

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance and Monitoring Inspection  
Report for Foster Care Services under the  
Child Care Act 1991**



<b>Name of Service Area:</b>	Dublin South West/ Kildare West Wicklow	
<b>Service Area ID:</b>	200-209-314/200-209-319	
<b>Dates of inspection:</b>	25/06/2014 - 03/07/2014	
<b>No. of Fieldwork days:</b>	6	
<b>Lead inspector:</b>	Maureen Burns Rees	
<b>Support inspector(s):</b>	Eva Boyle	
<b>Type of inspection:</b>	<input checked="" type="checkbox"/> <b>announced</b> <input type="checkbox"/> <b>unannounced</b>	
<b>Inspection ID:</b>	<b>687</b>	

## About monitoring of compliance

The purpose of monitoring is to safeguard vulnerable children of any age who are receiving foster care services. 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 continuous improvement so that children have better, safer lives.

The Health Information and Quality Authority (the Authority) has, among its functions under section 8(1) c of the Health Act 2007, responsibility to monitor the quality of service provided by the Child and Family Agency (CFA) to protect children and to promote their welfare.

The Health Information and Quality Authority (the Authority or 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 CFA and to report on its findings to the Minister for Children and Youth Affairs.

In order to drive quality and improve safety in the provision of child protection and welfare services, the Authority carries out inspections to:

- **Assess** if the CFA (the service provider) has all the elements in place to safeguard children and young people
- **Seek assurances** from service providers that they are **safeguarding children** through the mitigation of serious risks
- **Provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **Inform** the public and **promote confidence** through the publication of the Authority's findings.

Monitoring inspections assess continuing compliance with the regulations and standards, can be announced or unannounced and take place:

- to monitor compliance with regulations and standards
- arising from a number of events including information affecting the safety or well-being of children.

## Summary of compliance with the Child Care Act 1991 and the National Standards Foster Care for the Child and Family Agency (CFA)

This inspection report sets out the findings of a monitoring inspection:

- ☒ to monitor ongoing regulatory compliance with National Standards
- ☐ following receipt of solicited and unsolicited information
- ☐ following notification of a significant incident or event

During 2014, the Authority has made the decision to undertake themed inspections of foster care which focus on the leadership of the service, the experience of the child and the provision of the foster care service.

The table below sets out the themes which were inspected on this inspection.

<b>Theme 1: Individualised Supports and Care</b> Services for children are centred on the individual child and his/her care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.	<input checked="" type="checkbox"/>
<b>Theme 2: Effective Services</b> Effective services ensure that the proper support mechanisms are in place to enable children to lead a fulfilling life. Personal planning is central to supporting children to identify their goals, needs and preferences and what supports need to be put in place by the service to ensure that each child maximises his/her personal development.	<input checked="" type="checkbox"/>
<b>Theme 3: Safe Services</b> Services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect people from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities.	<input type="checkbox"/>
<b>Theme 4: Health and Development</b> Services support children so that they continue to enjoy a good quality of life and live their lives in keeping with their own social, cultural and religious beliefs. The quality of life for children is important in areas including health, educational development, physical and cognitive attainment, and social and emotional development. Children have access to universal health and social care services on the same basis as others in order to maintain and improve their health status.	<input type="checkbox"/>

<b>Theme 5: Leadership, Governance and Management</b> Effective governance in services for children is accomplished by directing and managing activities using good business practices, objectivity, accountability and integrity. In an effective governance structure, overall accountability for the delivery of services is clearly defined and there are clear lines of accountability at individual, team and service levels so that all people working in the service are aware of their responsibilities and who they are accountable to.	<input checked="" type="checkbox"/>
<b>Theme 6: Use of resources</b> The effective management and use of available financial and human resources is fundamental to delivering child-centred safe and effective services and supports that meet the needs of children.	<input type="checkbox"/>
<b>Theme 7: Responsive workforce</b> Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children's services organise and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.	<input type="checkbox"/>
<b>Theme 8: Use of Information</b> Quality information and effective information systems are central to improving the quality of services for children. Quality information, which is accurate, complete, legible, relevant, reliable, timely and valid, is an important resource for providers in planning, managing, delivering and monitoring children's services. An information governance framework enables services to ensure all information including personal information is handled securely, efficiently, effectively and in line with legislation. This supports the delivery of child-centred, safe and effective care to children.	<input type="checkbox"/>

## **1. Methodology**

As part of this inspection inspectors met with children, parents/guardians, other agencies and professionals. Inspectors observed practices and reviewed documentation, relevant registers, policies and procedures, children's files and staff files.

The aim of on-site inspection fieldwork is to gather further evidence of compliance with the National Standards and Regulations.

During this part of the inspection, the inspectors will evaluate:

- quality of care and safe service
- the timeliness and management of referrals
- the effectiveness of assessment and risk management processes
- assessment of foster carers
- assessment of safeguarding
- effectiveness of the Foster Care Committee
- the extent of focus on the child or young person's needs and

The key activities of this inspection involved:

- the interrogation of data
- the review of local policies and procedures, minutes of various meetings and local audits
- the review of 50 children's case files by both tracking and sampling information contained within their files
- the review of 24 foster carer's files by both tracking and sampling information contained within their files
- meeting with 10 children and young people, and seven carers
- telephone interviews were conducted with three parents and three foster carers
- meetings with two groups of social workers, two groups of team leaders, the area manager and three principal social workers
- interview with the chair and the coordinator of the foster care committee (FCC)
- observation of practice in one child in care review meeting.

## **Acknowledgements**

The Authority wishes to thank the carers, children and parents/guardians for the openness with which they embraced the inspection process and welcomed inspectors into their homes. Inspectors also wish to acknowledge the cooperation of the members of Child and Family Agency (CFA/the Agency) and senior managers in the Dublin South West Kildare West Wicklow service area (Area).

## **2. Profile**

### **2.1 Child and Family Agency (CFA)**

Child and family services in Ireland are now the primary focus of a single dedicated State agency – the CFA overseen by a single dedicated government Department. The Child and Family Agency Act 2013 (No. 40 of 2013) established the CFA. The Agency was established with effect from 1 January 2014.

The CFA have service responsibility for a range of services, including:

- Child Welfare and Protection Services, including family support services;
- Existing Family Support Agency (FSA) responsibilities;
- Existing National Educational Welfare Board (NEWB) responsibilities;
- Pre-school Inspection Services;
- Domestic, sexual and gender based violence services;
- Services related to the psychological welfare of children.

Child and Family services have been merged into 17 Service Areas (SAs) and are managed under area managers.

