

Statutory foster care service inspection report

Health Information and Quality Authority
Regulation Directorate monitoring inspection
report on a statutory foster care service under the
Child Care Act, 1991



Name of service area:	Dublin South Central
Dates of inspection:	12 -16 October 2020
Number of fieldwork days:	4 days x 3 inspectors & 1 day x 1 inspector
Lead inspector:	Una Coloe
Support inspector(s):	Grace Lynam Pauline Clarke Orohoe Erin Byrne
Type of inspection:	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced <input type="checkbox"/> Full <input checked="" type="checkbox"/> Focused
Fieldwork ID:	MON 0030297

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

About monitoring of statutory foster care services

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

HIQA is authorised by the Minister for Children and Youth Affairs 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 and Youth Affairs. HIQA monitors foster care services against the *National Standards for Foster Care*, published by the Department of Health and Children in 2003.

In order to promote quality and improve safety in the provision of foster care services, HIQA carries out inspections to:

- **assess** if the Child and Family Agency (Tusla) — the service provider — has all the elements in place to safeguard children
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop compliance plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of HIQA's findings.

HIQA inspects services to see if the National Standards are met. Inspections can be announced or unannounced.

As part of the HIQA 2019 and 2020 monitoring programme, HIQA is conducting focused inspections across 17 Tusla service areas focusing on **The child and family social worker, Assessment of children and young people, Care planning and review, Matching carers with children and young people, Safeguarding and child protection and Preparation for leaving care and adult life**. These focused inspections will be announced, and will cover six of the national standards.

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

Theme 1: Child-centred Services	<input type="checkbox"/>
Theme 2: Safe and Effective Services	<input checked="" type="checkbox"/>
Theme 3: Health and Development	<input type="checkbox"/>
Theme 4: Leadership, Governance and Management	<input type="checkbox"/>
Theme 5: Use of Resources	<input type="checkbox"/>
Theme 6: Workforce	<input type="checkbox"/>

1. Inspection methodology

As part of this inspection, inspectors met with the relevant professionals involved in the child in care service and with children in care, young people availing of the aftercare service and with foster carers. Inspectors observed practices and reviewed documentation such as care files, and relevant documentation relating to the areas covered by the relevant standards.

During this inspection, the inspectors evaluated:

- the social worker role
- assessment of children in care
- matching of children in care and foster carers
- care plans and placement plans
- safeguarding processes
- the leaving and aftercare service.

The key activities of this inspection involved:

- the analysis of data submitted by the area and questionnaires completed by 56 children in care, nine young people in aftercare and one parent
- telephone conversation with five children, and with two young adults availing of the aftercare service
- telephone conversation with eight foster carers
- telephone conversation with six parents
- interviews/meetings with the area manager, the two principal social workers for the children in care, the aftercare manager and the child-in-care reviewing officer
- two focus groups with children in care social workers, social work team leaders for children in care team and with aftercare workers
- observation of a child-in-care review and a review meeting of the "active on duty" system
- review of the relevant sections of 56 files of children in care as they relate to the theme.
- In previous foster care inspections children were visited by inspectors in their foster homes but these visits were not carried out for this inspection due to COVID-19.

Acknowledgements

HIQA wishes to thank the staff and managers of the service for their cooperation with this inspection, the children in care who completed questionnaires, and the children in care, parents of children in care, and foster carers who spoke to inspectors.

2. Profile of the foster care service

2.1 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 and Youth Affairs. 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 (Tusla) has responsibility for a range of services, including:

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

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions each with a regional manager known as a service director. The service directors report to the chief operations officer, 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.

2.2 Service Area

According to data published by Tusla in 2018, the Dublin South Central service area had a population of children from the ages of 0-17 years of 65,564.

The area is under the direction of the service director for Tusla, Dublin Mid-Leinster, and is managed by an area manager. There were three principal social workers in the area, who had responsibility for the foster care, children in care, leaving care and aftercare services.

The long-term children in care team, and the leaving care and aftercare team were based in two offices in Dublin. Child protection teams, who had responsibility for the

care of children in care until they were transferred to the long-term children in care team, were located in two offices in the service area.

At the time of the inspection there were 310 children in foster care in the area. Of these, 91 children were placed with relatives and the remaining 219 children were placed with general foster carers, 81 of whom was placed with private foster carers.

The organisational chart in Appendix 2 describes the management and team structure as provided by the Tusla service area.

3. Summary of inspection findings

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

This report reflects the findings of the focused inspection, which looked at the role of the social worker, the assessment of children's needs, care planning and statutory reviews, matching, safeguarding and child protection, and preparation for leaving care and adult life.

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

- two standards were compliant
- four standards were substantially compliant

Children who spoke with inspectors all reported that they had a good relationship with their social worker, although some said they experienced a number of changes to their social workers. The children said they were happy with the contact they had with their social worker and they liked living with their foster carers. Young adults who spoke with inspectors were happy with the aftercare service provided.

There were examples of good practice initiatives in the area, particularly in relation to increasing the participation of children. Two participation groups had been set up and an open day was held for children in the area, last year. Social workers had committed to engaging in direct and fun work with children to obtain their views about the service. The children had developed a Child in Care Day Case Note and there were plans to develop three further additions, the content guided by the children with support from the team. The service had provided an information pack to children with information relating to rights, complaints, their files and the National Standards.

Two hundred and sixty-six (86%) children in foster care had an allocated social worker and 44 (14%) did not have an allocated social worker. While this was not in line with standards, there was an effective system in place to manage the unallocated cases of children in care to ensure they received statutory visits by a social worker and had up-to-date care plans.

All children were visited and the quality of the visits were good. Children were met with on their own by a social worker and observations of a child were recorded when

they were too young to communicate with the social worker. Children were generally met with in their foster home. Although the frequency of visits to children were not carried out in line with statutory requirements, predominantly in 2019, there was an improvement in the frequency of contact with children this year. There were good systems in place to ensure management oversight of children's files and the quality of visits to children in care but the quality of record-keeping in some children's files was in need of improvement.

There was some difficulties ensuring consistency in terms of social worker allocation as a number of children had experienced changes to their social workers over the last two years. In addition, despite efforts to transfer children, there was a large number of children who were not receiving social work services from the areas in which they now lived.

Children had been provided with information about their rights and how to make a complaint. Despite this, some children said they were unsure how to make a complaint. The area did not have a system for tracking and trending issues of dissatisfaction with the service that may be arising for children in care. The area had committed to sharing learning about complaints made about the service.

Assessments of need were carried out on all children placed in foster care. The majority of the assessments of need were of good quality. Children and family members participated in the assessment, when appropriate and input of other professionals was included, when required. The assessments considered previous assessments, family background and social work interventions where relevant. There were systems in place to ensure that children had medical examinations upon admission to care.

The area had an effective system in place to ensure care plans and child-in-care reviews were up-to-date for all children in care. The quality of the care plans and reviews minutes were good and only a small number of reviews did not take place in line with the frequency required by regulations. Children who had complex needs and disabilities were adequately supported and there was an effective system to support children and foster carers when a placement was at risk. Placement plans had been developed but some improvements were required. Voluntary care agreements were up-to-date for all children whose files were reviewed.

The area attempted to ensure that children were placed with foster carers who could meet their needs but there was a shortage of foster care placements, which had a direct impact on the areas ability to match children with local foster carers. As a result, children were placed outside of the area and a significant number in private

placements. There were no formal matching meetings to consider a foster carers capacity to meet the needs of a child. However, social workers liaised with the fostering department to source placements for children but this was not always recorded on the child's file. There were a number of children awaiting approval of long-term placements to provide stability for children residing in foster care placements.

Social workers were committed to ensure that children were protected from all forms of abuse. Inspectors found that the allegations and serious concerns against foster carers and child protection and welfare concerns were categorised correctly and the risks were managed. Concerns were assessed and managed but the assessments were not always completed on the documents required by Tusla's standard business processes. There were systems in place for governance and oversight of serious concerns and allegations against foster carers but this had yet to be developed for oversight of other child protection and welfare concerns relating to children in care. While safety plans were developed for individual cases, the recording of these plans was varied and they were not consistently recorded on the formal template to ensure the implementation of safety plans and to enable oversight, through monitoring and review.

The aftercare service was developing and managers were enthusiastic about and committed to providing a good quality, accessible service to all young people leaving care that needed it. Children had their aftercare needs assessed and aftercare plans were developed in a timely manner. However, there was no mechanism, such as exit interviews, for seeking regular feedback from children and young people about the quality of the service. The drop-in service required further development and the area had yet to produce an annual adequacy report for the aftercare service.

Issues outlined above and other issues identified during the inspection are contained within the body of the report and the compliance plan.

