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:	Midlands	
Dates of inspection:	17 – 19 May 2016 23 – 25 May 2016	
Number of fieldwork days:	6	
Lead inspector:	Niamh Greevy	
Support inspector(s):	Eva Boyle Caroline Browne Erin Byrne	Una Coloe Ann Delany Ruadhan Hogan
Type of inspection:	☒ **Announced** ☒ **Full**	☐ **Unannounced** ☐ **Themed**
Inspection ID:	**758**	

About monitoring of Statutory Foster Care Services

The Health Information and Quality Authority (HIQA) monitor 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 continuous 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 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, the Authority carries out inspections to:

- **assess** if the Child and Family Agency (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 action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

HIQA inspects services to see if the National Standards are met. Inspections can be announced or unannounced.
This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child-centred Services	☒
Theme 2: Safe and Effective Services	☒
Theme 3: Health and Development	☒
Theme 4: Leadership, Governance and Management	☒
Theme 5: Use of Resources	☒
Theme 6: Workforce	☒

1. Inspection methodology

As part of this inspection, inspectors met with children, parents and or guardians, other agencies and professionals involved in foster care services. Inspectors observed practices and reviewed documentation such as care plans, relevant registers, policies and procedures, children's files and staff files.
During this inspection, the inspectors evaluated the:

- quality of care and safety of the service
- organisation and management of the foster care service
- assessment of foster carers
- safeguarding processes
- effectiveness of the foster care committee
- effectiveness of interagency and multidisciplinary work
- oversight of children placed with non-statutory agencies
- outcomes for children.

The key activities of this inspection involved:

- the analysis of data
- reviewing local policies and procedures and minutes of various meetings
- reviewing 111 children's case files
- reviewing 82 foster carer's files
- meeting 27 children
- visiting 10 households
- interviewing 33 foster carers
- meeting with six young people using the aftercare service
- meeting with one group of children in care social workers
- meeting with one group of aftercare workers
- interviews with fostering link workers
- interviews with children in care, fostering and child protection team leaders
- interviews with the area manager and principal social workers
- interview with the chairperson of the foster care committee
- meeting with the aftercare coordinator
- observation of two child-in-care review meetings
- observation of a training planning meeting
- interviews with five parents.

Acknowledgements

HIQA wishes to thank the children, parents, staff and managers of the service for their cooperation with this inspection, and foster carers and children who welcomed inspectors into their homes.

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. 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
- service response to 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 the Health Information and Quality Authority (HIQA) in each of the 17 service areas. Tusla also places children in privately run foster care agencies and has specific responsibility for the quality of care they receive.

2.2 Service Area[1]

The Midlands Area comprises the counties of Laois, Offaly, Westmeath and Longford. The area is predominantly rural in nature and has five main urban areas, Portlaoise, Tullamore, Athlone, Mullingar and Longford.

Based on the 2011 census of population, the area had a population of 282,410 of whom 77.726 (6.8%) were between 0-17 years. The Pobal HP deprivation index (SA) would classify the Midlands area as disadvantaged.

The area is under the direction of the service director for Tusla, Dublin Mid Leinster and is managed by the area manager.

The service comprised of three principal social workers (PSWs) – one with responsibility for duty intake, one child protection and welfare and one for children

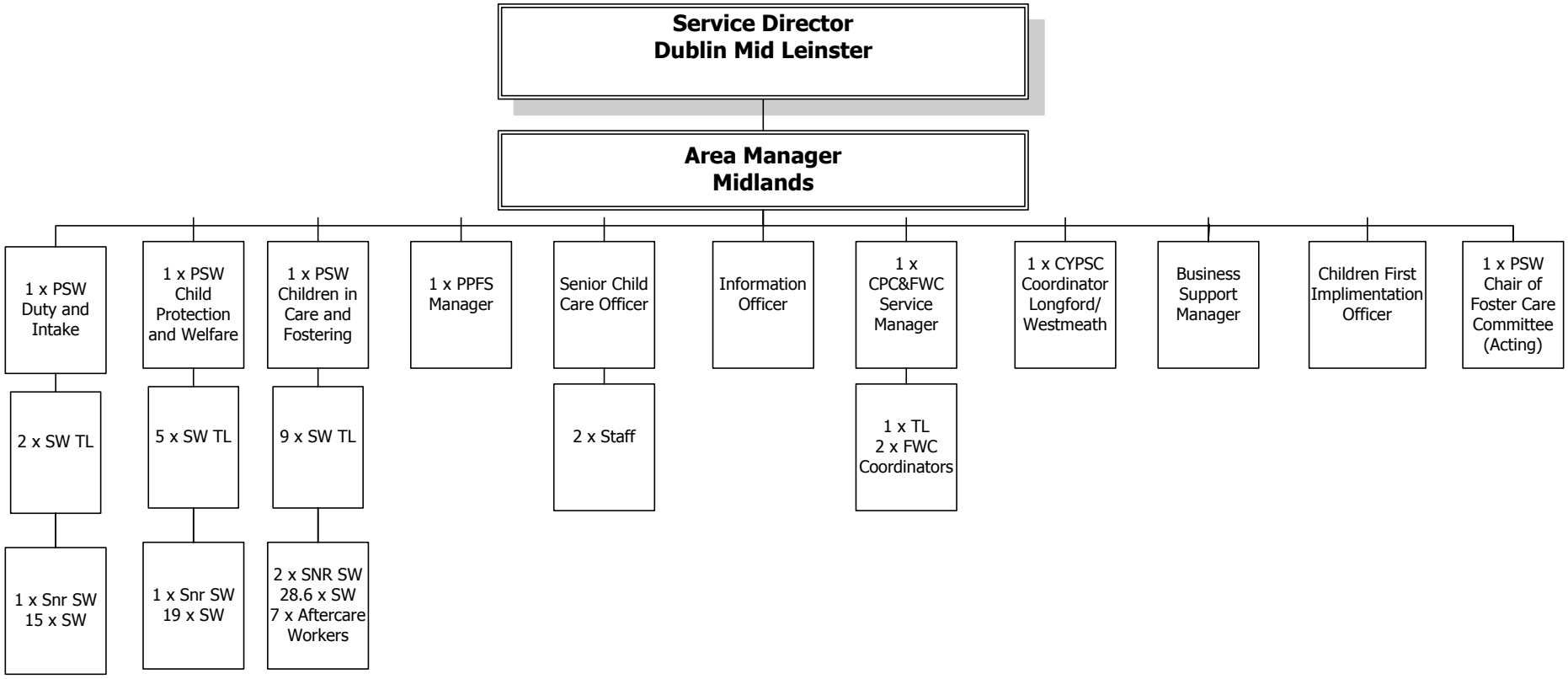
[1] Source Child and Family Agency Midlands service area

in care and foster care. A manager for Partnership, Prevention and Family Support and two chairs of child protection conferences/management of the family welfare conference service. Services were based within the five main urban areas.

At the time of the inspection there were 357 children in foster care. Of these 101 children were placed with relatives and the remaining 256 children were placed with general foster carers.

The organisational chart in Figure 1 on the following page describes the management and team structure as provided by the service area.

Figure 1: Organisational structure of Statutory Foster Care Services, in Midlands Service Area*



* Source: The Child and Family Agency
CPC = Child protection conference
CYPSC = Children and young people's services committees
FWC = Family welfare conference
PPFS = Partnership, prevention and family support
Snr SW = Senior social worker
SW = Social worker
SW TL = Social work team leader

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 inspection, which are set out in Section 5. The provider is required to address a number of recommendations in an action plan which is published separately to this report.

In this inspection, HIQA found that of the 26 standards assessed:

- no standards were met
- 20 standards required improvement
- significant risks were identified in relation to six standards.