Children's foster care services will be inspected by the Authority at SA level with governance inspected at an area manager level.

### **2.2 Service Area**

Dublin South West Kildare/West Wicklow covers the main geographical areas of Dublin 12 & 24, County Kildare and West Wicklow. This is a large geographical area and one of the largest areas for Child & Family Services. The area comprises of both urban and rural areas, and with some parts of the area having high deprivation rates. Census figures (2011) show that the child population for the Dublin South West area was 39,727 and for Kildare West Wicklow was 79,449.

In the Dublin South West area, census figures (2011) and State of the Nation's Children Ireland 2012<sup>1</sup> showed that the child population was 39,727 which was above the national average. Of those aged 15 years and over for whom full time education had ceased, 15.1% were educated to at most primary level; 55.4% attained second level and 29.5% were educated to third level. The percentage of children under 18 years living in lone parent households in the area was 26%, which is above the national figure of 18.3%. There were 1051 travellers in the area which is 0.7% of the total population in the area. 83% of the population in Dublin South West were white Irish. Non-Irish nationals accounted for 10.9% of the population of the Dublin South West area compared with a national average figure of 12%.

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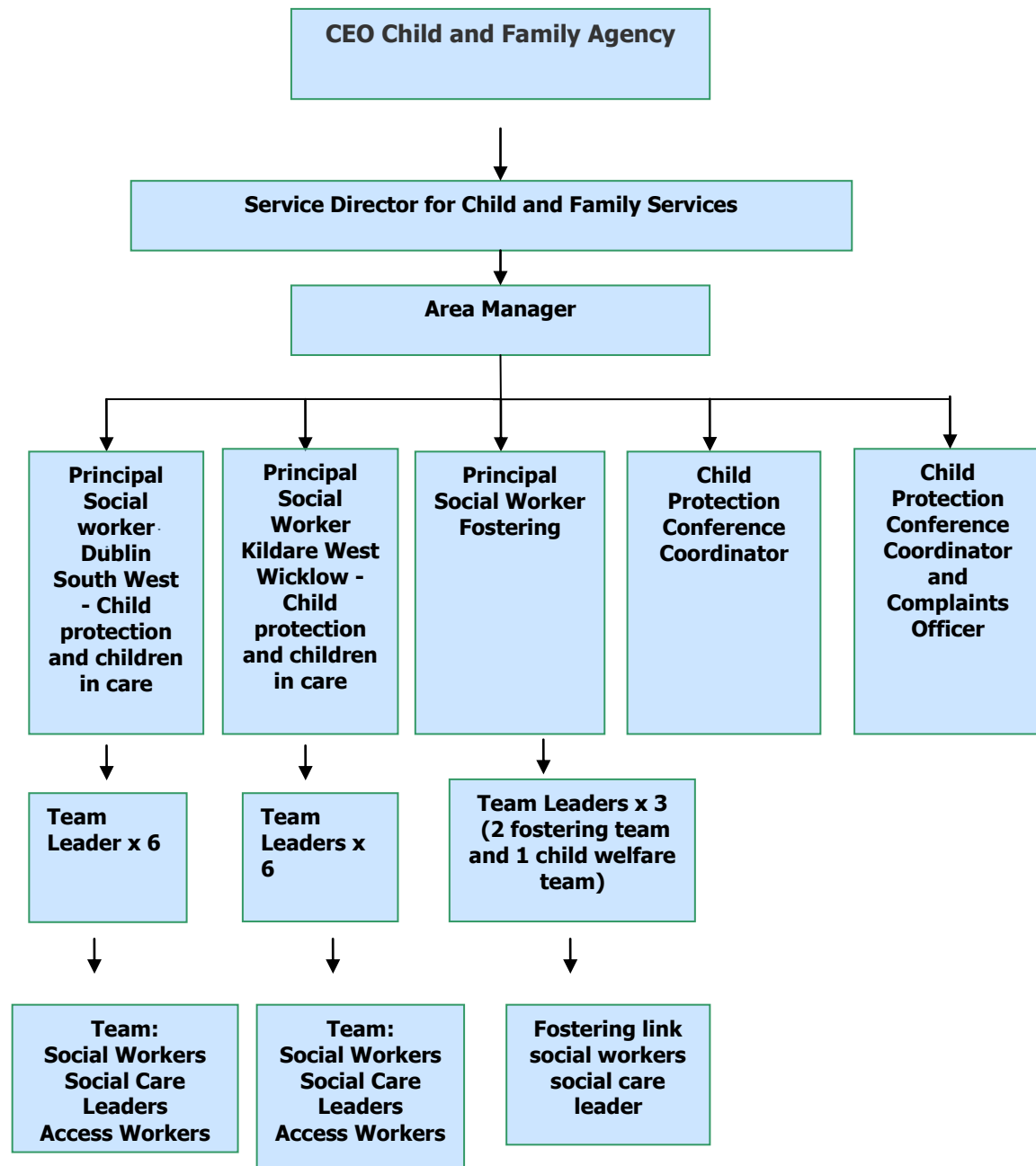
<sup>1</sup> Department of Children and Youth Affairs (2012) State of the Nation's Children Ireland 2012

In the Kildare West Wicklow area, census figures (2011) and state of the Nations Children (2012) showed that the child population was 79,449. It was estimated that education ceased at 17 years for 9.17% of the population and that 3.9 % of children were living in a household with mother with primary only or no formal education. There were 970 children from the travelling community in the area. 84.4% of the population represented the white Irish community. There were 5042 foreign national children in the area.

At the time of inspection, according to data provided by the agency, there were a total of 429 children in foster care within the total area of Dublin South West/ Kildare West Wicklow. Of these, 287 children were placed with non relative foster carers and 142 with relative foster carers. In total there were 309 foster carers providing care to children in the area.

The organisational chart in Figure 1 describes the management and team structure as provided by the Service Area.

**Figure 1: Organisational structure of the Children's Foster Care Services, Dublin South West/ Kildare West Wicklow Service Area\***



\* Source: the CFA



### **3. Summary of Findings**

The Child and Family Agency (the CFA/the Agency) has statutory 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 work practice. Foster carers must be able to provide them with warm and nurturing relationships in order for children to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

The outcomes for many of the children in foster care in the area were positive but the level of staff vacancies had a significant impact on the foster care service. In the main, children's primary needs were met, they were treated with dignity and respect, their rights were promoted by social workers and carers and they were consulted about decisions that affected their lives.