4. Summary of judgments under each standard and or regulation

During this inspection, inspectors made judgments against the National Standards for Foster Care. They used four categories that describe how the national standards were met as follows. We will judge a provider to be compliant, substantially compliant or non-compliant with the regulations and or national standards. These are defined as follows:

- **Compliant:** a judgment of compliant means that no action is required as the provider or person in charge (as appropriate) has fully met the standard and is in full compliance with the relevant regulation.
- **Substantially compliant:** a judgment of substantially compliant means that some action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.
- **Non-compliant:** a judgment of non-compliance means that substantive action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

National Standards for Foster Care	Judgment
Theme 2: Safe and Effective Services	
Standard 5: The child and family social worker	Substantially Compliant
Standard 6: Assessment of children and young people	Compliant
Standard 7: Care planning and review	Compliant
Standard 8: Matching carers with children and young people	Substantially Compliant
Standard 10: Safeguarding and child protection	Substantially Compliant
Standard 13: Preparation for leaving care and adult life	Substantially Compliant

What children told us and what inspectors observed

During the inspection, inspectors spoke with five children living in foster care in the area. Inspectors received 56 completed questionnaires from children in care and nine young people over 16, which expressed their views of the foster care service. In addition, inspectors spoke with two young adults availing of the aftercare service.

Children who spoke with inspectors and responded to questionnaires described the things they liked about living in foster care:

- "I can tell them (foster carers) anything."
- "They're kind and I feel safe. They listen to me. They make sure I get to see my family".
- "Feel part of the family. Nice and cosy. Live in an alright area".
- "What I love - my foster family that are caring, loving, funny, and always there for me. They make me feel safe, loved".
- "They listen to me when I have a problem".
- "I like that my foster family care for me. I like it when we have fun at the dinner table. They listen. They love me".
- "Everything I'm happy".
- "They take care of me. They surprise on my birthday. They love me very much".
- "They're great".
- "Nice house, happy family, fun. Have my own room and lots of toys and things to do. All good".
- "Really nice, and I love them more than anyone or anything. This is my home and I love it".
- "Great food, nice people, funny and they take their time to help and listen to me".
- "I feel happy, secure and loved".
- "I love everything about life with my foster family. They're nice people. They treat me like their own kid and give me great advice and life skills. They took me everywhere around the world. I am very grateful".
- "I like that they respect me and treat like their own, I like that every time I feel sad or angry I always have someone to talk to, I like the fact that I am cared for and looked after really well".
- "Everything. I like it all. Stability. It is my home".

Children outlined that they liked living with their siblings, their pets, toys they had access to and the house they lived in. They said they liked the dinners, having their own room and the activities they engaged.

Children also told inspectors some hard things about living in foster care:

- "I didn't like moving schools".
- "It's hard at the start but everything gets better".
- "Foster carer is very careful about internet use".

Of the children who had completed questionnaires, 58 indicated that they had an allocated social worker, three children said that they did not have a social worker, two did not know and two did not respond. Twenty-seven children responded that their social worker visits them regularly, 25 children said that their social worker visits them "sometimes" and 11 children replied that they were not visited regularly. Two children replied that they did not know.

The majority of children who had an allocated social worker were positive about their social workers. Children said:

- "It's good, been really comforting to know someone is there for you, it's a nice thing to have".
- Their social worker was "helpful a lot" and would "be there if I need them".
- "My social worker talks to me about my meetings and asks how we are getting on and checks on us".
- "Fairly good job over the years, had three or four over the years".
- "She is very nice".
- "My social worker is kind".
- "Is the best social worker in the world"
- "I find my social worker very helpful and communicates with me regularly. He does his best to answer questions I have".
- "I would love to play a soccer match and do art with my social worker".

Some children wrote or said things about their care that could be better:

- "I have had loads of social workers, and I don't get to see them much or get to know them".
- "They help me but I hate that I keep getting new ones all the time as it's hard getting to know them".
- "I can't make choices in my daily life as I'm not allowed to do anything without my social workers permission".

Out of the 65 questionnaire respondents, 55 said they had a care plan and three children said they did not have a care plan. Six children said that they did not know if they had a care plan and one child did not respond to the question. Out of the 65 children who completed the questionnaire, 48 said that they felt listened to by their social worker, while four children said they did not feel listened to. Nine children replied that they sometimes felt listened to and four children were unsure.

Out of the 56 children who were aged between six and fifteen who responded to the questionnaire, 21 children replied that they had attended their child in care review. Thirty-three children said they had not while one child said they had "sometimes" and one was unsure. Eight out of nine children who were over 16 said they had attended or had been invited to their review, while one was unsure. One child who spoke with inspectors said they had attended all their reviews but "doesn't really like them. They're awkward with loads of adults sitting around talking about you". Another child said "they're grand" when asked about their review.

Of the 65 children who completed the questionnaire, 47 said that their social worker talked to them about the decisions made at the child-in-care review meeting, seven children said they did not know and nine said their social worker did not talk to them about the decisions made at their review. Two children said their social worker talked to them "sometimes" about the decisions at their review.

Of the 65 children who answered the question on whether or not they see enough of their birth family and friends, 52 indicated they did, seven said "sometimes", four said they did not, while two were unsure.

Nine young people over the age of 16 responded to the questionnaire. Three of these replied that they had an aftercare plan. Two young people responded that they did not have an aftercare plan and one of the respondents said they did not know if they had an aftercare plan. Three young people did not respond to the question. It was possible that the young people who did not have an aftercare plan and those who did not know or did not respond may not have reached the age of 17 and a half, by which time aftercare plans should be in place.

Eight out of nine young people said they had been helped to learn skills to manage on their own and seven out of nine said they were able to look after their money and manage it. One young person who was accessing aftercare services described a positive experience of the aftercare service stating that the aftercare worker "definitely listens to me and my wishes are in the plan while another young person said their aftercare plan was progressing. Two young adults in receipt of

after care services spoke with inspectors about their experience of the aftercare service. Both were very positive about their experiences of aftercare and how they had been supported to live independently and pursue their goals.

5. Findings and judgments

Theme 2: Safe and Effective Services

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs. In order to provide the care children require, foster carers are assessed, approved and supported. Each child receives the supports they require to maintain their wellbeing.

Standard 5: The child and family social worker

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

Summary of inspection findings under Standard 5

Data provided by the area prior to the inspection showed that there were 310 children in foster care in the service. Two hundred and sixty-six (86%) children had an allocated social worker while 44 (14%) did not have an allocated social worker. There were no children who did not have an allocated social worker living in foster placements where the foster carers did not have an allocated link social worker (dual-unallocated).

Data provided to inspectors showed that there were two vacant social work posts on the child-in-care team. There had been a restructuring of the child-in-care team in the area in 2019. There were two principal social workers with responsibility for all children in care in the area. The area manager told inspectors that significant work was undertaken to ensure there was a stable staff team. The principal social workers told inspectors that there was a dedicated focus towards staff retention. This included a commitment to ensuring social workers and team leaders had manageable caseloads which had been achieved and this was reflected in feedback from social workers who spoke with inspectors.

There was an effective system in place to manage the unallocated cases of children in care. A principal social worker outlined that there was an 'active on duty' system managed by a social work team leader. There was a dedicated team who managed

these unallocated cases which included a senior social work practitioner, a social care worker and a rota where by each social worker from the child-in-care team assisted one and a half days every five weeks. There was a standard operating procedure which outlined that the purpose of the system was to ensure that all emergencies were responded to and that statutory work was carried out. The principal social worker maintained oversight of this system and provided inspectors with the tracker utilised in the area which detailed when children were visited and when their child-in-care reviews took place or were due, as well as other key information. In addition to this tracker, the principal social worker chaired monthly review meetings where cases were discussed. Inspectors found that all cases had been reviewed within two months prior to the inspection and had been subject to consistent reviews since the children were placed on this list. An inspector observed a review meeting and found that there was a comprehensive overview of the statutory requirements for each child listed, clear rationales if children were to remain on the system or be allocated and responsibilities were delegated to relevant workers to complete actions.

Of the 44 unallocated children in care, there were 24 children who had stipulations on their care order regarding the allocation of a social worker. The court orders stipulated that if the child became unallocated to a social worker for more than four weeks, the case must be returned to court, however, this had not occurred. Inspectors brought this to the attention of the principal social worker and area manager. Following the inspection, the area manager provided details of communications with Tusla's legal team regarding this matter and confirmed that the legal team were satisfied that the area was fulfilling its statutory duties to children in care placed on the 'active on duty' system and there was a robust system in place for care planning, statutory visits and aftercare planning. The area manager stated that the courts had not raised any concerns regarding this system.

The frequency of visits to children in care was not in line with statutory requirements. Statutory visits were not carried out in line with requirements of regulations over the last two years but there was an improvement in the frequency of contact with children this year. Inspectors reviewed 17 children's files to examine whether or not the statutory visits to the children during the two years prior to the inspection were in line with regulations and found that they were in four (24%) of the 17 files reviewed. In the 13 files whereby visits were not completed in line with regulations, 11 of these related to gaps in visits in the latter part of 2018 and 2019. The longest delay between visits was four months overdue for one child. In another case, although visits were not completed by the allocated social worker, safeguarding visits had taken place by the fostering link worker with management oversight of this evident. Despite these gaps, inspectors found that there was an

improvement in the frequency of statutory visits to children this year. All children whose files were reviewed had regular contact from their social workers including home visits and telephone contact during the Covid 19 restrictions. Inspectors viewed a further four files for evidence of contact with children during Covid 19 restrictions and found that although this was not in line with the frequency required by the service's own policy, it was above the requirements of statutory regulations. Inspectors found that children who were unallocated had been visited as required.