This report sets out the findings of the inspection of the Midlands foster care service. Overall, there was a lack of placements in the area and social workers sought placements within children's families and communities. However, a lot of children's placements were crisis led. Inspectors identified a number of serious risks over the course of the inspection and the following were escalated at the end of the fieldwork:

- In high-priority, unallocated children-in-care cases, safeguarding visits had not taken place. Where they had taken place they were not always of a good quality to provide assurances to Tusla around potential or known risks.

- There were long delays in the commencement and completion of Section 36 assessments and in achieving a decision from the foster care committee – some children have been placed since as far back as 2011 without a decision being reached.

In addition, 12 of the 111 children's cases sampled and one in 10 of the foster carer's cases sampled were escalated by the inspection team to the principal social worker for review due to a lack of timeliness and or appropriate action.

Overall, children's rights were respected and promoted, but 8% of children did not have an allocated social worker and there was neither a social worker nor link worker assigned in nine children's placements. Almost half of all children in care did

not have an up-to-date written care plan. Due to a limited number of placements, matching children to foster carers was not always possible and 41 children were placed outside of the local area at the time of inspection. However, the vast majority of children had warm relationships with their foster families, continued contact with their birth families, some supports and were involved in a range of activities. Children reported positively about the aftercare service, but also spoke about the impact of placements far from home on their relationships with family and friends.

The assessment of general foster carers was good and there was a regional initiative in place to process new fostering applications. While there was a system in place to conduct fostering reviews, reviews did not occur on a consistent basis in response to unplanned endings or where allegations had been made. The support received by foster carers varied, and the quality of supervision of carers needed improvement.

The service had experienced significant changes in the structure, management team and systems over the last 15 months. Key roles, including that of the Area Manager, within the current management team had been appointed within the previous six to eight months on an interim basis and were given the responsibility of leading the service and creating stability. The Area Manager was endeavouring to put systems in place to support the service towards better outcomes by implementing a management improvement plan. However, there remained significant challenges in managing cases awaiting allocation, completing assessments on relative carers, ensuring children had up-to-date care plans and foster carers having timely reviews.

The foster care committee was not operating in line with Tusla policy. The committee, while appropriately constituted, had not received formal training in relation to their role and responsibilities. In addition, the committee were not receiving all appropriate information, including disruption reports, allegations and foster carer reviews. In turn the committee did not have a formal system to track its own decision-making where information was outstanding.

There was insufficient planning in relation to the use of resources and services. Information systems were not fit for purpose for the service. However, a new system was due to be operational by the end of May 2016. The quality of record keeping in the service varied.

The workforce were skilled and competent but the management team had identified that they required additional resources. In addition, placements outside of this service area meant that social workers spent a considerable amount of time travelling to and from foster placements to meet with children. Training opportunities for staff had improved and in general, there was some good supervision occurring.

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 standards were met as follows:

- **Exceeds standard –** services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

National Standards for Foster Care	**Judgment**
Theme 1: Child-centred Services	
Standard 1: Positive sense of identity	Requires improvement
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
Theme 2: Safe and Effective Services	
Standard 5: The child and family social worker	Requires improvement
Standard 6: Assessment of children and young people	Requires improvement
Standard 7: Care planning and review	Significant risk
Standard 8: Matching carers with children and young people	Significant risk
Standard 9: A safe and positive environment	Requires improvement

National Standards for Foster Care	**Judgment**
Standard 10: Safeguarding and child protection	Significant risk
Standard 13: Preparation for leaving care and adult life	Requires improvement
Standard 14a: Assessment and approval of non-relative foster carers	Requires improvement
Standard 14b: Assessment and approval of relative foster carers	Significant risk
Standard 15: Supervision and support	Requires improvement
Standard 16: Training	Requires improvement
Standard 17: Reviews of foster carers	Requires improvement
Standard 22: Special Foster care	Requires improvement
Theme 3: Health and Development	
Standard 11: Health and development	Requires improvement
Standard 12: Education	Requires improvement
Theme 4: Leadership, Governance and Management	
Standard 18: Effective policies	Requires improvement
Standard 19: Management and monitoring of foster care agency	Significant risk
Standard 23: The Foster Care Committee	Significant risk
Standard 24: Placement of children through non-statutory agencies	Requires improvement
Theme 5: Use of Resources	
Standard 21: Recruitment and retention of an appropriate range of foster carers	Requires improvement
Theme 6: Workforce	
Standard 20: Training and Qualifications	Requires improvement

5. Findings and judgments

Theme 1: Child-centred Services
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.

Summary of Inspection Findings under Theme 1

While the rights of children were often respected and promoted, children who did not have an allocated social worker did not receive the same level of advocacy as their peers. The quality of the service received by children with diverse needs was varied, as was the quality of communication with children. Complaints were not effectively managed.

Overall, children maintained positive relationships with their family but sibling groups were not always placed together in line with their care plan and it was more difficult for children placed outside of their communities to have regular contact with their family.

Children's rights

Children's level of understanding about their rights varied. Some children visited by inspectors had a full or partial understanding of their rights. However, other children had not been given information about and did not have an understanding of their rights. Children who had an allocated social worker were given information about their rights but this was not always reflected in records.

The rights of children who had an allocated social worker were usually respected and promoted. Where children had an up-to-date care plan, some rights were promoted through clear plans for family contact and access to services. Inspectors found some social workers had completed good-quality direct work with children around their rights. However, for children who did not have an allocated social worker, they did not have the same opportunities to meet with social workers and to develop trusting relationships with a social worker.

Records did not show that any children had accessed their file. Some young people told inspectors that they knew they had a file but had not accessed it, while other children told inspectors that they did not know that they could access their file.

Some social workers told inspectors that children were aware they had a file but there was no record on files sampled that children had read their files.

There were occasions when children were not listened to. Inspectors found that some children felt able to raise issues with their social worker, and had these issues resolved as a result. However, other children reported that they were not listened to.

There were a small number of incidents where the wishes of children were not respected, for example, around how their personal information was managed or having contact with family. For some children and families, there was poor communication with the social work department which meant that there may be barriers for parents to raise any future concerns with the social work department. Children's rights were often advocated for by their allocated social worker but some children also had a court appointed guardian ad litem, whose role was to represent the views of the child in court. In addition to this, the service was liaising with EPIC, a national organisation that advocates for children in care, in order to establish a group of children in care to inform service provision.

Diversity

The quality of care provided to children with diverse needs varied. Inspectors reviewed a range of cases where children were from diverse ethnic or religious backgrounds, or had a disability. There was evidence of timely assessment, and good planning and co-ordination of services for some children in order to meet their needs.

Considerable efforts were made by social workers to follow parents' wishes around cultural practices, maintain contact with parents who were difficult to locate and provide supports for children. However, children's ethnicity was not always identified in care plans or recorded in their files. Some children were placed in culturally appropriate placements, while others were not. It was a challenge for the service to meet the cultural needs of children who were not placed in culturally appropriate placements. While other measures were put in place to address these needs in some cases, this was not the case for others. Some children did not know about their ethnic background and planned work to address this was delayed due to carers having no allocated link worker. The shared rearing project, which provided culturally appropriate placements to children from the travelling community, was available in the Midlands area but children had not been placed through this project. The need for training for foster carers around caring for children with diverse needs had been identified by the area and diversity training for foster carers was scheduled for June 2016.

Some children with a disability had good access to appropriate services but others did not. Some foster carers received good supports to manage children's disability. However, for others there was no plan in place around the children's additional support needs. Inspectors found that carers were not always given information about the child's particular needs and some carers reported that they did not get enough support when caring for children with disabilities.

