, stories and rap lyrics. Children also supported the development of an information card which could be shared with a child's school to provide key contact details for the child without the child needing to account and explain their circumstances in the classroom.

The service's own process for managing complaints and responding to compliments was aligned to Tusla's national policy and the majority of foster carers who spoke to inspectors were aware of these procedures. They said that they were mostly satisfied that they knew how to make a complaint and that it would be responded to appropriately. However, some foster carers were less confident about the process and said that foster carers needed more support from the service during the management and investigation of complaints. There were a number of other mechanisms to support foster cares to provide feedback to the service, for example, support and supervision visits, review meetings and exit interviews, amongst others. Similarly, individual foster care records did not always document ongoing discussions between foster cares and social workers about the ways in which they could provide feedback to the service.

The area maintained a register of all compliments and complaints and metrics were monitored and reviewed to ensure that complaints were followed up in a timely manner. Data provided by the service to HIQA prior to this inspection showed that

there were four complaints and five compliments made to the service in the 12 months prior to this inspection. Complainants were routinely advised of the outcome of their complaint and there was an appeals process for complainants if they were not satisfied with the outcome. Whilst the service completed an overarching analysis of the nature and frequency of complaints made in 2020 and 2021, there was no detailed analysis of the learning from complaints to share with staff, to ensure that any areas for improvement were identified.

Social workers said that there was good communication and information sharing between them and their line managers in relation to feedback from children and foster carers about the service. When required, this feedback was acted upon by managers. Individual supervision records reflected good review and oversight of feedback from children, foster carers and families. The use of team meetings and peer support groups, as a means for sharing learning and areas for improvement from feedback and representations made was less evident.

While there was good oversight and monitoring structures in place to track compliments and complaints, the process of capturing all complaints in line with the policy and procedure needed improving. One complaint, which was appropriately discussed and reviewed during line management supervision and identified as a formal complaint, was not included in the service's tracking system. While this complaint was being managed, it needed to be counted and included within the management and oversight system and included on the Tusla national incident management system (NIMS), in line with policy. This was rectified after the inspection.

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