Data provided to inspectors prior to the inspection showed that there were five children who had not been visited by a social worker in line with regulations. The principal social worker advised that there were no children that had not been visited at the time of the inspection. Inspectors viewed two of these children's files and found that there was a two month delay completing the visit in 2019 for one child and a statutory visit was cancelled for another child due to the risk of Covid 19 in February of this year but subsequently this child received appropriate contact.

Social work team leaders returned monthly data to the principal social worker in relation to statutory visits, child-in-care reviews and schedule of audits. They said that any gaps were discussed during their supervision. In addition they signed records of statutory visits and any deficits in relation to the frequency were addressed with the social worker.

The quality of statutory visits was good. Inspectors found that in 14 out of 15 files reviewed, children were met with on their own by a social worker. Observations of a child were recorded when they were too young to communicate with the social worker. Children were generally met with in their home, except on two occasions where a child was met with in school and brought on a trip as it was not suitable to visit their home on that occasion.

The recording of statutory visits was good. The records of statutory visits viewed by inspectors were on standardised forms, apart from one instance where they were contained in case notes. The records on these forms reflected good quality visits with detailed and comprehensive notes of discussions. It was evident whether a child had been seen in private and observations were noted of children who were too young to speak with the social worker. In three cases, where the required records of statutory visits were not evident on file, the records were uploaded when requested by inspectors.

Children who spoke with inspectors were positive about their social worker and the majority were satisfied with the frequency of the contact with their social worker. Fifty-two (80%) out of 65 children who completed questionnaires, said that their

social worker visited them regularly or “sometimes” visited them regularly while 11 (17%) said their social worker did not visit them regularly. Many of these children had very positive things to say about their social workers.

Inspectors viewed 14 files to examine if children had a consistent professional in contact with the child over the last two years. Inspectors found that five (36%) children had consistency, nine (64%) did not. Some parents, foster carers and children reported that they had experienced changes in social workers. This lack of consistency impacted on their relationship with their social worker. Inspectors spoke with seven foster carers over the course of the inspection. Foster carers described mixed experience of social workers allocation and involvement. The foster carers were all happy with current social workers but described changes to social workers and children having numerous social workers over a number of years. They all said there was sufficient contact with the children in care and could contact the social workers if they needed to. Parents in their calls with inspectors had mixed views about their experience of social workers advising that they had experienced a number of changes to their child’s social worker. The principal social worker said they tried to maintain consistency for children on the ‘active on duty’ system by assigning the same social worker to carry out visits with children but this was not always possible.

There was evidence that social workers were actively involved in implementing the children’s care plans. For example, there was good coordination of services for children with disabilities, complex needs and illnesses. The area manager and the principal social workers identified this as a challenging area and outlined plans to devise a specific dedicated team of social workers to work with children with disabilities and complex needs. There was a Tusla and Health Service Executive (HSE) forum where cases were discussed but a challenge arose if a child was placed outside the area which impacted on aftercare planning, for example. The area manager was committed to funding private assessments and services if required and this was confirmed by social workers and managers in the area. Inspectors reviewed the files of seven children with disabilities or complex needs and found there were good practices and these children had access to the services required. One foster carer told inspectors that the child in their care engaged in play therapy and another carer advised of numerous services involved with the child in her care who has complex medical needs and commended the social work department on their advocacy and support.

During the inspection, the principal social worker told inspectors of good practice in relation to an initiative for children in care in the area. Two participation groups had been set up and an open day was held for children in the area last year. Social

workers advised that there was a focus on youth participation and how they facilitated groups of children to engage in informal opportunities to seek their views on aspects of the service.

Social workers maintained links with the children's families. Plans for contact between children and their families were outlined in the care plans and placement plans. Contact was impacted due to the restrictions of Covid 19 but inspectors found that efforts were made to ensure there were alternative forms of contact for the children including video calls and visits in gardens. Data provided by the area outlined that 46 children in care had access with their families in the foster carers home. In their questionnaire responses, 51(80%) of 64 children who answered the question said that their social worker kept in contact with their family and made sure that they got to see them regularly. Three out of five parents who spoke with inspectors were happy with arrangements in place for contact with their children but two were not satisfied with the level of contact. In addition, some parents were not satisfied with the level of contact from social workers about their child's care.

Social workers responded well to significant events involving children in care, such as when children went missing from care. Data provided by the area indicated that there had been 27 notifications of children missing from care in the 12 months prior to the inspection, relating to nine children. Inspectors reviewed the files of one child who had been missing from care on a number of occasions. Social workers followed the missing from care policy and liaised appropriately with An Garda Síochána (police) and the foster carers. Social workers took appropriate measures to ensure the safety of the children such as holding strategy meetings to discuss concerns and absence management plans were put in place when required. There was a system to track the details relating to any child who went missing from care.

There were a number of children who were living in other Tusla areas but the responsibility for their care had not transferred to the areas in which they lived. Data provided by the area showed that there were 33 children awaiting transfer outside of the area. The principal social worker held a record of cases awaiting transfer and the attempts made to progress the transfers. There was evidence that the principal social worker had written to the relevant area and requested a transfer but this was unsuccessful for reasons such as Covid 19 restrictions and waiting lists. Inspectors viewed the files of five children living outside the area and found that they were receiving a satisfactory service. The children were visited in line with statutory requirements and child-in-care reviews had taken place. The children had been in these placements for one and half years, three and four years and 13 years. Aftercare workers told inspectors that supporting children outside the area placed significant additional pressures on their team.

Data provided by the area showed that there were two complaints made by children during the previous 12 months. Social workers told inspectors that it was their responsibility to ensure that children were informed of their rights including how to make a complaint. Inspectors found evidence that information packs regarding rights were sent to children and of social workers meeting with children to ensure they understood the content. In addition, inspectors noted that there was a complaints section on the statutory visit form where issues for the children could be recorded. The area's service improvement plan identified the need to develop a system to record complaints from children that do not meet the threshold for the formal complaints procedure but this had not been developed at the time of the inspection. Social work team leaders said that although there was no system for recording complaints, formal complaints were managed by a principal social worker.

Inspectors reviewed two complaints which related to the child-in-care service. One was well managed, with a timely response and actions attached to ensure the complainant had support regarding the concerns. The other complaint did not relate to this area but it was evident that the child was being supported. Inspectors reviewed the minutes of team meetings and there were records of workshops where learning from complaints was shared and discussed. Social workers confirmed that there was a process of learning from the outcome of complaints. The principal social worker outlined the plans to review complaints at future team meetings to support the learning process arising from complaints. In the questionnaires submitted by children, 40 (66%) of 61 children who answered the question said that their social worker explained how to make a complaint if they were not happy with something while 21 (34%) said that their social worker had not. Nine (14%) out of 65 children who responded to questionnaires said they made a complaint and five of these children were happy with how it was managed, one said they were happy after a second complaint, while three said the question was not applicable.

Tusla's National Child Care Information system (NCCIS) for recording children's information was implemented in the area. The area used the electronic system for recording children's information. Social workers told inspectors that they have access to administrative support and there was oversight by their team leaders regarding the quality of their records. Inspectors were advised by team leaders that the principal social worker had delivered workshops on writing good quality care plans and there were audits of records on the system. These audits were evident on the files reviewed and there were actions attached where gaps were identified. Inspectors viewed 17 files to assess the quality of case management and supervision. Inspectors found that this was good in all of the files reviewed. There was evidence of regular case management of the cases with actions attached for any pieces of work required. There were records of reviews from the active on duty system. However, some records were

not uploaded in a timely manner with some records uploaded the week prior to the inspection and other records were provided upon request. In addition, the business support person had audited all files in conjunction with the social worker to ensure essential information on the system was accurate and in line with the child-in-care register.

Inspectors found evidence of good record keeping in 16 (47%) of the 34 reviewed for this purpose. The records were comprehensive and easily accessible. However, the quality was in need of improvement in 18 (53%) of the files reviewed. Inspectors found that not all case notes had been uploaded or had not been uploaded in a timely manner. In other cases, there was no evidence of the matching process on file and there were some care plans and child-in-care reviews minutes that had not been signed. There was no standardised case chronology template in use in the area.

While not all children in care had an allocated social worker, there was an effective system in place to ensure the children were receiving the required statutory visits. The quality of statutory visits was good, and while they were not consistently carried out as frequently as required by the regulations, in 2019, improvements were noted in this area in 2020. A large number of children were not receiving social work services from the areas in which they now lived and some children experienced a number of changes to their social worker. Some children stated that their social worker had not explained to them how to make a complaint. The area did not have a system for tracking and trending issues of dissatisfaction with the service that may be arising for children in care in the area. The quality of record-keeping in some children's files was in need of improvement. For these reasons, the area was judged to be substantially compliant with the standard.