However, a considerable number of children in foster care did not have a social worker to advocate on their behalf and ensure that their needs were being met. Statutory child in care reviews were not being undertaken in line with statutory requirements which meant that some children did not have up-to-date care plans to guide their care. Not all foster carers had a link worker allocated to provide them with support and supervise the care they were providing and there were a number of children living in foster care households which no professional was visiting the household to identify if the child was safe and their needs were being addressed. There were insufficient number of foster carers in the area and foster carer's assessments were not being undertaken in a timely manner. Foster carer reviews were not being routinely undertaken;

Management and governance structures were in place but systems and managerial oversight were not robust. The processes in place to monitor unallocated cases were weak and there was little formal risk management in place. Service planning was at an early stage of development and there were quality assurance initiatives in place. However, there was no formal quality assurance or monitoring system to ensure that the service was compliant with standards, regulations, policies and legislations. In addition, there were no service level agreements in place with private foster care agencies and so these could not be monitored.

The Authority provided an action plan to the Child and Family Agency. Following several iterations, the Authority is publishing this final plan and recommends that actions under Standard 13 and Standard 17 are again reviewed and more detail included to ensure that the failings as identified are effectively addressed.

#### 4. Summary of judgments under each standard

Theme	National Standards for Foster Care	Judgment
<b>Theme 1: Individualised Supports and Care</b>	Standard 1: Positive sense of identity	Meets the standard
	Standard 2: Family and Friends	Requires improvement
	Standard 3: Children's rights	Requires improvement
	Standard 4: Valuing diversity	Requires improvement
	Standard 25: Representations and complaints	Requires improvement
<b>Theme 2: Effective Services</b>	Standard 5: The child and family social worker	Requires improvement
	Standard 6: Assessment of Children and Young People	Meets the standard
	Standard 7: Care Planning and Review	Requires improvement
	Standard 8: Matching children with carers	Requires improvement
	Standard 13: Preparation for leaving care and adult life	Requires improvement
	Standard 14a: Assessment and approval of foster carers	Requires improvement
	Standard 14b: Assessment and approval of relative foster carers.	Requires improvement
	Standard 15: Supervision and Support	Requires improvement
	Standard 17: Reviews of Foster Carers	Requires improvement
<b>Theme 5: Leadership, Governance and Management</b>	Standard 18: Effective policies	Requires improvement
	Standard 19: Management and Monitoring of Foster Care Services	Requires improvement
	Standard 21: Recruitment and retention of an appropriate range of Foster Carers	Requires improvement
	Standard 23: The Foster Care Committee	Requires improvement
	Standard 24: Placement of Children through non-statutory agencies	Requires improvement

## 5. Findings and judgments

### Compliance with the Child Care Act, 1991 and National Standards for Foster Care for the Child and Family Agency

#### Theme 1: Individualised Supports and Care

*Services for children are centred on the individual child and his/her care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.*

#### References:

##### **National Standards for Foster Care (2003)**

Standard 1: Positive Sense of Identity  
Standard 2: Family and friends  
Standard 3: Children's Rights  
Standard 4: Valuing Diversity  
Standard 25: Complaints

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

Part II, Article 4: Welfare of child  
Part III, Article 8: Religion  
Part III, Article 11: Care plan  
Part IV, Article 16: Duties of foster parents

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

Part II, Article 4: Welfare of child  
Part III, Article 8: Religion  
Part III, Article 11: Care plan  
Part IV, Article 16: Duties of relatives

## Children's Rights

The rights of children were upheld and promoted by the fostering service to a degree, but children themselves were generally unaware that they had such rights.

Inspectors met with children, foster carers and parents and found that children's rights to dignity, respect, privacy and confidentiality was respected. The inspectors reviewed child-friendly review forms on case files which had been completed by children in advance of their child in care reviews. These sought children's opinion on the services being delivered to them and the care they were receiving. There was evidence that children where appropriate, were invited to child in care reviews, although many decided not to attend. Children who met with inspectors said that they felt they were consulted with about decisions that affected their lives and that they had been given

opportunities to engage in a range of activities of their choosing. For example, dance classes, drama groups, foot ball, hurling and a running camp. Inspectors noted in case files that children had accessed advocacy and guardian ad litem services and this was facilitated by the area.

Some of the children who met with inspectors were unsure or unaware of their rights. This meant that children's rights to dignity, respect, privacy and choice could be undermined. The majority of children met with could not recall having been advised or given information about their rights. There was no documentary evidence in case files that social workers had spoken to children about their rights. The majority of children who met with inspectors did not fully understand their rights to access their case files. None of the children met with had accessed their case files. Inspectors observed that the area was using family files versus individual child files for a number of cases in Dublin South West. There was a risk that children would not be viewed as individuals. There was limited documentary evidence available to show that those children, who decided not to attend their child in care reviews, had been spoken to by their social workers after the meeting regarding decisions made.

## **Diversity**

The area had some anti-discriminatory practices in place in working and caring for children from different ethnic, cultural and religious backgrounds. However, the service was challenged to provide appropriate cultural placements for some children and provided limited anti-discriminatory training for foster carers and staff. This meant that some children might not have their cultural identity understood, that specific needs might not be met and that stability of placements could be undermined.

Data provided by the area demonstrated that 60 out of 429 (14 %) of children came from diverse ethnic, cultural and religious backgrounds. There was evidence that some social workers had received specific training relating to the ethnicity of a child to whom they were the allocated social worker. A small number of social workers within the team were from a different ethnic origin and were informally used as a source of advice for other social workers on the team. There was evidence that two foster carers from different ethnic origins had been recruited and approved as non relative foster carers in the area but at the time of inspection were not caring for children from the same ethnic background as themselves. The principal social worker reported that at the time children were placed with these carers, no children from the same background were awaiting placement.

With the exception of a small number of children placed with relative foster carers, children from a different cultural or ethnic group were not placed with carers from their own backgrounds. This meant that children's identity in terms of religious or cultural needs could be undermined particularly as children come into teenage years. A number of foster carers who met with inspectors reported that they had not received any specific training and limited information or advice regarding the cultural origins and care requirements for children from different ethnic backgrounds. Social workers reported that they had received limited training on anti-discriminatory practices. The area did not collect specific data relating to the ethnicity of children in foster care. This meant that

the areas ability to plan for the delivery of appropriate services for different ethnic groups was limited.

Children with a diagnosis of moderate to severe intellectual disabilities received appropriate services and supports to assist them to maximise their potential. A planning multi- disciplinary forum for children with complex needs was in place, and this forum included the input of Health Service Executive Services such as the child and adolescent mental health service, disability services and public health nursing. The forum met bi-monthly, and was an effective forum. However, children with mild intellectual disabilities found it more difficult to access services in a timely manner. This meant that the needs of all children with a disability might not have been met.