Communication

The quality of communication by the service with children and families was inconsistent. Inspectors found evidence of good collaboration between professionals, children and families. Where children had additional communication needs, relevant staff were trained to use sign language to communicate with them but other communication systems, such as a Loop system, were not available within the service to assist children with sensory disabilities.

Children were provided with information in an accessible way that helped them participate in decision-making. For example, inspectors reviewed records of direct work with children that helped them to have a better understanding of issues in their lives. Social workers used resources such as speech and language therapists to find out how best to communicate with children.

Family and Friends

In the main, children had regular contact with their family, in line with their care plan. Almost one in three children, 101 out of 357 children, were placed with relative carers. However, inspectors found a number of cases where contact with birth families had not taken place for many months. This included where children had requested visits but this was not acted on, resulting in long periods where children did not have contact with siblings or parents. This was usually as a result of children not having an allocated social worker.

Due to the lack of available placements within the area, priority could not be given to placing children in their local community. Forty one children were placed outside of the service area. Children told inspectors that being placed long distances from family, for example in a different county, made it difficult for them to see their family. This issue was confirmed by staff.

Again, due to the lack of available placements, priority could not be given to placing sibling groups together, in line with their care plan. Data provided by the area identified that 22 children were placed separately from their siblings. The regularity of contact between siblings in these arrangements varied.

Research shows that developing "a positive personal identity and a sense of personal history is associated with high self-esteem and emotional wellbeing".[2] However, inspectors found that some children were not always aware of their family background or that they were in foster care. This may impact on the welfare of these children, particularly in relation to their understanding of their developing identity.

Family contact arrangements were appropriately developed based on the individual circumstances of each case. Family contact was automatically supervised if there was an ongoing assessment and the service sometimes used private services to supervise family time. In other cases inspectors found that contact was stopped where it was not in a child's best interest. In a small number of cases, visits took place in the foster carers' home, which is promoted by the national standards. In general, significant people in children's lives were kept informed about the children and participated in events, as appropriate. Inspectors spoke to parents about their satisfaction with family contact arrangements and received a mixed response. While most were happy with the arrangements, some parents felt children were losing family connections.

Peer relationships were encouraged and promoted. Children had friends visit them and took part in community activities with their school friends and others. Adoption arrangements were pursued in appropriate circumstances. Inspectors reviewed some cases where adoption was being pursued and found the area had provided their support to the process as needed.

Complaints

The system to record, manage and resolve complaints was not sufficiently robust. It was the policy of the area to manage complaints locally, where possible. Staff were aware of this and inspectors found that some issues were resolved appropriately at this level but were not logged centrally. Data submitted by the area indicated that there had been five complaints, one of which was from a child, in the last 12 months. However, inspectors identified a number of other complaints in files that were not identified or managed as complaints.

Confidence in the efficacy of the complaints system was mixed. Some foster carers were confident that there would be follow through on complaints, while others carers were fearful that children would be removed from their care if they made a complaint. The response from children and young people was similar, with some

[2] National Institute for Health and Clinical Excellence, Promoting the quality of life of looked-after children and young people. Available from: http://www.scie.org.uk/publications/guides/guide40/files/PH28Guidance.pdf. Page 41 October 2010

children feeling confident that a complaint would be listened to, while others felt it would be ignored.

A review of the complaints register found that complaints were not dealt with in a timely way, full records were not available in relation to the management of complaints and it was unclear if complainants were satisfied with the outcome of their complaint. Records did not show clear correspondence to complainants about the management of their complaint.

Appropriate action had been taken to address some issues that were subject to repeated informal complaints. Working groups had been established to address issues such as family visits, which had become a greater challenge due to the number of out-of-area placements. However, due to the absence of a central record of locally resolved complaints, the area was not in a position to see trends or learn from all of these complaints.

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.

Summary of Inspection Findings under Theme 2

This inspection found the quality of the service provided to children and families varied significantly. Some children experienced comprehensive and ongoing assessment of their needs, along with good co-ordination of services. However, not all children had an allocated social worker and the system in place for child-in-care reviews was not effective as significant numbers of children did not have an up-to-date care plan. The quality of some statutory visits was poor, particularly for unallocated cases. HIQA escalated this risk to the Area Manager at the end of fieldwork and she responded with the steps she was taking to address the identified risk.

Where foster care assessments were completed they were of good quality. However, timeframes for bringing relative foster care assessments to their conclusion was not adequate. Following the fieldwork HIQA escalated risks associated with outstanding relative foster care assessments to Tusla. Although Tusla's response identified a plan with timelines to address outstanding relative carer assessments, the timeframe was February 2017. While there was evidence of good practice, the quality of supervision and support for foster carers overall needed to be improved and the majority of foster carers did not have an up-to-date review.

Child protection concerns were not always managed in line with Children First (2011) guidance.

Assessment and Care Planning

Child and Family Social Worker

Not all children had an allocated social worker. At the time of inspection there were 27 children who did not have a social worker. Some of these children had been without an allocated social worker for long periods in the past, and this had impacted on the quality of care that they had received. HIQA wrote to the area manager due to concerns about the management of unallocated cases. The area manager responded, identifying the actions which would be taken to improve the efficacy of systems in place to safeguard children who did not have an allocated social worker.

Not all children had received statutory visits as often as they should have. The national standards and regulations for children in foster care require that children are visited by a social worker at least every three months for their first two years in their placement and at least once every six months thereafter. These visits are called statutory visits in this report. While the majority of children had received statutory visits within the months prior to inspection, inspectors found that in the 12 months prior to inspection, a number of children had not been seen by social workers for periods greater than six months. Where visits had taken place, case notes did not consistently reflect whether children were seen alone or not. Some children described poor quality visits that were brief and organised at the last minute while other children told inspectors that they could talk to their social worker about their worries and felt their concerns were taken seriously. Statutory visits are a necessary safeguard, and give children an important opportunity to talk to their social worker about any issues coming up in their placement and in their lives in general. In addition to missing out on such an opportunity, there was also a lack of follow-up on issues relating to the care of these children.

Assessment of Need

Assessments of need prior to or immediately following a placement were not completed consistently. The area used a standardised template to facilitate the assessment process. Comprehensive assessments of need were completed for some children that included health, emotional and behavioural and educational needs. However, some files did not contain this assessment, and as such, records did not always reflect that the child's needs had been assessed to inform how the service could care for them. If children do not have an assessment of need, it is not possible for the service to identify carers who can meet those needs.

Matching[3]

The matching process was not effective. The area had a procedure in place to identify suitable placements for children but only some elements of the process were implemented. This was due to the area having an insufficient number of placement options which undermined the matching process. Insufficient placement options coupled with a lack of assessments of need meant that children were not always matched with carers who could meet their needs. Inspectors found a number of cases where poor matching had resulted in placement breakdowns, such as where children were placed with carers who had children of a similar age.

Care Planning and Review

Care planning was not always effective as it did not occur in line with the regulations. Data provided by the area identified that 45%, or 162 out of 357, of children did not have up-to-date care plans in place. Inspectors found that some children had not had a care planning meeting in over 24 months, including young people over 16 years who should be preparing for leaving care. This meant that these children did not have care plans to meet their current needs. Inspectors found that issues that would normally be addressed through good care planning were not dealt with for some children, resulting in serious drift. For example, actions identified at previous reviews were not followed up or plans had not been updated to reflect their changing needs.

Assessments of need did not always inform care plans. Not all files contained a standardised assessment of need form; although inspectors found that some reports provided by social workers to care planning meetings included an assessment of the child's needs. However, in other cases there was no evidence of an ongoing assessment of children's needs, which is necessary in order to plan for a child's changing needs.