Judgment: Substantially Compliant

Standard 6: Assessment of children and young people

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

Summary of inspection findings under Standard 6

Social workers carried out assessments of the needs of children placed in foster care. There was no stand-alone assessment of need document or template to record the outcome of the assessment and to outline any children's needs. However, in the absence of this, children's needs were recorded on a variety of documents, including care plans, child protection case conference reports, initial assessments and social work court reports. The recording of an assessment of need depended on whether the admission to care was planned or an emergency admission.

According to data provided by the area, 66 children were admitted to foster care in the previous 24 months. Five children had an emergency admission to care and 38 children had experienced a change of placement during that time.

Inspectors sampled the files of eight children to review the quality of needs assessments. The majority of the assessments of need were of good quality. Children and family members participated in the assessment, when appropriate and input of other professionals was included when required. The assessments considered previous assessments, family background and social work interventions where relevant. Inspectors reviewed one file and found that although there was comprehensive background family information, the child's needs had not been fully assessed. The placement was required on a short-term basis but when the need arose for a further placement, inspectors found that a more comprehensive assessment of need was completed. Social workers told inspectors in focus groups that assessment of a child's needs was a continuous process and when children's needs were assessed through an initial assessment or case conference process, these were comprehensively completed by colleagues on the child protection team. They outlined that they had engaged in workshops to help strengthen the quality of the assessments and this was reflected in improved quality of children's assessments.

Inspectors reviewed the files of three children admitted to care in an emergency. The assessments were comprehensive and recorded on initial assessments and care plans. It was evident that care plans were completed within the required timeframes and children were involved in these plans and their assessment. Social work team

leaders said that when children were admitted to care in an emergency, they ensured that assessments were completed in a timely manner with a care plan developed within the required timeframes.

There was also evidence that social workers ensured that children had medical examinations upon admission to care. When children were admitted to care from hospital, it was evident that there was comprehensive engagement with medical professionals to ensure there was sufficient medical information in relation to the child.

Inspectors reviewed three files where a child had experienced a change of placement to assess the quality of the assessment of need. In one case, the care plan was completed within one month of the placement change and inspectors found this was a comprehensive overview of the child's current needs. In another case there was a delay updating the child's care plan following an unplanned move. This was completed after three months and therefore not within the requirements of the standards. However, strategy meetings had been held to discuss concerns within the placement and to plan interventions so up-to-date information was recorded regarding the child's needs. In the third case examined, inspectors found that there had been a review meeting to discuss the placement which was at risk and strategy meetings held when concerns presented. This was a recent case and the area were still within the timeframes to update the care plan and inspectors found that there was a good analysis of the child's needs on file.

Assessments of need were carried out on all children placed in foster care and were of good quality. There were systems in place to ensure that assessments of need were undertaken and updated when a child moved placement. The area ensured that children had medical examinations upon admission to care. For this reason, the area was judged to be compliant with this standard.

Judgment: Compliant

Standard 7: Care planning and review

Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

Summary of inspection findings under Standard 7

The area had an effective system in place to ensure care plans and child-in care reviews were up-to-date for all children in care. Care planning and reviews for children in care were generally good quality. Social workers and managers had focused on improving on the quality of plans but there were a small number of child-in-care reviews which had not been completed within the timeframes required by regulations and management oversight of the process was not always evident.

Data provided by the area prior to inspection indicated that 298 (96%) children had up-to-date care plans and there were 12 (4%) children that did not have an up-to-date care plan. The area manager during an interview with inspectors advised that this figure had improved since the data was submitted and that 99% of children had an up-to-date care plan by the time of the inspection. There was a dedicated child-in-care reviewing officer who told inspectors that since her commencement in the role, through efforts by social workers and the management team, there had been an improvement in the care planning process, quality of care plans and the timeliness of reviews. She advised that she chaired reviews if the case was referred by a social worker and team leader. Invitations to reviews were managed by individual social workers and they had responsibility to ensure the relevant people received a copy of the minutes when the chair completed them.

Social workers told inspectors in focus groups that they used the standard templates for recording care plans and that reviews were rarely delayed. They advised that they attended a workshop in relation to care planning, the focus of this was to improve the quality of the process. Social work team leaders provided monthly statistics to the principal social workers regarding child-in-care reviews and outlined that there had been significant progress made, mainly due to social workers having manageable caseloads. The principal social workers then provided the area manager with this information for oversight of compliance in this area. The management team used NCCIS to track timeframes and quality of care plans and reviews. Team leaders also advised that they had completed audits of care plans and subsequently the quality of the care plan had improved.

Child-in-care reviews and care plans were of good quality. Inspectors reviewed the minutes of child-in-care reviews and care plans to assess the quality of how children's needs were considered in line with statutory requirements. Inspectors reviewed 25 files for this purpose and found that the quality was good in all cases. It was evident that children's health and education needs were considered and multidisciplinary input was included, when required. The plan for family contact was included, where appropriate. The care plans and review minutes included clear actions and timeframes in the majority of cases. Management oversight of care plans was an area identified by inspectors that needed to improve as a small number (five care plans and five child-in-care review minutes) had not yet been signed by a social work team leader, to demonstrate that they had quality assured the care planning and review process, and had management oversight of children's care plans, in a timely manner.

In 23 out of 25 cases examined, inspectors found that children were involved in the care planning process. In one case a child refused to participate and it was listed as an action to support the child in relation to this which was very good practice. In the other case, there were clear reasons recorded as to why the child did not participate. Observations of children were recorded where they were too young to participate and there was evidence of social workers meeting with children before a review to obtain their views if they chose not to attend the meeting. The child-in-care reviewing officer told inspectors that participation of children in review meetings had improved since Covid 19 restrictions were lifted. She outlined that improving participation had been a major focus of their work.

Inspectors reviewed 28 files for timeliness of child-in-care reviews and found that 15 (63%) had been completed in line with statutory requirements while 13 (46%) had not. In nine of these cases, the delays were not significant in that there were delays of under one month. In the remaining four cases, one six month review had not taken place when required and there was no record of a review in 2019 for another child but these were subsequently completed. There were delays of two and three months for the other two children whose reviews did not take place on time. Inspectors found that there were some discrepancies regarding dates of care plans and reviews, with the date of the review completed after the care plan was completed.

Of the 56 children who were aged under 16 who completed the section of the questionnaire in relation to care planning and reviews, 22(38%) said that they had attended their child-in-care review, while 33 (59%) said that they had not. Of the nine children who were over 16 who responded to the same question, 7 (89%) had attended. Forty-eight children (74%) of the 65 respondents said they felt listened

too in relation to their care plan, while, four children (6%) did not. The remaining children were either unsure or said sometimes.

Forty-seven (72%) of children who completed questionnaires said their social worker explained the decisions made at their reviews. Nine (14%) children said their social worker did not and another nine (14%) children did not know if the decisions were explained or said they were "sometimes". The majority of parents who spoke with inspectors had mixed views regarding child-in-care reviews and said they did not receive reports or feel included in the process. Foster carers who spoke with inspectors said the reviews were regular and included the children in their care. Inspectors found that 12 (50%) out of 24 files reviewed had evidence that decisions taken in reviews were communicated to children. In a further nine (37%) of files, it was found that although decisions were not communicated, this was for a valid reason such as the age of the child.

Inspectors observed a child-in-care review meeting, which was attended by the child's parent and their support person, an allocated social care worker, a fostering link worker, a professional from another organization and foster carers. The review covered the main aspects of the child's care, including their health and education, routine and developmental needs. The child's view was represented by the social worker and the parent views were given due consideration. Actions were discussed and further meetings were planned to address contact and life story work for the child.

There had a proactive approach to managing and supporting placements that were at risk of ending and when a child's placement ended unexpectedly, strategy meetings were held promptly. When significant events arose which threatened a child's placement, it was evident that significant supports were put in place to support the child and foster carers. The area manager advised that significant resources were allocated to ensure children had access to clinical therapies, support and interventions when required. Inspectors reviewed three cases where the placements were at risk of ending. Strategy meetings were held in a timely manner and supports were put in place for the children and foster carers as required. There was a process in the area to review complex cases. The area manager and principal social worker attended these meetings to ensure there was a sharing of ideas and experience and ensured senior management had oversight of these complex cases. Inspectors reviewed two files that had been reviewed at these meetings and found there were good efforts made to support the children in their placements. In addition, inspectors reviewed two files where a placement had broken down. It was evident that significant efforts were made to resolve the complex issues prior to the breakdown and the appropriate supports had been put in place. A disruption

meeting was held in one case and the foster care committee were alerted but in the other case, the disruption meeting did not take place until five months after the placement ending and the foster care committee had not been advised.

Data provided by the service area indicated that in the 12 months prior to the inspection 11 of the 14 placements which ended in an unplanned way had been subject to a review following the unplanned ending. In addition to these, 16 reviews were undertaken where there was a risk of placement breakdown in the 12 months prior to inspection. The principal social worker maintained a tracker of progress regarding disruptions. This noted the dates of the placement breakdown, when the disruption took place, when the disruption report was reviewed by the foster care committee and any actions arising from this review. There were four disruptions in 2019 which still needed to be finalized but inspectors found that more recent disruptions were managed in a more timely manner.