Data provided by the area demonstrated that 26 out of 429 (6%) of children in the area had a disability. Carers of children with a disability told inspectors that they generally felt supported by their social workers. A sample of care files reviewed demonstrated that children were in receipt of assistance to meet their identified needs in accordance with their care plan and that there was ongoing inter-professional working and consultation regarding children's care plans.

Inspectors found limited evidence that carers of children with a disability had received ongoing training and information on the child's disability, diagnosis and implications for care. Hence, some children's specific needs might not be met and carers might not understand behaviours, future prognosis and children's particular needs. Social workers reported that while the majority of children were in receipt of assistance to meet their identified needs in accordance with their care plan, they sometimes had to wait to receive a service.

## **Communication**

For children and families where a social worker was allocated, the inspectors found that the area communicated effectively with these children, but this was not the case for those who did not have an allocated social worker.

Children and parents, (who had an allocated social worker), reported that they felt they were spoken to, in a respectful and effective way. Through case file reviews, inspectors found evidence of a good level of consultation with children and communication about important issues in their lives. Inspectors found evidence of where translation services had been appropriately used to aid effective communication with a number of parents of children in foster care. The area had recently revised their complaint leaflet and had a number of other leaflets which were appropriate to children.

However, inspectors found that in cases where a social worker was not allocated, children were not being effectively communicated with. Through case file reviews, inspectors noted that these children did not have regular contact with a social worker to whom they could voice concerns and that decisions made at child in care reviews or other meetings, where the child was not in attendance, were not subsequently communicated to the child. Inspectors found through interviews with children and social workers that information leaflets available were not routinely provided to all children.

## **Family and Friends**

Children living in the area, were able to maintain positive relationships with their parents, siblings and significant others. However, the foster care service was not sufficiently resourced, by staff or with sufficient foster carers, to allow all children to remain within their own community or to enable all sibling groups to stay together according to their plan. This meant that the ability of some children to maintain positive kinship ties with their parent, siblings and significant others could have been undermined.

Data provided by the area showed that 142 of the 429 (33%) children in foster care were placed with relative foster carers. This reduced the impact for these children of being in care and promoted a positive sense of identity. Efforts were made by the service to identify a relative carer in the first instance and this was reflected in a sample of case files reviewed. Inspectors found that contact with family members was actively promoted and that the social workers had supported parents to attend access by arranging transport. Carers who spoke with inspectors outlined ways in which they facilitated children's access with parents and worked in partnership with parents. There was evidence that access took place in some foster carer homes. Parents, who spoke with inspectors, reported that they had a good relationship with their child's foster carer. Children said that they were happy with the level of access they had with their family and friends. Case notes reviewed by inspectors recorded occasions where access did not occur, the reasons for this and the measures taken to address difficulties with access. For children who had an allocated social worker, there was evidence that the quality and frequency of access arrangements was planned and reviewed by social workers as part of child in care reviews and through the social worker's contact with children, parents and foster carers. Children said that they each had a number of close friends who they met up with regularly either in their foster homes or friends home. Some older children said that they used mobile phones and social media to maintain contact with family and friends and that this was supervised by their foster carers.

Data provided by the area demonstrated that 67 sibling groups had been placed together but that six siblings had not been placed together contrary to their assessment. Although this percentage was not enormous, the impact of separating siblings cannot be underestimated. In addition, 75 out of 429 (17 %) of children were placed in foster care placements outside of the area either with relatives or in private foster care placements. Although, inspectors noted that some of these placements were within a short distance outside of the area, others were a considerable distance away. For children who did not have a social worker allocated, there was limited monitoring of access arrangements to ensure that the arrangements in place met the child's ongoing needs in terms of attachment to their families and friends. This meant that these children may not have been able to maintain positive relationships with their families or significant others.

## **Complaints**

The systems in place to record, manage and resolve complaints were not robust. This meant that opportunities for learning to inform service improvement were being missed.

Data provided by the area demonstrated that there were 20 complaints received in the previous 12 month period. Inspectors reviewed a sample of these and found that some of them, but not all, had been appropriately responded to and managed. The majority of children, carers and parents who spoke with inspectors reported that they had not and did not consider that they would need to make a complaint about the services being delivered. Inspectors found that the service had recently revised its complaint leaflet but that this had not yet been circulated to all children or families.

A number of children and parents who spoke with inspectors were unsure or unaware of how to make a complaint. This meant that children's worries and or concerns may not have been identified or addressed. Social workers told inspectors that many day to day complaints by children regarding care issues were responded to by the child's social worker. These complaints were not routinely recorded centrally or notified to the services complaints officer and hence there was no formal analysis to determine trends so as to share learning for the service. Inspectors reviewed a sample of the 20 complaints received in the previous 12 months and found that a number of these, particularly in the Dublin South West area, had been classified as a complaint but should have been recorded as an allegation. Inspectors noted that they had each been appropriately assessed and managed. Inspectors found that the outcome of complaints managed was not always appropriately recorded or timely so the service could not be assured that complaints had been managed appropriately. There was limited evidence that information arising from complaints had affected change.

## Judgment

Standard	Judgment
<b>Standard 1 Positive sense of identity</b>  Children and young people are provided with foster care services that promote a positive sense of identity for them.	Meets the standard
<b>Standard 2 Family and friends</b>  Children and young people are encouraged and facilitated to maintain and develop family relationships and friendships.	Requires improvement
<b>Standard 3 Children's rights</b>  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	Requires improvement

or the care they receive.	
<b>Standard 4 Valuing diversity</b>  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.	Requires improvement
<b>Standard 25 Representations and complaints</b>  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.	Requires improvement



## **Theme 2: Effective Services**

*Effective services ensure that the proper support mechanisms are in place to enable children to lead a fulfilling life. Personal planning is central to supporting children to identify their goals, needs and preferences and what supports need to be put in place by the service to ensure that each child maximises his/her personal development.*

### **References:**

#### **National Standards for Foster Care (2003)**

Standard 5: The child and family social worker  
Standard 6: Assessment of children and young people  
Standard 7: Care planning and review  
Standard 8: Matching carers with children and young people  
Standard 13: Preparation for leaving care and adult life  
Standard 14a. Assessment and approval of foster carers  
Standard 14b. Assessment and approval of relative carers

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

Part III, Article 5 (2) (a): Assessment of foster parents  
Part III, Article 6: Assessment of circumstances of child  
Part III, Article 7: Capacity of foster parents to meet the needs of child  
Part III, Article 10: Information on child  
Part III, Article 11: Care plans  
Part IV, Article 18: Review of cases  
Part IV, Article 19: Special review  
Part IV, Article 20: Frequent admissions to care

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

Part III, Article 5 (1) (a): Assessment of relatives  
Part III, Article 7: Assessment of circumstances of child  
Part III, Article 9 (1), (2) Contract  
Part III, Article 10: Information on child  
Part III, Article 11: Care plans  
Part IV, Article 18: Review of cases  
Part IV, Article 19: Special review  
Part IV, Article 20: Frequent admissions to care

### **Statutory Requirements for Children in Care**

The service was not fulfilling all of its statutory requirements in relation to children in foster care and the managers could not be assured that a safe and effective service was being delivered for all of the children in foster care.