Children were involved in their care planning. Inspectors found that there was good consultation with children as part of child-in-care reviews. A number of children attended their care planning meeting, but a reviewing officer identified that the number of children who attended was lower than she would have hoped for. Social workers did complete age appropriate child-in-care review forms with children that were considered at the care plan meeting. Inspectors observed two child-in-care review meetings which were very child-centred. However, some children and young

[3] Matching is a process that ensures a placement is suitable to meet the assessed needs of a child. This usually occurs in general foster care placements, after the child has spent a minimum of 6 months in the placement. Relative care placements differ in that, the match has been identified at the time of placement and the child usually knows the carer with whom they are placed. The matching process involves an assessment of the match and the presentation of a report to the Foster Care Committee (FCC) recommending (or not) the placement is confirmed as a long-term placement.

people reported that they felt that care plans changed following reviews without them being consulted. Parents, as appropriate, were also invited to care planning meetings and some chose to attend.

Relevant professionals were not always invited to attend child-in-care reviews. Inspectors found that there was good consultation with some services involved in children's lives within the review process and this informed the care plan. However, key professionals such as teachers were not routinely invited to attend child-in-care reviews. While relevant reports were provided by professionals to inform the child-in-care review, this meant that these professionals were not part of developing the care plan.

The quality of care plans varied greatly and plans were not available in a timely manner. Some care plans were of good quality and showed that children and parents were involved in the development of the plan. Inspectors found that these plans were implemented to improve outcomes for children. Other plans did not outline the reason for care, and actions were either vague or demonstrated a lack of progress by repeating actions from previous care plans. There was a significant delay, usually in the region of six months, between carrying out reviews and care plans being available and disseminated to all relevant parties. Not all care plans were signed by those involved in drawing up the plan.

Placement plans were not consistently used and those that were reviewed were of poor quality. Placement plans should give details about the length of placement, outline essential day-to-day needs of the child and be developed based on information contained within the care plan. While placement plans reviewed did outline the purpose of placements, the plan related only to access arrangements, and did not deal with the specific care needs of children in relation to areas such as education and medical needs.

Systems in place to learn from unplanned endings were not consistently implemented. Data submitted by the area showed there were 23 unplanned endings in the two years before inspection. Inspectors found that foster care reviews, disruption meetings and disruption reports were not always completed following unplanned endings. As a result, the causes for placement breakdowns were not identified and the area's senior management team or foster care committee were not able to collate information in order to improve the provision of stable, appropriate placements to children.

Quality of Care

While the quality of care received by the majority of children was good, this was not the experience for all children in foster care. Inspectors observed many examples of

good quality care, where carers celebrated children's achievements and nourished their self-esteem. Children who were visited by inspectors were observed to be well-dressed and living in warm, comfortable homes. Most of the children had positive relationships with carers, were part of the family, and were engaged in a wide range of activities, similar to their peers.

However, inspectors found evidence of some instances where children were treated in a disrespectful way, particularly around unplanned endings. For example, where children had to rely on black plastic bags to move their belongings or carers who refused to give children their belongings on leaving the placement.
While the majority of children had their own bedrooms, inspectors found a small number of examples where children were placed in houses, which caused overcrowding and resulted in unrelated children sharing bedrooms and sometimes beds. These arrangements did not promote privacy or good safeguarding practices.

Health and safety assessments were not always completed. In some cases, health and safety assessments were not completed even where it had been identified by social workers that it was needed. In addition, where health and safety checks had taken place, the recommendations of these assessments were not always followed up. As a result, actual or potential risks associated with some homes were not identified and managed.

Children with complex needs received a mixed quality service. Inspectors found evidence of good interagency work with professionals, up-to-date reports on files, strong advocacy and provision of specialist services where they were needed. Funding for private services was also requested and approved as necessary. In contrast to this, children without an allocated social worker who had complex needs were not assessed and supports had not been put in place as a result.

The level of support for foster carers caring for children with complex needs was mixed. Additional services had been obtained to support carers and inspectors found examples of good preparation being made in advance of the placement of children. In other cases, where children presented with behaviour that challenges, there was little evidence of support and the management of behaviour had not been addressed in the child's care plan. Some foster carers told inspectors they felt they did not get helpful advice from their link workers regarding the management of behaviour that challenges or how to meet the needs of children with a disability. Respite foster care was provided to support placements, but some carers reported that it was not usually timely or agreed clearly.

The area did not have a specialist foster care service. It was identified by the Principal Social Worker that a small number of children needed a care setting that

provided a therapeutic family placement but this was not available in the area and at least one child had been placed in a residential setting as a result.

Over the course of the fieldwork inspectors escalated 12 of the children's files reviewed to the Team Leader, Principal Social Worker or Area Manager in relation to care planning and or safeguarding. In some cases, appropriate paperwork was sourced for the file to confirm work had been undertaken. For others, the Principal Social Worker confirmed in writing the appropriate steps that were being taken to address any deficiencies.

While the quality of work undertaken with young people accessing aftercare was good, not all young people were receiving an aftercare service in line with Tusla policy. The area had an aftercare service, which was led by an aftercare co-ordinator and staffed by seven social care workers. The role of the service was to assess the needs of young people from 16 years of age in relation to being prepared for leaving care, and to develop leaving care and aftercare plans that would give young people the supports they need to implement these plans.

The quality of work undertaken by the aftercare service was good. Work undertaken by aftercare workers around independent living skills, education and health had improved outcomes for some young people. There was good collaboration between young people, foster carers, social workers and aftercare workers in relation to aftercare planning. During the inspection, the area held a consultation forum with young people using the aftercare service to learn from their experiences and planned to use this feedback to inform future service provision. Young people reported very positively about their experience of the aftercare service but named housing as their main concern. This issue was also acknowledged by aftercare workers. A further challenge identified for supporting this group was obtaining services for young adults with a disability. The service was working with a range of agencies to address matters relating to this group.

However, young people did not always receive an aftercare service in a timely manner. Data provided by the area showed that 30 young people over 16 years of age were not receiving an aftercare service in line with Tusla policy. Young people who were unallocated or had not yet been referred to the aftercare service were without a leaving care plan at a time of vulnerability in their lives. The two main criteria for prioritisation for assessment by the aftercare team was the level of need reported by the allocated social worker and 17-and-a-half-year-olds, as they were approaching adulthood.

The quality of aftercare plans was poor and assessment records of young people's leaving care needs were not comprehensive. Inspectors found that assessments and

plans lacked detail and did not reflect the individual needs and circumstances of the young people. Inspectors also found that the work undertaken with young people was often not reflected in plans. Due to this, it was not clear that work being done was based on young people's individual needs.

Foster carers – Assessment, Training and Support

The timelines around the assessment and reviews of foster carers needed improvement. General foster carer assessments reviewed by inspectors were of good quality. Inspectors found that assessments were thorough, and took consideration of the wider family context. While they were not always completed within the 16 week timeframe, some files reflected valid reasons such as where issues arose in network checks. Tusla had implemented a revised strategy for general foster carer assessments in the service area and a regional assessment team were completing all general assessments for the area since December 2014.

Relative foster carers were not assessed in a timely way. Screening checks[4] on relative foster carers were not consistent. There was some good quality screening checks undertaken that involved home visits, references and local An Garda Síochána checks prior to placing children. However, in other cases checks were not completed until a month or longer after children had been placed.

Where relative foster care assessments were completed, they were comprehensive in dealing with potential challenges for carers and were generally of good quality overall. However, none of the cases reviewed had been assessed within the 16 week timeframe set out in the standards.