Children who had complex needs and or a disability received specialist supports as required. Inspectors reviewed files of eight children with varying levels of disability. Inspectors found that there was good quality care planning, co-ordination of services and review of children's needs in all cases. Inspectors found that where a service was required for a child, the allocated social worker followed up on actions identified. Children had access to services such as occupational therapy, speech and language and were linked with children's hospitals if required.

Inspectors reviewed six files of children who were placed in care under a voluntary care agreement from their parents. In four of the cases reviewed, inspectors found that there were up-to-date, signed agreements which outlined the intended end date of the placement. On one form reviewed, the date of placement was not recorded. The principal social worker confirmed that the parent was aware that the consent commenced on the date the form was signed. On another form reviewed, the end date of the placement had expired. The social worker said this was an error on the form and agreed to amend the form and have the parent sign it again. The child-in-care reviewing officer advised that she checks all voluntary care agreements as part of the child-in-care review. This is a new aspect to her role since May of this year. The principal social worker said there was no report following an audit of voluntary care agreements, stating that, this detail was accessible on NCCIS. He advised that social workers in conjunction with their team leaders audited all voluntary agreements during the last 12 months.

Placement plans were completed as part of the child-in-care reviewing process. Inspectors reviewed the files of 16 children to examine the quality of the placement plans. The placement plans outlined the actions required arising from the review and

specific details relating to family contact. However, it was not evident in any of the plans reviewed that the social worker and link fostering worker visited the foster carers home to develop the plan. In addition, inspectors found that the plans were not consistently completed by the social worker and link fostering worker with only three of the plans reviewed containing signatures of both workers.

The area had an effective system in place to ensure care plans and child-in care reviews were up-to-date for all children in care. The quality of the care plans and reviews minutes were good but a small number of reviews did not take place in line with the frequency required by regulations. Children who had complex needs and disabilities were adequately supported and there was an effective system to support children and foster carers when a placement was at risk. Voluntary care agreements were up-to-date but there were some discrepancies relating to dates which needed further monitoring. Placement plans had been developed but improvements were required. While there were further improvements needed in these areas, the service area had demonstrated that they already had initiatives in place to address these and therefore for this reason, the area was judged to be compliant with this standard.

Judgment: Compliant

Standard 8: Matching carers with children and young people

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

Summary of inspection findings under Standard 8

The area tried to ensure that children were matched with foster carers who had the capacity to meet their needs and although there was some matching considerations, it was not sufficient to ensure children were placed with foster carers based on their capacity to meet the child's needs. There was no formal matching meetings, the social worker submitted information about the children to the fostering social worker, and this was considered by the fostering department who then responded by email or telephone call, however, the evidence for this was not consistently placed on the child's file.

All of the children who spoke with inspectors said they were happy in their foster home. Most of the children who completed questionnaires made very positive comments about their foster carers, their placements and the way in which they were looked after, listened to and cared for.

There was a significant shortage of foster carers, which in turn had an impact on the social workers ability to match children with foster carers. Local measures such as various media campaigns and strategies for recruiting more foster carers were active. Despite this, social workers and team leaders spoke with inspectors about the limited options in terms of matching. Due to the lack of available foster carers, a large number of children were placed outside the area. Data provided to HIQA prior to the inspection outlined that there were one hundred and eighty-three (59%) of children in care in the area placed outside of the area. In addition, 84 (27%) of children were placed with private foster care agencies.

There were eight available foster care placements at the time of this inspection. Principal social workers advised that despite the lack of available placements, children were not left at risk and consideration was always given to ensure the foster carers could meet the needs of the child and said they have refused placements previously as it was not a good match.

Data provided to inspectors showed that there were four foster care households where the number of children exceeded the standards. Inspectors reviewed two of these children's records who resided in the households that exceeded standards. In these cases, the placements were notified to the Foster Care Committee for their consideration and appropriate safeguarding measures were put in place to ensure the children were supported.

Social workers told inspectors that, when foster placements were required for children, they considered the children's extended family in the first place to see if a relative placement was possible. Ninety-one (29%) of 310 children were placed with relative carers who knew the children and their backgrounds. Inspectors found evidence of attempts to identify relative placements and if this was not possible, the social workers requested a general placement from the fostering social work team. If no suitable match was identified in the area, social workers considered private providers who may be in a position to offer a suitable placement.

Inspector viewed six children's files for the purpose of examining the process for matching children with foster carers who could meet their needs. Inspectors found there was no evidence that a matching meeting took place on any of the files reviewed. The principal social worker told inspectors that although meetings occurred with the fostering department, this was not always recorded or evidenced in the children's files. In two cases, there was evidence of some information that was sent to the fostering team including a referral form and a pen picture of the child. In another two cases, inspectors found evidence of some matching considerations in case notes and emails however there were no records on another two files reviewed of how children were matched with foster carers based on their capacity to meet the needs of the child. Inspectors found that a child was appropriately placed with their sibling in one instance.

Social workers told inspectors that, when children were admitted to care in an emergency, social workers did their best to match them to available placements even though the children's needs may not be well known. The area manager advised that they worked well with the out-of-hours service and private agencies to ensure all children who needed a placement in an emergency were placed in a suitable placement. Social workers said that a bridging placement was often required but this was not the preferred option. Inspectors reviewed the records of three children who had been admitted in an emergency and found that their needs were appropriately assessed and placements were found for them at short notice. In one instance a child was placed in a short-term placement and subsequently moved to a more suitable placement with a sibling. In the other two cases, the children have remained in the placements.

The area tried to ensure that children maintained their contacts with their local community when they were admitted to foster care. Of 59 children who answered the question of whether or not they had to change school when they moved in to their new foster home, 25 (38%) said that they had to change school while 35 (54%) said that they remained in their school placements. The remaining children said the question was not applicable to them. Of the 65 children who answered the question on whether or not they see enough of their birth family and friends, 52

(80%) indicated they did, seven (11%) said "sometimes", four (6%) said they did not, while two were unsure.

Social workers told inspectors that, when appropriate, children were given the opportunity to express their views about the proposed placement. This was not always possible as some children were placed as very young children and others were placed in an emergency. Of 65 children in care who answered the question of whether they got to meet or stay with their foster carers before they moved in, 44 (67%) children said that they had while 12 (19%) said that they had not. Another nine (14%) children said they did not know or they were babies when they moved in with their foster carers. Of the 65 children who answered the question about had they been asked how they felt about moving to their new foster home, 28(43%) children said that they had while 15 (23%) had not. The remaining children either replied that they did not know or were too young.

Since the capacity of foster carers to meet the needs of children was not always apparent at the beginning of a placement, the suitability of long-term matches between children in care and foster carers should be considered and approved by the Foster Care Committee once the child was in placement for over six months.

Data provided to inspectors during the inspection outlined that 30 children had been approved for long-term placements with their foster carers in the previous 12 months. Inspectors reviewed five children's records to assess the quality of the long-term matching where children had been residing with the foster carers for more than six months. The principal social worker provided the evidence of this process in the foster care committee files. Inspectors found that the records contained evidence of good quality long-term matching and the foster care committee had approved the long-term match for the five children. The required documents were submitted to the foster care committee in four of the five cases reviewed but the child-in-care review minutes, although referenced in the meeting, were not present on file. There were 64 children awaiting approval of long-term placements. The process for four of these were progressing, four had been requested and four were ready to present to the foster care committee. Finally, in one case an adoption process had commenced.

There was no formal matching meetings to consider a foster carers capacity to meet the needs of a children. Social workers liaised with the fostering department to source placements for children but this was not always recorded on the child's file. There was a shortage of foster care placements in the area, which had a direct impact on the areas ability to match children with carers in the area, resulting in children being placed out of the area and a significant number in private placements. Despite the shortage of carers in the area, no children were left at risk. The number of children awaiting approval of long-term placements was high and required improvement to

provide stability for children residing in foster care placements and therefore, the area was judged to be substantially compliant with this standard.

Judgment: Substantially compliant

Standard 10: Safeguarding and child protection

Children and young people in foster care are protected from abuse and neglect.

Summary of inspection findings under Standard 10

Allegations, concerns and complaints were categorised correctly and received an appropriate response. Child protection concerns were taken seriously and immediate actions were taken to protect children if this was required. Concerns were assessed and managed but the assessments were not always completed on the documents required by Tusla's standard business processes. There were no foster carer households that were dual unallocated, where the foster carers did not have an allocated link worker. A new system of safety planning had been implemented in the area and although the new template was not utilised in all cases, there was effective safety planning with the children and foster carers.

Data provided by the area indicated that there were three allegations and five serious concerns against foster carers in the 12 months prior to the inspection. One child had been removed from their placement due to child protection and welfare concerns.

Inspectors reviewed one allegation against foster carers. The allegation was appropriately categorised and was in the process of being investigated in line with Children First (2017). Immediate action was taken to remove the child from the placement, strategy meetings took place, an initial assessment of the child concerned was being carried out and An Garda Síochána were notified of the concern. The foster care committee was notified in a timely manner following the strategy meeting.