All children in non relative foster care placements were living with carers who had undergone a formal quality assessment and were approved by the foster care

committee prior to the children being placed with them. Inspectors found that children who had an allocated social worker were visited in line with the requirements outlined in the regulations and the majority had up-to-date and comprehensive care plans in place. In addition, statutory care reviews for the majority of children with allocated social workers had been undertaken in line with regulatory requirements. Inspectors found that carers and professionals participated in the review process. There was documentary evidence that children (where age appropriate) and parents had been invited to statutory care reviews although sometimes children and or parents opted not to attend. The assessment of children's needs, although not always recorded as a separate document but part of the care planning process, was comprehensive.

Not all children had an allocated social worker to monitor their welfare and safety needs. This meant that some children did not have a named professional advocating on their behalf and ensuring that they were safe, content and receiving all the services that they required. Data provided by the area demonstrated that 111 of 429 (26%) children did not have an allocated social worker. Inspectors found that a number of children with no allocated social worker had not been visited in line with the frequency outlined in the regulations. For example, in one of the case files reviewed by inspectors, there was no record of a statutory visit in over four years. Data provided by the area demonstrated that there were 46 relative foster carer households caring for children who had not yet been approved by the foster care committee. These included 20 cases where the assessment of the foster carers had not yet been commenced and 26 cases where the relative carers were undergoing assessment. The matching process for placing children with carers who have capacity to meet children's assessed needs was negatively impacted by a limited number of foster carers. This meant that the ability of the area to fully match children to carers based on their assessed needs was restricted. A number of these children were living with foster carers who had a link worker allocated, which the area proposed as a safety mechanism. However, inspectors found limited evidence of formal communication about the children's progress, between the link worker and team leader for the children in care team. Some children in the area had contact with an access worker when they were visiting with family members while, other children were assigned a social care leader to support them with particular needs but their supervision remained limited.

Inspectors identified that a number of children who did not have an allocated social worker were living with foster carers who also did not have an allocated link worker. Consequently, no professional was visiting these households to identify if care needs were being met and or if the placement was safe. Inspectors noted that this risk had not been assessed or included in the area's risk register. The area manager told inspectors that the risks associated with all unallocated cases had been considered and that cases were prioritised by the principal social worker. New arrangements had been put in place in the Kildare West Wicklow area whereby a dedicated member of staff was assigned responsibility for all unallocated cases since early June and it was proposed that this individual would visit all unallocated cases in the Kildare West Wicklow area. In the Dublin South West area, arrangements to actively monitor and manage all unallocated cases were in an early stage of development.

Another risk identified was that statutory child in care reviews for children were not being undertaken in line with regulatory requirements. This meant that there was no up to date plan directing these children's care. Data provided by the area demonstrated that there were 143 out of 429 (33%) children who did not have an up to date statutory child in care review and that 32 children (7%) did not have a written care plan in place. Inspectors reviewed registers held by the area and identified that there were a number of child in care reviews which had not taken place for in excess of a two year period.

## **Children's care needs**

Children lived with carers who met their needs in a safe and nurturing environment. Their welfare and developmental needs were met.

The sample of children who met with inspectors were nicely dressed. Inspectors observed that homes were well maintained, warm and homely, and provided opportunities for play and development. For example, there were an array of toys, books, board games, household pets, bicycles and scooters. Children told inspectors that they felt safe, were well cared for and had access to plenty of nutritious food and snacks. Inspectors found that children's primary care and safety needs were evaluated through the care planning process and social workers' direct work with children.

The assessment of foster carers included an assessment of the foster carer's home, but inspectors found that this was not always comprehensively documented from a health and safety perspective. The fostering principal social worker and team leader reported that in line with the CFA's standard business process a new safety check assessment tool had recently been implemented in the area and was being used for all foster carer assessments.

## **Preparation for Leaving Care**

The processes in place to prepare and support young people for leaving care and adult life were not in line with the national after care policy. This meant that managers could not be assured that children received the adequate supports or were adequately prepared for adulthood. As a result some young people could have left foster care without having the skills, knowledge and competence necessary for adulthood, at a particularly vulnerable time in their lives.

Young people who met with inspectors outlined ways in which they were supported to develop life skills by their foster carers. These included, managing their own money, household chores and laundry. Through file review and interview with young people, inspectors found that social workers had taken on the after care worker role and assisted young people in gaining skills for independent living and to secure college placement and accommodation, which young people said was a great help to them. Data provided by the area demonstrated that there were 84 young people over the age of 18 years who were in receipt of an after care service. Of these, 22 had remained

within their existing foster care placement. There was documentary evidence that children were supported with funding by the service after they turned 18 years once they had engaged in an educational programme.

Although, inspectors did not find evidence that young people leaving care had come to harm, the plans for some young people were not clear and the area did not have a dedicated after care service. There was an arrangement in place with an external agency to provide an aftercare service. However, there was a waiting list for this service. Data provided by the area demonstrated that there were 63 out of 429 (15%) children over the age of 16 years. Of these 21 (33%) had not yet been referred to the aftercare service and 57 (90%) did not have an allocated after care worker. Through review of a sample of case files, inspectors found that plans for when young people left care were sometimes documented within care plans. However, in other cases the plan for when young people left care was not clear and there was no formal after care plan in place.

### **Assessing and reviewing foster carers**

Foster carers' assessments were comprehensive and robust, but were not always undertaken in a timely manner. The assessment process supported the identification and approval of suitable carers by the area but the delay impacted on the numbers of non relative foster carers available. It also meant that children were placed for considerable periods of time with relative carers whose suitability to meet their care and safety needs had not been ascertained.