At the time of inspection, 12 relative foster carers were unallocated and awaiting an assessment, but had children placed with them. Some children were in placements for as long as nine years without the fostering assessment being finalised. There was a risk for these children that their carers would be found unsuitable to be approved as foster carers retrospectively, which would cause a big disruption in their lives when they have to move placement after living with a family for many years. HIQA sought assurances from the area manager and the service director in relation to the timeliness of relative carer assessments. While it was an improvement that there was a strategy in place, with timelines, to address outstanding assessments, it meant that the deadline for assessing some of these 12 foster carers was extended to February 2017.

[4] Screening checks include viewing the environment, checking social work records, speaking to referees and consulting with An Garda Síochána to make sure there is no information that would raise concerns about someone's ability to safely care for a child. These checks should happen before a child moves in with a family.

It was not always clear that children were related to or had an established relationship with carers who were due to be assessed as relative carers. In practice, the definition of a relative carer includes adults within the child's family or who have an established relationship with the child. In some cases children were placed with unrelated carers who they had no relationship with prior to the placement. While such placements allowed children to remain in their communities, these carers were waiting to be assessed as relative carers without having an established relationship with the child. Some of these carers may have been more suitably identified as general foster carers.

The area did not ensure that all carers were appropriate and able to meet the needs of children in their care. Inspectors found that a small number of foster carers who had been refused by the foster care committee continued to care for children, despite concerns about their ability to meet the needs of children in care. Inspectors brought these cases to the attention of the Principal Social Worker who confirmed in writing the appropriate steps that were being taken to address any deficiencies.

Garda vetting for foster carers was in place. Inspectors found that Garda vetting had been obtained prior to completion of assessments for foster carers. However, garda vetting was not always obtained for other adults living in, or with significant unsupervised access to foster homes.

Formal written contracts were not always on file. Inspectors found that contracts were available on some files but not on others. The absence of a contract may lead to foster carers not being fully aware of their roles and responsibilities.

Where foster care reviews took place the reviews were of good quality. However, the system to review foster carers was not effective as reviews did not always take place as required. Where reviews had taken place, they were comprehensive, detailed and usually addressed any issues that were arising. Some reviews included health and safety updates, medical updates and evidence of follow through on actions. Some reviews made a recommendation for training but this was not always followed through.

The majority of foster carers did not have three yearly reviews in line with the standards. The area had a system in place to review all carers and a dedicated reviewing officer who was responsible for bringing all carers' reviews up-to-date. Despite having a dedicated reviewing officer, other work was allocated to this person which delayed the plan to complete all foster care reviews. Reviews were prioritised based on recommendations from the Team Leader and the Principal Social Worker. Apart from every three years, reviews should happen in other circumstances such as

when there is an unplanned ending or an allegation against carers but inspectors did not find that this practice was followed consistently.

Over the course of the fieldwork inspectors escalated one in 10 of the foster carer files reviewed to the Team Leader or Principal Social Worker in relation to assessments and the management of allegations. In some cases appropriate paperwork was sourced for the file to confirm work had been undertaken. For others the Principal Social Worker confirmed in writing the appropriate steps that were being taken to address any deficiencies.

There were inadequate supports in place for foster carers and the quality of supervision and support sessions with foster carers was mixed. Data provided by the area identified that there were 77 foster families without a link worker. Some carers were satisfied with the level of support provided by the social work department. Other carers they told inspectors that they were expected to manage challenging situations without support and were viewed negatively when they asked for social work assistance. In a small number of cases, direct work with children was delayed due to carers not having an allocated link worker.

There was a practice in the area to visit unallocated foster carers every three months but inspectors found that these visits were sporadic, particularly where foster carers were unallocated. In one case, there was a gap of over six months for carers who had temporary approval and were awaiting full assessment. This meant that there was limited supervision and support of foster carers, even where carers were inexperienced or may lack an understanding of their role and responsibilities. Support groups were not being run by the area and it was noted by carers that they missed this source of support.

Although a standard template for supervision and support sessions was in place, some records reviewed by inspectors showed discussions between foster carers and link workers lacked structure and formality. Actions decided in visits were not consistently followed through by link workers; for example, where carers needed to get updated medical checks.

Inadequate supervision of foster carers impacted on the quality of care some children received. Case notes showed conversations were a check-in, rather than used to address issues or develop plans to support the placement. There were some cases of good quality joint visits with the child's social worker where concerns were addressed appropriately with carers. In other cases where there was no link worker, the child's social worker had to address issues with foster carers; for example, where complaints had been made by parents.

The area did not maintain an out-of-hours service for foster carers. As a result, there was no support for carers outside of office hours in the event of an incident. It was identified by some carers that this was an impediment to recommending fostering with the Child and Family Agency to other families who were interested in fostering. Inspectors found that some foster carers had sought enhanced rights where children had been living in a longer term placement. However, foster carers also reported difficulties in applying for these rights where children were in voluntary care. This meant that carers were unable to give consent for school activities where children had been in their care long term.

The majority of foster carers had not completed regular training. Some carers had attended training in areas such as Children First (2011), attachment, suicide prevention and 'dealing with difficulties'. However, a number of foster carers had not attended any training. For example, where training was recommended by the foster care committee to address particular concerns, but this had not occurred. This training deficiency had been identified in a Tusla monitoring inspection in October 2015 but the action plan to address the deficiency had not been implemented. The area had planned training for carers for quarter three and four of 2016 in areas such as aftercare, Children First (2011) and cultural diversity, with further areas of training under development.

Safeguarding and Child Protection

There were inadequate measures in place to protect all children in foster care. Inspectors found that some children had good individual discussions with social workers in relation to keeping safe. Inspectors also found that some children raised concerns with their social worker or foster carer, which is really important to keeping children safe. However, not all children's placements were monitored by an allocated social worker. The service endeavoured to ensure that either foster carers or children placed with them were allocated a social worker but nine children had no allocated social worker, and their foster carers were also without an allocated link worker. Children and foster carers often have competing needs and for this reason, it is good practice for each to have their own allocated social worker, as required by the standards.

The quality of some statutory visits to children without an allocated social worker was poor. Not all children were visited in line with the statutory requirements and for those that were, it was not always evident that children were met on their own. In addition, inspectors found that, in some cases, there was a lack of follow through on issues. For example, welfare concerns for some children had not been addressed for a period of months and patterns of behaviour were not picked up by social workers or team leaders as files had not been reviewed appropriately prior to arranging

visits. As a result of these concerns, HIQA wrote to the Area Manager in relation to statutory visits where children were unallocated and the Area Manager responded with measures the area was going to take to address the risk identified.
Decisions made in relation to children's care were not always underpinned by good safeguarding practices. As a result of a lack of available placements, some children were placed in arrangements, often in an unplanned way, where appropriate safeguarding measures were not taken. For example, children shared beds with unrelated children, or remained in unapproved placements for long periods. Inspectors also found a small number of cases where appropriate measures were not put in place to safeguard children during contact with family members where there was an identified risk. This meant additional measures could have been taken to reduce the risk of children being placed in inappropriate placements or unsafe situations, but were not done in a timely way, or in some cases, not until the issue was identified by inspectors.

Not all child protection concerns were managed in line with Children First (2011). Inspectors found the majority of child protection notifications sampled had been managed in line with Children First (2011) but in a small number of cases, records did not reflect that appropriate actions had been taken. Inspectors brought two cases to the attention of team leaders. One of these was addressed by the Team Leader but the other required escalation to the Area Manager before appropriate action was taken to safeguard the children.