Inspectors also reviewed one serious concern against a foster carer. This was investigated in line with the Interim Protocol for managing concerns and allegations of abuse or neglect against Foster Carers and Section 36 (relative) Foster Carers (Tusla, April 2017). The social worker met with the child and a safety plan was put in place. A further strategy meeting took place to review the safety plan and appropriate supports were put in place. The foster care committee were notified of the concern and the outcome.

Data provided by the area during the inspection indicated that there had been 74 child protection concerns made by children in care against people other than the children's foster carers in the 12 months prior to the inspection. Following the inspection the principal social worker reviewed the tracker and confirmed that there

were 39 child protection and welfare concerns made about 25 children, since their reception in to care, five of which were currently open.

Inspectors reviewed child protection and welfare concerns relating to four children in care. Inspectors found that all of the children were safe, the concerns were assessed in line with Children First and safety plans were in place when required. However, intake records and initial assessment records were not consistently completed as required by the standard business process. Children in care social workers managed child protection and welfare concerns which was not the process set out by Tusla whereby an independent person, usually the duty social worker or social worker from the child protection team, carried out the assessment. The principal social worker told inspectors that this approach was taken to ensure the child had the support of a social worker with whom they had a relationship with.

In one of the cases reviewed, inspectors found that there was a plan in place to address the risks to the child and meetings were held with the support services involved. A Garda notification was submitted and appropriate actions were taken to safeguard the child. However, a strategy meeting to categorise the concern did not take place, instead a decision was made in supervision to complete an initial assessment but this was not completed. Therefore there was no evidence that a full assessment of the child's needs was undertaken in light of the new child protection and welfare concern, to ensure that any emerging needs could be responded to in a timely manner. In another case reviewed, inspectors found that the concerns were managed in line with Children First and standard business processes. Inspectors found that in the third case, although the concern was classified correctly and the case was discussed at a complex case forum with an appropriate safety plan in place, an intake and initial assessment of the child's needs was not completed, as required. In the fourth case reviewed, while inspectors found that the work was completed to ensure the child was safe, the concern had not been categorised and the intake and initial assessment had not completed since July 2020. While actions were taken to ensure these children were safe, the inconsistent practice in managing child protection and welfare concerns meant that already vulnerable children in care, who may also have experienced previous trauma or neglect, did not have their needs fully assessed following an allegation, in order to identify any further supports required to meet their needs.

There were systems in place to ensure there was governance and oversight of allegations and concerns against foster carers. There was a tracker in place to monitor progress of concerns and quarterly meetings to review open allegations and concerns. Inspectors reviewed the tracker which contained details such as when the allegation or concern was reported, the nature of the allegation or concern, strategy meeting held and the final outcome. It also contained the dates the outcome report

was submitted to the foster care committee. While the tracker assisted managers in maintaining good oversight of allegations and concerns against foster carers, there were gaps of key information on the tracker which impacted on the effectiveness of the system. Information such as dates of final outcome submitted to FCC, dates of intake records or Garda notification for example were missing in some cases and the dates of when an initial assessment was completed or concluded was not included regarding allegations against foster carers, which could further improve the oversight process.

There were regular governance meetings to review open allegations and serious concerns against foster carers. The purpose of these meetings was to ensure oversight of the concerns and these were attended by senior managers and members of the foster care committee. In addition to this oversight, two audits had been completed of serious concerns and allegations. These audits found that there were delays progressing the assessments but found that there was an improvement in the timelines of more recent concerns.

There was a separate log which outlined other child protection concerns that did not relate to foster carers. This included the concerns which related to children's admission to care. The log referenced details such as the categorisation, priority level, process stage and if the concern was allocated or not. The principal social workers told inspectors that they have full access to the files to monitor the progression of a case and address the adherence to standard business processes during supervision with their team leaders. They have responsibility to sign off on all notifications to An Garda Síochána and advised that these notifications were discussed at Tusla/Garda liaison meetings. However, there was no overall tracking system to ensure adequate management oversight of allegations made by children in care against other people, including family members and people in the community to be assured that the correct process was being followed in each case and that children's needs were fully assessed, in a timely manner and that there was adherence to standard business processes.

In both individual contact with inspectors and in focus groups, social workers and social care staff presented as having the appropriate knowledge and skills in relation to keeping children safe and protecting them. They were able to clearly explain the process to be followed in the event of an allegation or serious concern against a foster carer or a child protection concern, and they outlined the policies that guided their practice. They advised of learning opportunities they had engaged in with their teams where anonymised cases were discussed to ensure effective learning from the cases. In addition, social workers advised of formal and informal opportunities to discuss cases with colleagues and managers through supervision, complex case reviews and through co-working cases with a senior social work practitioner. They

emphasised the importance of communicating with children about their rights, how to make a complaint if they needed to do so, and making sure that children knew who they could talk to if any issues of concern arose.

In questionnaires returned by children, 60 (92%) out of 65 children who answered the question said they knew how to keep safe and 58 (89%) of children said that their social worker had told them who to talk to if they felt unsafe. There was evidence in some children's files of social workers meeting with children to ensure they understood the content of the rights information pack that was sent to them.

Data provided by the area indicated that there were no dual unallocated households, that is foster care households where the foster carers did not have a link social worker and the children placed in these households did not have an allocated social worker. Inspectors found that where children were placed in unapproved relative foster care placements, safeguarding visits were carried out. There was an audit completed of these visits by senior management in July 2020 and a number of actions were outlined to address areas of poor practice.

Social workers ensured safeguarding measures were put in place for children who required them. The area had recently implemented a standardised system for recording formal safety plans for children. This system ensured that the essential information was recorded such as the risks involved, plans to mitigate risks and the arrangements to review the safety plan. However, this was in the early stages of implementation in the area.

Inspectors reviewed safety plans in relation to seven children. Inspectors found that all safety plans reviewed contained adequate information to ensure the children were safeguarded. Children were involved in their development and they were monitored and reviewed when required. The recording of safety planning varied. Inspectors found that some social workers had used the formal template to record the plan while in two cases, the safety plans were evident in the case notes, intake records and other documents on the child's file. This meant that oversight of safety plans was more difficult for managers, to ensure their implementation, or in the event that the child's allocated social worker was absent and another social worker needed to quickly access the safety plan.

There was a system in place to manage complaints in line with the Tusla complaints policy. Data provided by the area showed that there were seven complaints made by foster carers, parents, or family members in the previous 12 months and two complaints made by children in care. Inspectors reviewed the complaints log and found that although complaints were taken seriously, they were not always addressed in a timely manner. The area manager told inspectors that the complaints

officer was a principal social worker who did not have any operational responsibility for children in care. Inspectors reviewed the documents regarding three complaints, one by a previous service user and two foster carers. One of the complaints had been managed in a timely manner and where complaints were upheld, action was taken to address the issue. Two complaints were ongoing at the time of the inspection and there was a significant delay bringing the complaints to a conclusion. Although thorough investigations took place for the complex issues, one complaint remained open since 2019 and another from January 2020. However, it was evident when aspects of the complaints were upheld, recommendations were made to address the failing, for example through an apology to the complainant or through changes to protocols. The principal social worker told inspectors that learning from complaints was addressed during team meetings and this was evident in minutes of meetings reviewed by inspectors.

Social workers told inspectors that they had sent information to children regarding their rights, including complaints. It was evident from meeting minutes that the area were in the process of developing a system for managing complaints from children that did not warrant investigations through the 'Tell us' system. The statutory visit form had been adapted to include a section on complaints to ensure they were recorded.

Data provided by the area stated that there was one death or serious incident involving children in care during the previous twenty-four months. A rapid review had been completed. The area manager advised that there was a plan for an internal review and learning would be shared within the teams.

Inspectors found that the allegations and serious concerns against foster carers and child protection and welfare concerns were categorised correctly and the risks were assessed and managed. Although the necessary work was completed and the children involved were safe, the administrative records were not completed in line with standard business processes. There were systems in place for governance and oversight of serious concerns and allegations against foster carers but this had yet to be developed for oversight of child protection and welfare concerns relating to children in care. While safety plans were developed in individual cases, the recording of these plans was varied and was not consistently recorded on the formal template to ensure the implementation of safety plans was monitored and reviewed. For these reasons, the area was judged substantially compliant with this standard.

Judgment: Substantially compliant

Standard 13: Preparation for leaving care and adult life

Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

Summary of inspection findings under Standard 13

The aftercare service in Dublin South central was in a stage of development and management recognised that improvements were needed to the delivery of the service for children eligible for and in receipt of aftercare.

The aftercare service was informed by the Tusla National Aftercare Policy which was being implemented in the area. Under Tusla's Quality Improvement Framework, a service improvement plan for the aftercare service had been developed in which actions had been identified for improvements in the service and how these improvements would be evaluated. The aim of the service improvement plan was to ensure that the service was in line with statutory requirements for aftercare.

The aftercare manager and principal social worker outlined the progress made in relation to actions noted on the service improvement plan. For example, a review of the work of the steering committee had taken place in September 2020 and decisions had been taken to increase the membership of the committee and to improve the referral process for the service. Young people were being referred to the service by the time they reached their sixteenth birthday and an information pack had been developed for young people referred to the aftercare service. A standard operating procedure for the aftercare service was in development and exit interviews with young people and aftercare forums were planned. There were ongoing discussions relating to the acquisition of a building dedicated to the aftercare drop-in service. The aftercare manager advised inspectors that there was a plan to develop the database further to include additional information relating to finance and education.