Inspectors found evidence that the interim assessment process for relative foster carers when children were placed with them in emergency situations was robust in the main. This included preliminary assessments of accommodation, and medical and local area checks completed by both child protection and fostering assessment social workers. Data provided by the area demonstrated that there were five relative foster carers for whom Garda Síochána vetting had not yet been completed.

Inspectors examined records of foster carers who had been approved by the foster care committee. All approved non relative and relative foster carers had undergone a formal assessment carried out by professionally qualified social workers. These assessments were thorough and covered a wide range of aspects of issues about carers' lives and their abilities. Foster carers told inspectors that they had found the process thorough but fair. All non relative foster carers were approved by the foster care committee prior to children being placed with them. Inspectors found that the average timeline to complete assessments for both relative and non relative foster carers ranged between six months to over a year which greatly exceeded the timelines proposed in the national standards. There was documentary evidence to show that assessments, once completed, were presented to the foster care committee in a timely manner for approval.

Data provided by the area demonstrated that there were 20 relative foster carers on a waiting list for assessment and 26 were currently undergoing assessments, all of whom had children placed with them. It was good practice to place children coming into care

with their relatives as a first option, but delays in starting and carrying out assessments created a potential risk to children should relative foster carers be deemed to be unsuitable following their full assessment. Inspectors identified a significant risk whereby there were a small number of relative foster carers on whom an assessment had not been commenced but had children placed with them since 2012. The area manager reported that the delay and backlog was due to limited resources and that a regional assessment team was being established which it was proposed would undertake assessments of all relative foster carers and hence increase the capacity of the fostering team to deal with other prioritised areas of work.

Although there were processes in place for the An Garda Síochána initial vetting and re-vetting of all adults in foster care households, there was a short fall. Inspectors found that 105 out of 309 (34%) relative and non relative foster carers had not been re-vetted in the past three years. The area manager and principal social worker provided assurances to inspectors that these were actively being sought from foster carers. This was verified through case file review.

Formal processes for the review of all foster carers in line with regulatory requirements were at an early stage of development but not well developed. This meant that the area could not be assured that all carers continued to have the capacity to provide high quality care and meet the needs of individual children in their care. Data provided by the area demonstrated that 32 (10%) reviews of foster carers had been undertaken in the past 12 months. Inspectors found that where reviews had been completed they were comprehensive and that where clear needs were identified for training, there was evidence that this was followed through on. However, there was evidence that 192 (62%) foster carers had not had a review for more than three years contrary to regulatory requirements. Although, there was evidence that the outcome of some reviews had been presented to the foster care committee, the fostering team leader reported that the outcome of all reviews completed had not been submitted to the committee. This meant that the Foster Care Committee could not be assured of the suitability of foster carers to provide care for children in the area on an ongoing basis.

Inspectors found, through case file review and interview with staff and carers that there were a number of carers in the area who had been approved for short term placements, but children had been placed with them for longer periods without re-presenting to the foster care committee. Consequently these carers were providing long-term care for which they had not yet been approved. This meant that children may have been placed with carers who did not have the capacity to meet their needs on a longer term basis. The principal social worker reported that the delay was due to limited availability of fostering social workers to complete assessment reports to present to the committee.

### **Supports for children with complex needs**

Some supports were provided for children with complex needs but there were insufficient placements where foster carers could meet such needs.

Data provided by the area demonstrated that there were no special foster care places within the area. The area manager and principal social workers reported that placements for teenagers and children with behaviour that challenges were hard to find within the area and that some placements had ended due to challenges posed for foster carers in caring for children's complex behaviour. As a consequence a number of these children were placed with non-statutory agencies outside of the area at a distance from their families. Inspectors reviewed a small number of case files where it was unclear as to what supports had been put in place for children with behaviour that challenges and for their carers. There was limited evidence of specific training provided to foster carers for children with behaviour that challenges and complex needs.

Data provided by the area demonstrated that there were 13 children in foster care whose placements had ended in an unplanned way in the last 12 months. Inspectors found that the reasons for these unplanned endings related to issues such as incompatibility of foster carers and children, change in foster carer's personal circumstances, allegations against foster carers and an inability of some carers to manage specific behaviours. Inspectors reviewed a sample of unplanned ending files and found that each of the children had complex behaviour needs such as sexualised behaviour, physically assaultive behaviours and psychological issues. Inspectors considered that foster carers would need both experience and high levels of specialist supports (psychologists, behavioural specialists, etc.) to manage these placements and these were not always in place in the sample of cases reviewed, although good practice was also noted, such as the involvement of social care staff in working directly with children and carers and the involvement of specialist services. The area had a therapy committee which met on a bi-monthly basis which considered and approved the provision of specialised support for children in care. This support was frequently sourced from a private provider. The principal social worker reported that processes had been put in place to undertake disruption reports for all recent breakdowns. There was evidence that information on unplanned endings was not always presented to the foster care committee for oversight or formal review of placement endings. Social workers reported that formal exit interviews were not always conducted with children or carers post a placement breakdown to identify issues that might affect a future placement. This meant that the services' ability to learn from these unplanned endings was undermined, that breakdowns in the future might not be prevented and that the urgency of seeking specialist supports could not be supported by robust evidence.

### **Supports and supervision for foster carers**

Not all foster carers had sufficient access to the necessary information, advice, supervision and support required to enable them to provide high quality foster care.

Data provided by the area demonstrated that 176 out of 309 (57%) foster carers had a link worker allocated to them. The majority of foster carers with a link worker who spoke to inspectors reported that they received regular visits, felt well supported and that the social work department was approachable and responsive to them. Inspectors reviewed case notes which verified that these carers received regular visits and that link workers also met with children of foster carers on visits. There was evidence that some support groups were in place for foster carers but that the level of attendance was low.

Foster carers who met with inspectors were aware of their duties and were considered to provide good care and support to children placed with them. The area manager reported that in the Kildare West Wicklow area, new arrangements had been put in place within the previous month whereby a dedicated social worker was being assigned with responsibility to deal with cases that did not have an allocated link worker and it was hoped that this person would undertake visits and actively follow up on all these cases. In the Dublin South West area, management of unallocated cases was the responsibility of the Team leader. A number of foster carers without a link worker told inspectors that they had received written notification from the fostering team leader advising them to contact him/ her if they had any issues, which they found helpful in terms of having a named contact person.