Allegations were not always managed in a timely manner. According to the area's policy, allegations against foster carers should be referred to the duty social work team for assessment. It was evident in recent months that these referrals were being prioritised by the duty team. Inspectors found that while some allegations had been assessed appropriately, there were delays in completing initial assessments of other allegations. In addition, strategy meetings were not always held, as per the policy. Inspectors escalated four cases to the Principal Social Worker who reviewed the cases and took action on one case.

Records in files did not identify that these allegations were consistently notified to the foster care committee in line with Tusla policies. This meant that the foster care committee did not have oversight of all allegations made against foster carers in order to fulfil their role in ensuring that children were placed in safe and suitable placements.

Carers were not always informed that an allegation had been made against them. This meant that these carers did not know about concerns reported about them to the social work department. Some carers reported they were unable to contact a link worker to talk about the allegations that had been made against them.

As a result of these issues, inspectors found systems in place did not support the service to ensure all children were consistently safe in their placements.

While some foster carers had attended Children First (2011) training, and further training was planned in June 2016, not all foster carers had received training in safeguarding and child protection issues.

The social work team and foster carers managed children missing from care in line with policy. Date provided by the area identified that five children had gone missing from foster care within the last 12 months. Files reviewed by inspectors found that these incidents were managed in line with policies and procedures.

Theme 3: Health and Development
The health and development needs of children are assessed and arrangements are in place to meet the assessed needs. Children's educational needs are given high priority to support them to achieve at school and access education or training in adult life.

Summary of Inspection Findings under Theme 3

Children's healthcare needs were met and there was a record of parental consent in children's files. However, records did not reflect that a medical examination had been completed on admission to care, as appropriate. The majority of children were in an educational placement but some children had multiple placements in completely different parts of the country and the lack of planning around this had an impact on their education.

Healthcare Needs

The healthcare needs of children were managed through individual work by social workers and carers. Inspectors found that the health of children improved following admission to care. While the majority of files showed that children had medical assessments on admission to care, this was not reflected in all files. Some children's files showed that children's health needs were assessed and addressed on an ongoing basis, with clear evidence of good co-ordination between the social work department, foster carers and health services to achieve this. In addition to this, files contained medical consent from parents, where appropriate, and records of meaningful conversations between staff and parents to help them understand the need for medical interventions.

Inspectors found that medical card and general practitioner (GP) information was recorded on files. Inspectors also found referrals to appropriate services were made by the social work team and private funding was secured as needed. Some foster carers had received first aid training.

However, some files relating to children-in-care on a long term basis did not reflect how their health needs were being addressed. This was particularly an issue where care plans were out of date or for children who did not receive adequate monitoring by a social worker.

Education Needs

The vast majority of children had an educational placement. However, out-of-area placements had an impact on children's attendance at school. In the majority of cases, there were good efforts to keep children in the same school they attended prior to their admission to care. Some children were also being supported by foster carers who had arranged grinds where it was needed. However, some children had multiple placements in completely different parts of the country and the lack of planning around this had an impact on their education. Data submitted by the area showed that there were five children out of education at the time of inspection.

There was a lack of consistency in planning for children's education. Some children's files had records of good planning around their educational needs but others did not. Schools usually contributed to child-in-care reviews by submitting a report but in some files reviewed, there were no school reports and inspectors did not see evidence of schools being invited to attend any child-in-care review, even where there were identified educational issues.

The quality of engagement with schools impacted on the ability of the service to plan for and meet the educational needs of some children who were not fully engaging in education. While there was evidence of good communication between the social work department and schools for some children, this was not always the case. For example, where poor school attendance was an identified issue, there was no liaison with the educational welfare officer and measures had not been put in place to address the problem. In another case, the responsibility was left with the foster carer to meet with the school to develop a plan to meet the child's educational needs.

Theme 4: Leadership, Governance and Management
Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed and the system is subject to a rigorous quality assurance system. Services provided on behalf of the area are robustly monitored. The Foster Care Committee is a robust mechanism for approving both placements and foster care applications.

Summary of Inspection Findings under Theme 4

Significant changes had occurred in the service's structure, management team and systems over the last 15 months. Key roles including that of the Area Manager within the current management team were appointed within the previous six to eight months on an interim basis and were given the responsibility of leading the service and creating stability. The Area Manager was endeavouring to create stability in the management team and was implementing additional management systems. However, there remained significant challenges in managing cases awaiting allocation, completing assessments on relative carers, ensuring children had up-to-date care plans and timely reviews for foster carers. The foster care committee was not operating in line with Tusla policy.

Management Structures and Systems

Management structures in the area had been unstable due to changes in managers and the interim filling of posts. There was a defined management structure in place with clear lines of accountability and responsibility. Inspectors found that the line management structure was clear to all staff, and staff across the service were aware of the roles and responsibilities of all grades of staff. Over the course of the previous 15 months, the service had four different managers, including the previous chief operations officer of Tusla. The current interim Area Manager, who had previously worked as a principal social worker, was appointed in October 2015 and was endeavouring to provide good leadership and direction.

Staff were carrying significant caseloads and morale on some teams was low, as the pace of work had taken its toll on teams. Inspectors found that social workers provided good quality care to allocated children when they saw them and observed staff teams working diligently and with commitment to their work.

A number of senior and middle managers were in interim posts due to vacancies and long-term leave. Staff stated that they were accountable to managers in a range of ways, through supervision and performance development and within their day-to-day practice. However, not all staff had received a handover on starting in their post and not all managers were familiar with all cases that they were responsible for.

Management systems required further development and improvement. The Area Manager told inspectors that she attended a due diligence meeting on becoming appointed to her position with the Chief Operations Officer and the Regional Service Director. This had provided an overview of the service and the priorities.

There were policies in place to guide practice and there was evidence that new policies had been discussed at team meetings. The majority of social workers were aware of key policies but there was evidence that some policies were not consistently adhered to. For example, the supervision, inter-area transfer, foster care committee and the allegation against foster carers policy. While not all staff were aware of the protected disclosure policy, they were all clear that they would approach a team leader or principal social worker if they had any concerns.

Communication systems were good. The principal social workers reported regularly to the Area Manager through informal day-to-day contact, supervision, management meetings and reports. Staff reported that they were kept up-to-date through staff meetings and team meetings were occurring regularly for each of the teams. In addition, the fostering team, including child in care and link workers, had met twice in the last five months to share issues and identify solutions. The children in care teams held team meetings every two months. These meetings were used to discuss policies, case transfers, the child and family participation group and audits. Fostering team meeting minutes showed good discussion on a range of issues but no agreed decisions, person responsible, or timeframes were recorded on minutes.

Monthly meetings took place between team leaders to discuss unallocated cases and co-ordinate tasks that involved both children in care and fostering social workers. The Area Manger attended senior management team meetings and regional meetings in relation to risk management and the regional fostering service. Inspectors found that the regional fostering service meetings were informative in relation to the number of general foster carers coming on stream.

Staff at different grades were aware of their scope of decision-making, and decisions were made at appropriate levels. Inspectors found that the Area Manager and Principal Social Workers had the ability to source therapeutic supports and private placements were secured with the agreement of the Service Director.

Planning the Service

Despite having a plan set out for the service, in some respects the service was crisis led. The service had a 2016 business plan which identified a number of priorities including decreasing the number of unallocated cases, the introduction of an IT system and the development of the aftercare service. However, the availability of placements was an ongoing issue for the service that had a range of implications and led to crisis management.

Effective management of the service was challenged for a number of reasons including the geographic spread of the area, the lack of available placements and out-of-area placements. Insufficient placements meant it was not possible for matching to be part of day-to-day practice, and at times the area did not have enough placements for children who needed them. Inspectors found that social workers, who had children placed in foster care outside of the area, spent a significant amount of time travelling to visit children and this took them away from direct work with children and families. Forty one children were placed outside of the area. However, the inter-area transfer policy was not implemented for these cases. The service operated out of five offices across four counties and inspectors found that the majority of team leaders managed teams across two offices. One Team Leader had staff in all five offices. This meant that this Team Leader spent a lot of time travelling between offices to oversee and manage the team and this created an unrealistic workload.