Information provided for the inspection indicated that there were 46 young people aged 16 years and over in foster care, all of whom were eligible for aftercare. The aftercare service was provided by an aftercare team which comprised an aftercare manager and five aftercare workers, two of whom were on temporary contracts. The aftercare manager told the inspector that these were permanent positions but the people in the role were acting up in the position. Aftercare workers advised that this was an area that caused stress for the team and felt there was not enough staff to

meet the demands in the area. The aftercare manager post was a fulltime position and the aftercare manager was in post since November 2019. There was a team leader position for aftercare which was vacant. The aftercare manager reported to the principal social worker with responsibility for children in care and aftercare.

Since March 2020, due to the Covid 19 pandemic, the aftercare manager told the inspector that the aftercare service was provided remotely where appropriate. Aftercare workers kept in contact with young people through emails and telephone calls and, when required, conducted face-to-face visits with young people. In some cases the restrictions due to the Covid 19 pandemic magnified the isolation felt by some young people. The aftercare manager said that some young people were engaging with the service for the first time or re-engaging for support as they no longer had access to the attachments provided by their work or education. Support was provided on a one-to-one basis as required by the aftercare team. In April 2020 Tusla issued guidelines for Covid-19 for young adults in receipt of an aftercare service which included the continuation of financial supports for young people attaining the age of 18 years during the pandemic. The aftercare manager told the inspector that all young people would be financially supported as needed.

Nine young people over the age of 16 years responded to the questionnaires. Of the seven who answered the question about whether they had an aftercare worker only one said they had an aftercare worker. Three young people said they had an aftercare plan which they had a say in preparing. It was possible that the young people who did not have an aftercare plan and those who did not know or did not respond may not have reached the age of 17 and a half, by which time aftercare plans should be in place. Eight young people responded that they had been helped to learn skills to manage on their own. Five out of nine who responded to the question said they knew what money they were entitled to, and seven young people said they were able to look after their money and manage it.

The inspector spoke with two young adults in receipt of after care services. Both were very positive about their experiences of aftercare and how they had been supported to live independently and pursue their goals. Plans were underway in the area to conduct exit interviews with young people who had received aftercare services and to facilitate young people's participation in forums on aftercare.

There was a system in place for ensuring that all eligible children were referred to the aftercare service and the aftercare manager maintained good oversight of this. Inspectors reviewed the files of eleven young people over the age of 16 years and all had been referred by their social workers to the aftercare service, the majority of them shortly after their 16th birthday.

As there was no national caseload weighting system, there was no mechanism for gauging how many cases should be carried by an aftercare worker. The aftercare manager told inspectors that aftercare workers had mixed caseloads. These included young people for whom they were the allocated aftercare worker and providing an aftercare duty service on a rota basis to support the full time duty worker. The aftercare manager said that aftercare workers carried caseloads of between 15-23 cases but that a national caseload management system was due to be rolled out in quarter one of 2021.

The aftercare team provided sufficient information to young people approaching leaving care age and their foster carers. An aftercare information pack was issued to young people referred to the aftercare service. This included information about the service and how to access it, a leaflet on an advocacy service for young people in care, a consent form and information on how to make a complaint. Involvement in the aftercare service was voluntary for each young person therefore young people had to give their consent to engage with the service. There was evidence that the aftercare team provided information and briefings on aftercare for children in care to new social work colleagues as part of their induction.

Tusla holds statutory responsibility to ensure that all young people receive a good quality aftercare service. Tusla had commissioned an external organisation to provide an aftercare service to some young people. There was a service level agreement in place with this organisation which was overseen by the area manager. There were oversight systems in place to ensure a good quality service was provided. These included quarterly senior management meetings between Tusla and the commissioned service, formal monthly meetings between managers of the two services, bi-monthly reports to Tusla on the service provided to each young person and team meetings of aftercare workers and managers. In addition, formal monthly meetings were held between the manager of the aftercare service and the manager of the external service. There were also bi-monthly reports submitted to the aftercare manager on each of the young people referred to this service to ensure that actions identified in aftercare plans were being implemented. The aftercare manager maintained a tracker of aftercare plans which he reviewed regularly to ensure identified actions were being implemented.

At the time of the inspection the aftercare manager told the inspector that there were eight young people recently referred to the service for an assessment of their aftercare needs. Four of these were young adults who were eligible for an aftercare service and the other four had been allocated to the commissioned service. The aftercare manager told the inspector that all of these young people would be allocated by the end of October 2020 for their assessment of need to be completed.

Aftercare workers told inspectors that there were meetings within the team to discuss priorities and the referral list but they said that the process was not always fair and the service could vary depending on the care order the child was subject to and whether they had a Guardian ad Litem advocating on their behalf.

The aftercare manager told the inspector that every young person that was referred was allocated to an aftercare worker for an assessment of need to be completed with them. If there were young people with additional needs they were prioritised for early assessment. The principal social worker advised that there were four assessments of needs overdue as it had been four months since they were referred. Inspectors reviewed data provided during the inspection and found that none of the young people awaiting an assessment of need were 17 years and six months.

Inspectors reviewed the files of eight young people over the age of 16 years and found that all had their aftercare needs assessment completed. The assessments addressed all aspects of the young person's needs as required but there were two templates used to record the information gathered, one was a Tusla document and the other was that used by the commissioned service. The aftercare manager told the inspector that he reviewed all assessments of need to ensure they were of good quality. Six of the eight assessments of need had been completed before the child was 17 years and 6 months. In one case, the child had only recently turned 16 and in another the delay in the completion of the assessment of need did not have a negative impact on the child.

Data provided by the area during the inspection outlined that there were 52 aftercare plans completed in the last 12 months and there were no children aged 17.5 years who did not have an aftercare plan. Inspectors reviewed the aftercare plans of seven young people. The aftercare plans were based on the young person's assessments of need and addressed all areas of their needs as appropriate. However, inspectors noted that some were more detailed than others. The aftercare manager told the inspector that the template for the aftercare plan had been amended to include more individual detail of the young person. There were plans in place to ensure consistency and standardisation of practice between the two services providing aftercare to young people in this service area and these actions formed part of their service improvement plan. Recent meetings had been held between Tusla and the external service where decisions had been made to standardise the service provided and to ensure a consistent quality aftercare service was provided to all young people who required it.

The young people were involved in the development of the aftercare plans and this was evident in six out of seven aftercare plans reviewed by inspectors. However, only two of the seven plans reviewed had been signed by the young person.

The area had an aftercare steering committee which was chaired by the aftercare manager which was comprised of a number of organisations including one providing advocacy services for children in care and the service commissioned by Tusla to provide aftercare services. As already outlined, the development of the aftercare service included increasing the membership of the steering committee so that it represented all organisations and services that might be required to provide a service to young people in aftercare. The steering committee had not met during the period of restrictions for Covid 19.

The aftercare manager told the inspector that the steering committee reviewed the aftercare plans of young people with complex needs and those that required a multi-agency response. Young people with a disability were referred to the steering committee at an early stage but the HSE disability service had only been represented at two meetings in the past 11 months. Inspectors reviewed the minutes of the steering committee and found that relevant issues pertaining to the aftercare service were discussed. This included discussions on what accommodation options were available for young people, the development of the committee and the drop-in service. The plans to support individual young people were also discussed and actions identified to meet their needs. Young people's aftercare needs were reviewed until all actions were completed. Young people were supported through the aftercare duty service as appropriate when they were no longer being reviewed by the steering committee. The aftercare manager told inspectors that the aftercare steering committees worked really well and they had fostered good working relationships between the different agencies.

The area's drop in service required improvement. They had two permanent locations but the aftercare manager and aftercare staff described the facilities as inadequate. Aftercare workers said the current location was not suitable and the young people did not like the space provided and a location separate to the social work department was required. The service was trying to source an alternative building to provide this service and there was ongoing discussions in relation to this. At the time of the inspection young people were required to make initial contact with aftercare workers by phone or email so appropriate precautions could be put in place due to Covid 19 restrictions. The service was open to all care leavers regardless of their age. Records were maintained on the number of contacts made with the drop-in service. Information provided during the inspection showed that overall the numbers of contacts made with the drop-in service in 2020 were increasing with 102 contacts made in September 2020.

There was no annual adequacy report of aftercare services available. However, records were maintained on young people who had left care and quarterly returns were submitted to Tusla national office on numbers of referrals to the service, education and training aftercare plans and allocated aftercare worker. The metrics provided for quarter two of 2020 indicated that 173 young person or adults were in receipt of an aftercare service in Dublin South Central. Fifteen new referrals of young people under 18 years of age had been received. All of these young people were eligible for an assessment of need and nine of these had been completed during that reporting period.

According to the statistics for quarter 2 in 2020 there were 137 young people in the aftercare service between the ages of 18 and 22 years, and 74 (54%) were in educational or accredited training placements as follows:

- 24 (17%) were still in second level schools
- 7 (5%) were in post-leaving cert courses
- 16 (11%) were in vocational training
- 22 (16%) were in third level college or university and
- 5 (3%) was in accredited training/other placements.