One hundred and thirty three foster carers (43%) did not have a link worker allocated. Through review of case files, inspectors found that some of these foster carers did not receive regular visits in line with the standards. Inspectors identified a number of cases where a foster carer had not been visited for an extended period. For example, one of the case files reviewed by inspectors did not have a monitoring visit since 2012. The principal social worker reported that within the constraints of staffing shortages that link workers were allocated to foster carers based on those with need for greatest support. Inspectors found that this process was not formalised and that documentary evidence to verify this was not robust. Through case file review and interviews with foster carers, inspectors found that carers were not always provided with sufficient information, in terms of a child's background and medical history, prior to a placement being made so carers may not have been prepared or equipped to meet a child's needs. There was no formal out-of-hours service to support foster carers and this is a national issue. Link workers' supervision meetings with foster carers were not clearly documented in case files reviewed. Although case notes recorded support and advice given, there were no records in the files reviewed to demonstrate that foster carers practices or abilities to meet children's needs were being formally monitored so that deficits could be addressed. Link workers told inspectors that they discussed issues relating to the performance of foster carers with team leaders at their formal supervision meetings. However, due to the large caseloads assigned to each link worker, not all cases could be discussed at each supervision session. This was verified through review of supervision records which it was noted occurred on a four to six weekly basis and focused on cases where there were issues arising or any concerns.

Inspectors found that some allegations made against foster carers were not managed and investigated in line with Children First: National Guidance for the protection and welfare of children, 2011 (Children First, 2011). Data demonstrated that three allegations had been made against foster carers and reported to the foster care committee within the past 12 months. Inspectors reviewed each of these and found that the management and investigation of a number of the cases had not been timely or in line with the requirements as outlined in Children First, (2011). For example, An Garda Síochána notification had not been made in one of the cases and the completion of initial and child protection assessments had not been timely. As referred to elsewhere in the report, inspectors identified that other allegations made against foster carers, although appropriately investigated, had been inappropriately logged as complaints. This meant that the area were underestimating the number of allegations which had

been made against foster carers and hence may have been missing opportunities to learn lessons and improve services.

## Judgment

Standard	Judgment
<b>Standard 5 The child and family social worker</b>  There is a designated social worker for each child and young person in foster care.	Requires improvement
<b>Standard 6 Assessment of children and young people</b>  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	Meets the standard
<b>Standard 7 Care planning and review</b>  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.	Requires improvement
<b>Standard 8 matching carers with children and young people</b>  Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children and young people.	Requires improvement
<b>Standard 13 Preparation for leaving care and adult life</b>  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.	Requires improvement
<b>Standard 14a Assessment and approval of non-relative foster carers</b>  Foster care applicants participate in a comprehensive assessment of their ability to	Requires improvement



carry out the fostering task and are formally approved by the health board prior to any child or young person being placed with them.	
<b>Standard 14b Assessment and approval of relative foster carers</b>  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.	Requires improvement
<b>Standard 15: Supervision and support</b>  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.	Requires improvement
<b>Standard 17: Reviews of foster carers</b>  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.	Requires improvement

## **Theme 5: Leadership, Governance and Management**

*Effective governance in services for children is accomplished by directing and managing activities using good business practices, objectivity, accountability and integrity. In an effective governance structure, overall accountability for the delivery of services is clearly defined and there are clear lines of accountability at individual, team and service levels so that all people working in the service are aware of their responsibilities and who they are accountable to.*

### **References:**

#### **National Standards for Foster Care (2003)**

Standard 18: Effective Policies

Standard 19: Management and Monitoring

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

Standard 23: Foster Care Committee

Standard 24: Non Statutory Agencies

Standard 25: Representation and Complaints

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

Part III, Article 5: Assessment of foster parents

Part IV, Article 12: Maintenance of a register

Part IV, Article 14: Fostering allowance/financial and other assistance

Part IV, Article 15 Support services for foster parents

Part IV, Article 17 Supervision and visiting of children

Part IV, Article 22 (2): Termination of placement by Health Board

Part VI, Article 24: Arrangements with voluntary bodies and other person

Part VI, Article 27: Placement of child with person in another area

#### **Child Care (Placement of Children with relatives) regulations 1995**

Part III, Article 5: Assessment of foster parents

Part IV, Article 12: Maintenance of a register

Part IV, Article 14: Fostering allowance/financial and other assistance

Part IV, Article 15 Support services for foster parents

Part IV, Article 17: Supervision and visiting of children

Part IV, Article 22 (2): Termination of placement by Health Board

Part VI, Article 24: Arrangements with voluntary bodies and other person

### **Effective leadership, management structures and systems**

Robust management and governance structures were in place but systems in place were not robust.

Although a number of changes had recently been made to the governance arrangements, the area had clearly defined governance and accountability structures in

place. Staff who met with inspectors were clear about their roles and responsibilities, including their reporting arrangements and lines of accountability. Social workers told inspectors that they were held to account for their practice decisions through their supervision meetings with team leaders. Likewise, team leaders reported that practice issues would be discussed as part of their supervision meetings with principal social workers, with decisions reached regarding actions required. This was verified through review of supervision records where it was also evident that performance issues, of individual staff members, was formally managed.

While some of the management structures in place were effective, there were a number of significant deficiencies and inspectors found that the management oversight was not robust. Inspectors found that managers monitoring and prioritisation of cases was not always formalised or appropriately recorded. The area had a suite of national policies in place which had been signed off by the national director of CFA. However, a number of these had not been fully or consistently implemented in the area, such as the 'Foster Care Committee Policy, Procedure and Best Practice Guidance' (2012) and the 'Leaving and Aftercare Services' (2011) national policy and procedure document. Inspectors found that inter area transfers when they happened worked generally well. Data provided by the area suggested that there were three cases awaiting transfer outside of the area and one awaiting transfer into the area. However, it was evident that there were a number of long-term placements outside of the area which had not been put forward for inter area transfer. For example, inspectors reviewed a case which was ready for transfer and requested since 2008 to Wexford. However, the transfer had not progressed nor did it appear to have been followed up on by the area. Inspectors reviewed the areas register of children placed with foster carers and panel of foster carers, but found that the register was not complete in a number of cases or did not fully comply with the requirements as outlined within the standards and regulations. Hence, the structures in place to support the management and monitoring of the foster care services, was not robust.

## **Planning**

The communication systems put in place by the area supported the sharing of information and the implementation of decisions between national, regional and local levels. However, the communication of risk required improvement and plans for the delivery of services were not formalised.