Gaps in the workforce had been identified and all vacancies had been approved to be filled. Three team leader positions were assigned to a reviewing officer role[5] for both child-in-care and foster carer reviews. However, the identified management structure for reviewing children and foster carers were not effective as there continued to be considerable waitlists for both child-in-care and foster carer reviews. Inspectors found that this was due to reviewing officers being on leave, in some cases for up to 12 months, and reviews did not always occur in their absence. As a result, children did not have up-to-date care plans and foster carers were not reviewed to ensure they were meeting the needs of the children.

The combination of the lack of these resources compromised the delivery of a safe and effective service.

Risk Management

[5] Team leaders who have line management responsibility for cases usually also have responsibility for chairing child in care reviews. In this area, three independent team leader positions without line management responsibilities were assigned the role of reviewing officer. This involved chairing child-in-care reviews or foster carer reviews and developing the associated reports.

Risk management systems were not robust. While a number of significant risks were known to the service, inspectors found that the identified controls were not effective. For example, inspectors identified significant risks in relation to unallocated children and outstanding section 36[6] relative foster care assessments. Both of these risks were identified on the risk register, but the identified controls had not been successful at reducing the risks.

A system was in place to alert national managers of concerns arising from the management of specific cases that may come to public attention. This system was called a 'need to know' procedure. Eleven 'need to know' reports were escalated from the area to the Service Director in the 24 months prior to inspection. The reports ranged from children missing from care, data protection issues, and specific concerns in relation to cases. All issues escalated were within the remit of the process.

Quality Assurance and Monitoring

Quality assurance and monitoring systems were in the early stages of development and as a result inspectors did not see evidence of improvements resulting from these systems at the time of inspection. Some audits had been undertaken such as records management and supervision audits. Team leaders audited two files per supervision session. However, where audits identified issues on files, records did not reflect that the issues had been addressed. The findings of file audits were not collated for the overall area and therefore patterns or learning were not identified for improvement throughout the service. In addition, not all actions identified following the supervision audit had been implemented consistently. Children's files were in the process of being audited in relation to regulatory requirements and were due for completion by end of June 2016.

Two local reviews had been undertaken in the area by an independent reviewer in the last two years. While both these reports included recommendations, inspectors found that some issues identified were also found during this inspection, such as poor quality background checks of relative carers and a lack of foster care reviews.

The area had taken steps to increase the level of feedback sought from children and families on the running of the service. During the inspection, the aftercare team met with young people using the aftercare service in order to get their views on the quality of the service. It was evident in the area's business plan that an increase in the level of participation of children and families in informing decisions around the

[6] Section 36 of the Child Care Act, 1991 allows for Tusla to make suitable arrangement to place a child with a relative, who is assessed as a foster carer.

direction of the service was an objective and team meeting minutes showed that the service was in the process of trying to establish a number of fora to achieve this. Monitoring and oversight of the service had not led to improvements. Tusla monitoring officers had audited the service against the regulations and national standards in October 2015 and a report was provided to the Area Manager. This report identified deficiencies, including children having no allocated social worker, the impact of vacancies on the ability of the service to meet the demands placed on it and care plans being out of date. While an action plan had been developed to address the identified deficiencies, the issues identified at that time were similar to the findings of this inspection.

Not all statutory visits were effectively monitored by team leaders and principal social workers. Tusla were relying on social work visits to ensure the safety of children in foster care, particularly those without an allocated social worker. However, inspectors found that social workers had not always reviewed the unallocated child's file prior to the visit to ensure identified issues were addressed or followed up as part of the visit. Following the fieldwork, inspectors escalated this issue to the Area Manager who identified the steps she would take to improve the efficacy of these visits.

Other aspects of the service were not used to learn and bring improvements. Unplanned endings were not consistently reviewed to see if there was any learning. In addition, there was no oversight of all complaints brought to the attention of staff within the service. Therefore the management team were losing an opportunity to identify trends that could be remedied.

There was no service level agreement in place for private foster care providers and the area had no overall monitoring mechanisms in place to assess the quality of the service being provided. Individual contracts were in place for individual children. Monthly reports were on some children's files that had been provided by foster carers and or link workers. However, inspectors found that there was no proactive review of these services to ensure that children received a high-quality service. Inspectors were advised that monitoring the quality of these services was done on a case-by-case basis.

The Foster Care Committee

The foster care committee was not in compliance with national standards and did not function in line with Tusla policy. However, this had been identified by the interim chair of the committee and they were in the early stages of planning the implementation of some improved systems.

The membership of the current committee was in line with the Tusla foster care committee policy, dated January 2012. The committee consisted of an appropriate range of professionals with a clinical psychologist due to join the committee in July 2016.
There was not a level of continuity in the functioning of the committee. The current chair of the committee was the fifth chair since 2015 and had been appointed in February 2016. While nine meetings had occurred in 2015, inspectors found that there had been no formal handover between the previous chair and the new chair when the role changed.

The committee members had not received any formal training in regard to their role and responsibilities. The annual report identified that aspects of the policy were being focussed on at foster care committee meetings from May 2016 in order to ensure that committee members were aware of their responsibilities.

The committee made timely decisions on assessments presented in recent times. Minutes reflected that staff were requested to attend a committee meeting if clarification was required on aspects of the assessment. Some potential foster carers' assessment reports were presented to the foster care committee and were not approved to foster children[7]. An appeals process external to the local foster care committee was available to these carers.

The committee did not consistently receive referrals in relation to issues that should have been presented to them. The committee had only received two disruption reports, which are reports completed after a child's placement has broken down. There had been 23 unplanned placement endings in the two years before this inspection. Inspectors found numerous examples of children who were placed outside of the foster carer's status; for example, where the carer was approved to provide short-term care to children but a decision had been made that the child would be in care on a long-term basis. These foster carers and children had not been referred to the foster care committee to review their foster care approval status. There was also no formal process for communicating that a social worker or fostering link worker needed to return to the committee to provide an update on specific issues. However, the acting chair outlined that they were putting this in place with immediate effect.

The committee were not meeting all of its governance functions. Inspectors found that the Committee did not always ensure recommendations made by it had been followed through or that there was a good rationale where they had not. This meant

[7] The role of the foster care committee is to make recommendations, based on the assessment of potential foster carers, regarding whether carers should be approved (or not) as suitable carers for children in care.

that some children remained in placements where carers were unapproved. In addition, the committee did not question that reviews were not being presented to them or that there was a system for ensuring all allegations against carers were brought to the attention of the committee. This raised issues around how effective the committee was in ensuring children were living in appropriate placements that could meet their needs.

Use of Information

The information systems that operated in the area were poor and not fit for purpose. The management team had recognised this and had planned to introduce an electronic information system in the first quarter of 2016, while they awaited the introduction of the national childcare information system. However, this had been delayed for some months and was expected to be in place by the end of May 2016.

The information system did not assist the management team to have access to quality information. Data was manually gathered on a monthly basis in relation to children in foster care who were prioritised as high, medium and low level cases, who were allocated or awaiting allocation, and the period of time they were unallocated. This information was reported on a monthly basis to the regional and national offices of Tusla.

There were a range of inconsistencies in the service's data. Information was stored on multiple databases in operation throughout the area, none of which were integrated. Inspectors found that the data requested as part of the inspection changed during the inspection. For example, the data returned for the number of children with a disability altered during the inspection when inspectors sought a list of these children and social workers provided information. The absence of an integrated information system led to delays in staff accessing information in a timely manner.