The accommodation arrangements of the 137 young people in the 18-22 years age group were as follows:

- 65 (47%) remained with their former foster carers
- 33 (24%) were living independently
- 7 (5%) were living at home
- 13 (9%) were in residential care
- 8 (6%) were in designated care leavers' accommodation
- 1 young person was in supported lodgings and
- 10 (7%) were in "other" accommodation

There were a number of good practice initiatives such as an aftercare newsletter which provided an overview of relevant information required to support care leavers in their transition out of care. The September 2019 issue had focused on how one young person had successfully negotiated their transition into independent living.

The aftercare service in Dublin South Central was developing and managers were enthusiastic about and committed to providing a good quality, accessible service to all young people leaving care that needed it. There was a service improvement plan in place but some actions were outstanding at the time of the inspection. The

process to ensure all aftercare plans were of good quality needed to improve and the drop-in service was not adequate. A process to obtain the views of young people who had used the service had not commenced and the area had yet to produce an annual adequacy report for the aftercare service. For this reason the area was judged substantially compliant with this standard.

Judgment: Substantially compliant

Appendix 1 — Standards and regulations for statutory foster care services

<i>National Standards for Foster Care (April 2003)</i>
Theme 1: Child-centred Services
<p>Standard 1: Positive sense of identity Children and young people are provided with foster care services that promote a positive sense of identity for them.</p>
<p>Standard 2: Family and friends Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.</p>
<p>Standard 3: Children's Rights Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and have their views, including complaints, heard when decisions are made which affect them or the care they receive.</p>
<p>Standard 4: Valuing diversity Children and young people are provided with foster care services that take account of their age, stage of development, individual assessed needs, illness or disability, gender, family background, culture and ethnicity (including membership of the Traveller community), religion and sexual identity.</p>
<p><i>Child Care (Placement of Children in Foster Care) Regulations, 1995</i> <i>Part III Article 8 Religion</i></p>
<p>Standard 25: Representations 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.</p>

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

National Standards for Foster Care (April 2003)

Theme 2: Safe and Effective Services

Standard 5: The child and family social worker

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

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part IV, Article 17(1) Supervision and visiting of children

Standard 6: Assessment of children and young people

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

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 6: Assessment of circumstances of child

Standard 7: Care planning and review

Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 11: Care plans
Part IV, Article 18: Review of cases
Part IV, Article 19: Special review

Standard 8: Matching carers with children and young people

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

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 7: Capacity of foster parents to meet the needs of child

Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 7: Assessment of circumstances of the child

National Standards for Foster Care (April 2003)

Standard 9: A safe and positive environment

Foster carers' homes provide a safe, healthy and nurturing environment for the children or young people.

Standard 10: Safeguarding and child protection

Children and young people in foster care are protected from abuse and neglect.

Standard 13: Preparation for leaving care and adult life

Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

Standard 14a — Assessment and approval of non-relative foster carers

Foster care applicants participate in a comprehensive assessment of their ability to carry out the fostering task and are formally approved by the health board* prior to any child or young person being placed with them.

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

Part III, Article 5 Assessment of foster parents

Part III, Article 9 Contract

Standard 14b — Assessment and approval of relative foster carers

Relatives who apply, or are requested to apply, to care for a child or young person under Section 36(1) (d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board.

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

Part III, Article 5 Assessment of relatives

Part III, Article 6 Emergency Placements

Part III, Article 9 Contract

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

National Standards for Foster Care (April 2003)

Standard 15: Supervision and support

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

Standard 16: Training

Foster carers participate in the training necessary to equip them with the skills and knowledge required to provide high-quality care.

Standard 17: Reviews of foster carers

Foster carers participate in regular reviews of their continuing capacity to provide high-quality care and to assist with the identification of gaps in the fostering service.

Standard 22: Special Foster care

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

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.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 5 (3) Assessment of foster carers

Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 5 (2) Assessment of relatives

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

National Standard for Foster Care (April 2003)**Theme 3: Health and Development****Standard 11: Health and development**

The health and developmental needs of children and young people in foster care are assessed and met. They are given information, guidance and support to make appropriate choices in relation to their health and development.

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

Part III, Article 6 Assessment of circumstances of child

Part IV, Article 16 (2)(d) Duties of foster parents

Standard 12: Education

The educational needs of children and young people in foster care are given high priority and they are encouraged to attain their full potential. Education is understood to include the development of social and life skills.

National Standards for Foster Care (April 2003)**Theme 4: Leadership, Governance and Management****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.

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

Part III, Article 5 (1) Assessment of foster carers

Standard 19: Management and monitoring of foster care agency

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

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

Part IV, Article 12 Maintenance of register

Part IV, Article 17 Supervision and visiting of children

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

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.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part VI, Article 24: Arrangements with voluntary bodies and other persons

National Standards for Foster Care (April 2003)**Theme 5: Use of Resources****Standard 21: Recruitment and retention of an appropriate range of foster carers**

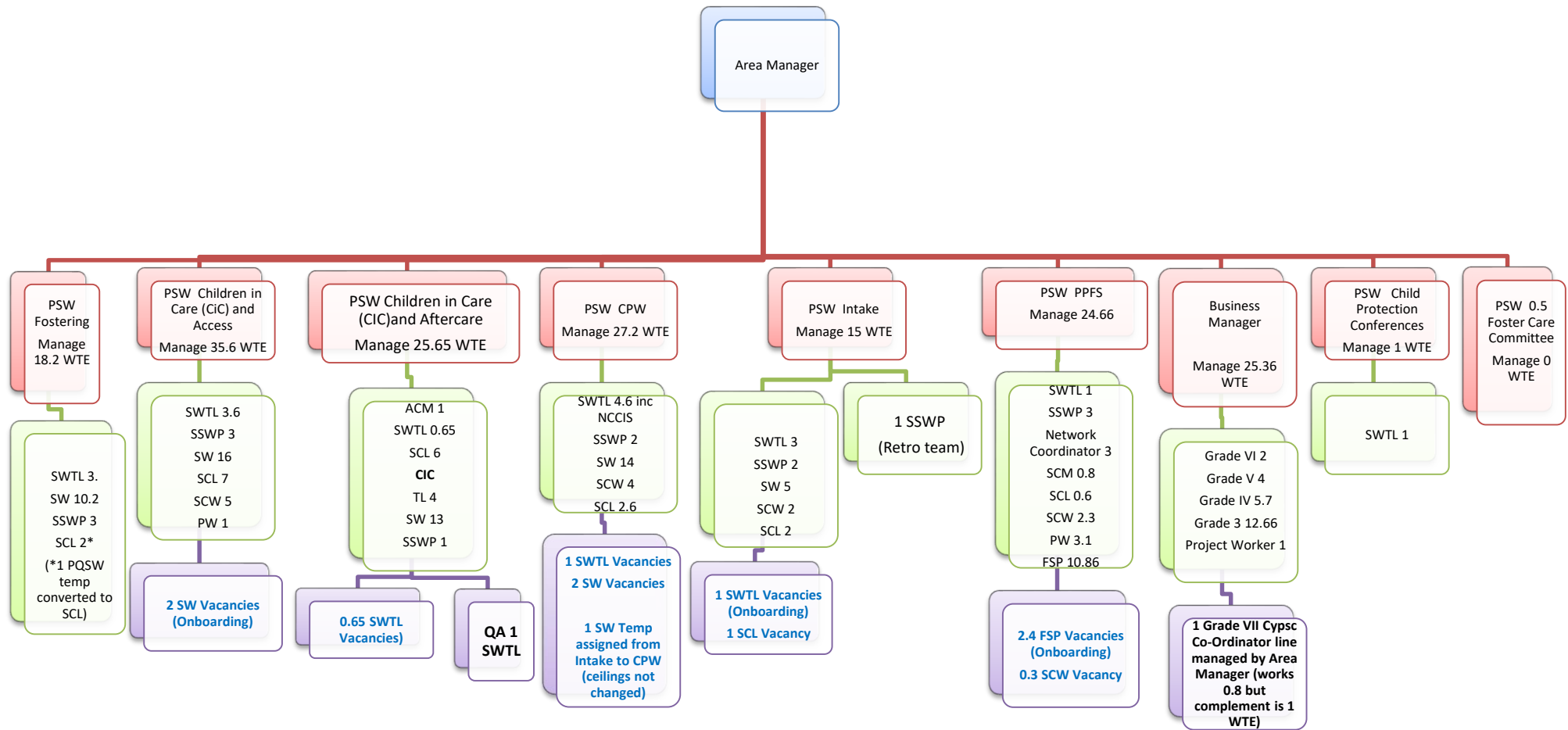
Health boards are actively involved in recruiting and retaining an appropriate range of foster carers to meet the diverse needs of the children and young people in their care.

National Standards for Foster Care (April 2003)**Theme 6: Workforce****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.

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

Appendix 2: Organisational structure of Statutory Alternative Care Services, in Dublin South Central Service Area*



* Source: The Child and Family Agency