A regional operational and strategic plan were reported to be in the process of being developed at the time of inspection but had not been completed or implemented in the area. An action plan dated 2014 relating to specific targets for the fostering service had been put in place but timelines and person responsible were not always recorded. Inspectors reviewed a fostering strategy position paper dated May 2014, which included an assessment of risk within the regional fostering team. However, the area did not have a formal risk management framework in place which was clearly understood by staff and addressed operational risk. There was evidence that risk assessments and a risk register had been developed by the area but it was not being maintained as an up-to-date or living document. Inspectors noted that some risks had not been formally assessed. For example, there was a risk associated with children who had no allocated

social worker living with a foster carer who had no allocated link worker, meaning that no professional was routinely visiting the household. As a result inspectors considered that the communication of local risk to the area manager, principal social worker and team leaders was not robust and could be improved so as to ensure that service planning was informed by an appropriate assessment of all pertinent risks in the area.

Inspectors found that formal communication took the form of a series of monthly meetings held at various levels within the service. The services director and area manager met formally on a monthly basis. Social workers reported that communication at a local level was generally good. The area had held two service planning days with staff in 2014. Inspectors reviewed a strategy position paper dated May 2014, which included an assessment of risk within the fostering team in the region. Data provided by the area demonstrated that 36 adverse events and 63 'Need to Know' events had been recorded by the area in the preceding 12 month period. Inspectors reviewed a sample of these and found that they had been appropriately reported and managed.

## **Quality Assurance**

The service had some informal quality assurance processes in place but no formal quality assurance or monitoring system. This meant that there were limited arrangements to ensure that the service was compliant with standards, regulations, policies and legislation or that the service was safe and of a good quality for foster children.

Inspectors reviewed documents which demonstrated that the area collected data on monthly key performance indicators, which were submitted to the CFA National office. The principal social workers and team leaders reported that supervision meetings were used to monitor the quality of services and to agree areas for service improvement. The area used the CFA's 'Framework for measuring and managing and reporting social work intake assessment and allocation activity as a tool to monitor workloads and assess risk within social work teams but acknowledged that it was not specific to the foster care service.

Inspectors found that a quality monitoring system was in the early stages of development and a member of staff at principal social worker level had been assigned with a quality improvement role in the months preceding the inspection. However, limited initiative had been taken. There was no evidence that a satisfaction survey had been undertaken with children and families to determine the quality of the service which they received. There was evidence that some audits of case files had been done in the past but these had not been being routinely undertaken during the past 12 months. There was no evidence that a formal audit of compliance against the standards and regulations had been carried out.

There were 25 children placed with non- statutory agencies at the time of this inspection. There was evidence that non statutory agencies undertook reviews of foster carers. The area did not have formal service level agreements in place with non- statutory agencies used so formal arrangements were not in place for the monitoring of

the safety, effectiveness and value of the services provided by these agencies. There was some documentary evidence that meetings took place with some of the agencies used but these were not always at regular intervals so that the service could monitor or assure itself regarding the services being delivered.

### **The foster care committee**

There was an effective Foster Care Committee in place. However, the national 'Policy, Procedures and Best Practice Guidelines for Foster Care Committees, 2012' was not being fully implemented and some of the work of the committee was not being undertaken in accordance with the standards and regulations.

Overall, inspectors found that the Foster Care Committee had carried out its functions to a good standard in an effective and efficient way. The committee was made up of people with an expertise and experience in child welfare and foster care and that the chairperson was independent and had suitable expertise. Inspectors found that all members of the foster care committee had appropriate Garda Síochána vetting and had received training pertaining to their role on the committee. Inspectors reviewed the committee's annual report for 2013 which had recently been drafted and submitted to the area manager as required by the national policy. There was evidence that the committee met on a regular four to six weekly basis with meetings generally lasting for the duration of a full day. Inspectors reviewed minutes of foster care committee meetings which showed that foster carer assessments once completed and submitted to the committee were dealt with in a timely manner with rationale for decisions made clearly recorded.

Inspectors found that the Foster Care Committee did not meet a number of requirements as outlined in the national policy. All allegations, placement breakdowns, or complaints against foster carers were not notified to the Foster Care Committee within the required timelines. Reports pertaining to investigations of these allegations, placements breakdowns or complaints were not always presented to the committee when completed. The chair of the Foster Care Committee and the area manager reported that the committee did not formally contribute to service planning in the area. As referred to elsewhere in this report, reviews of all foster carers were not being routinely undertaken or submitted to the committee. This meant that the foster care committee could not be assured of the suitability of foster carers to provide care for children in the area on an ongoing basis. Inspectors found that reports presented to the committee regarding long term approval were generally addendum reports versus a full long term assessment report. The chair of the Foster Care Committee told inspectors that this issue had been raised with the area manager and would be addressed over the coming period.

### **Recruitment and retention of an appropriate range of foster carers**

The area did not have a formal strategy in place for the recruitment and retention of foster carers. This meant that the area was at risk of not having an appropriate range

of foster carers to meet the diverse needs of children in the area, and in fact this was the case at the time of inspection.

The retention rates for foster carers in the area was good, despite the fact the area did not have a proactive strategy in place. Data provided by the area demonstrated that no foster carers had left the panel in the preceding 12 month period.

The last recruitment drive in the area was in 2012 and there was no active strategy in place to recruit foster carers. The fostering team leaders and social workers reported that limited resources negatively impacted on the timelines for responding to enquiries and for completion of assessments for potential applicants. Data provided by the area demonstrated that 68 enquiries and 12 applications from potential foster carers had been received by the area in the past 12 months. The area manager and fostering principal social worker told inspectors that the service did not have the capacity to process new applicants at the time of inspection. As a consequence the deficit in terms of the numbers of foster carers in the area was unlikely to be addressed.

Inspectors found that weaknesses in the supports in place for foster carers could undermine the retention of foster carers and stability of placements. For example, and as referred to elsewhere in the report, not all foster carers had an allocated link worker or regular visits from a link worker and foster carers attended limited ongoing training. Data provided by the area demonstrated that there were 18 children awaiting foster care placement at the time of inspection. The area manager told inspectors that there were a limited number of foster carers in the area to meet the demand for services which necessitated some children being placed with non statutory carers outside of the area. Inspectors found that there were insufficient foster carers from different cultural and ethnic minority backgrounds.

## Judgment

Standard	Judgment
<b>Standard 18 Effective Policies</b>  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.	Requires improvement
<b>Standard 19 Management and monitoring of foster care services</b>  Health boards have effective structures in place for the management and monitoring of foster care services.	Requires improvement
<b>Standard 21 recruitment and retention of an appropriate range of foster carers</b>	Requires improvement

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.	
<b>Standard 23 The foster care committee</b>  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.	Requires improvement
<b>Standard 24 Placement of children through non-statutory agencies</b>  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.	Requires improvement