The register for children in care was not up-to-date and was not maintained in line with the regulations. While the area maintained a register of children-in-care, not all information in relation to children's placements was up-to-date. For example, the location of some children's placements was incorrect on the register. In addition, the register did not always include the names and addresses of parents, and the date when placements ceased.

The quality of records varied and not all records were held in line with the record management policy. Some files were in excellent condition, with clear recording and the necessary documentation on file. However, inspectors reviewed other files that did not contain all of the necessary regulatory information and some records were not dated or signed. For example, social workers reported to inspectors that

screening checks had been carried out on some foster carers but details had not been recorded on files. Key information such as up-to-date child-in-care review meeting minutes and care plans were not present in a number of files sampled and health records were not present on some children's files. Therefore, there could be delays in staff implementing children's plans. Inspectors found that some carers' files were missing critical documents such as assessments, contracts or references.

Chronologies were only present on a small number of files reviewed by inspectors. The inclusion of a case chronology may have assisted staff in having easy access to a full history of the main issues and events in children's lives.

Theme 5: Use of Resources
Services recruit sufficient foster carers to meet the needs of children in the area. Foster carers stay with the service and continue to offer placements to children.

Summary of Inspection Findings under Theme 5

There was an insufficient range of carers to meet the diverse needs of children. Limited resources had an impact on the area's capacity to improve strategies to retain carers.

Retention and Recruitment of Foster Carers

There was an insufficient range of carers to meet the diverse needs of children and demands for the service. Insufficient placements meant it was not possible for matching to be part of day-to-day practice, and at times the area did not have enough placements for children who needed them. Data provided by the area identified that 13 children were awaiting a foster care placement. A small number of children had been placed in emergency private foster care placements on a short-term basis due to not having a general foster care placement available. A number of children were also placed with unapproved carers.

As a result of a shortage of carers, there was a reliance on out-of-area placements. This in turn had an impact on children being placed outside of their community and increased distances for social workers to travel to see children on their caseload. There was a recruitment strategy but it was too early in its roll out to see an impact. The Dublin Mid-Leinster region of Tusla had piloted and then rolled out a regional fostering assessment team that was responsible for assessing general foster carers. This meant that local link workers were responsible for relative assessments and retention of general and relative carers.

However, there was no effective strategy in place to develop and retain foster carers. The absence of an adequate training plan for foster carers and the inconsistency in foster carers being reviewed meant that the area was not developing the skills of foster carers sufficiently.

Data provided by the area identified that five foster carers had left the service in the previous 12 months. Inspectors sampled exit interviews and found that while one interview had been declined, for the other carers, the reason for leaving was due to getting older or they had been a relative carer.

Theme 6: Workforce
Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children's services recruit and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.

Summary of Inspection Findings under Theme 6

This inspection found that the service was provided by a skilled staff team who were supported by supervision. There was also an improvement in the training opportunities available to the team. However, there were insufficient staff in place to deliver a safe and effective service. A number of staff files did not have a record of An Garda Síochána vetting.

Recruitment

The majority of staff were recruited in accordance with legislation, standards and policies but not all staff files were up-to-date. Staff were recruited centrally through a national panel. Inspectors reviewed 24 staff files, most of which were paper files. The majority of files contained appropriate documentation such as references, job descriptions and a full employment history. However, of the files reviewed, one in five did not have any An Garda Síochána vetting and there was no evidence of a rolling programme of vetting in place. For staff on interim appointments, their file did not always identify this arrangement. The area had a system in place to ensure that social work staff had up-to-date professional registration. In the recent past, the area had employed temporary staff through an agency but at the time of inspection, all of these workers had begun working on a direct contract with the service.

Induction and orientation processes were not consistently followed and or documented in staff files. Staff told inspectors they had mixed experiences of the induction process. While social workers had a reduced caseload when initially appointed and met with their supervisor every two weeks, in line with the policy, they had not all experienced a formal induction process.

A comprehensive probation process was completed. In addition to supervision, newly appointed staff met formally with their manager twice in relation to their probation.

Sufficient Staff and Skill Mix

The area had a number of vacancies that limited their capacity to meet the demands placed on the service. The area had also identified, as part of a service improvement plan, that an additional principal social work and team leader post were required in

order to deliver the service. Approval for filling vacancies had been given but, similar to other areas, there were a lack of people available to fill roles. Efforts were being made to recruit upcoming social work graduates. In the interim, unallocated children and carers were the responsibility of the relevant team leader. This meant that they had an additional workload on top of their team leader responsibilities.

While staff were qualified and experienced, there were insufficient staff in place to deliver an effective service. Inspectors found a considerable number of experienced staff on all teams, mixed with a number of less experienced social workers. However, as previously identified, supervision and support visits, assessments and reviews of foster carers were not occurring in a timely manner. In addition, the area had dedicated two posts to chairing child-in-care reviews but due to leave, one or both of these posts were vacant for some months, resulting in reviews not being held.

Managers in the service were appropriately trained and had some experience of their current role. Inspectors found that a number of managers had been appointed to their current position in the previous six months.

Supervision and Support

Supervision took place regularly but the quality of supervision varied. Not all managers were trained in supervision. Inspectors reviewed supervision files and found that supervision sessions took place regularly though not consistently in line with policy. The majority of files reviewed had up-to-date contracts. Supervision sessions included caseload review, professional development and support. Staff identified that supervision was a positive aspect of the job, where clear decisions were made on their cases. However, it was not evident from supervision records how the supervisor established if agreed tasks were carried out. Inspectors found examples where tasks were implemented and also, where important tasks had not been carried out, such as actions identified to follow up on concerns. Records were not consistently signed by both parties.

Caseload management tools had been fully implemented in recent months. Some supervision records reflected that the social worker had a caseload that was 'busy but manageable' and some that were 'unmanageable'. However, the supervision record did not always identify how this was addressed when caseloads were consistently unmanageable. The Principal Social Worker advised that the tool had not been in effect long enough to be able to identify trends.

All files reviewed had personal development plans in place that were discussed during supervision.

Training

Access to training had improved. All social workers spoken to said that they had good opportunities to attend training and were positive about the quality of the training. A training needs analysis had been completed in February 2016. The Regional Manager for Workforce, Learning and Development told inspectors that the area's training needs analysis was informed by the national business plan and the area's business plan objectives, in addition to other sources of information such as recommendations from local review reports and personal development plans.

The training plan was of good quality. A clear training plan was developed based on the identified learning and development needs of the workforce. In consultation with the Area Manager, priority areas for training for the staff team were identified based on the overall needs of the area, and training was offered on some of these issues. For example, some staff attended training in disorganised attachment and dealing with aggression, and other training needs for the area had been identified such as enhanced courtroom skills and working with children with mental health needs.
Not all staff had received mandatory training. Data provided by the area identified that not all staff had up to date training in Children First (2011). The training plan did identify that this deficit would be addressed in 2016.

Appendix 1 – Standards and Regulations for Statutory Foster Care Services

National Standards for Foster Care (April 2003)
Theme 1: Child-centred Services
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.
Standard 2: Family and friends Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.
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.
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. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III Article 8 Religion*
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.

[¥] Where reference is made to Health Boards these sservices are now provided by 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*
Standard 9: A safe and positive environment Foster carers' homes provide a safe, healthy and nurturing environment for

National Standards for Foster Care (April 2003)
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[8] 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 9 Contract*
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

[8] Formally known as Health Boards at time of writing Standards, now known as The Child and Family Agency.

National Standards for Foster Care (April 2003)
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.

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.

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

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

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

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.

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.