Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of service area:	Sligo, Leitrim, West Cavan
Name of provider:	Tusla
Type of inspection:	Thematic
Date of inspection:	17th May, 26-29 July 2021
Fieldwork ID:	Mon-0032632

About this inspection

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency (Tusla) and to report on its findings to the Minister for Children, Equality, Disability, Integration and Youth.

This inspection report, which is part of a thematic inspection programme, is primarily focused on assessing the efficacy of governance arrangements across foster care services and the impact these arrangements have for children in receipt of foster care.

This thematic programme is the third and final phase of a 3-phased schedule of inspection programmes monitoring foster care services.
The previous two inspection programmes were as follows:

- Phase 1 (completed in 2018) - Assessed the efficacy of recruitment procedures, foster carer supervision, and assessment of foster carers.
- Phase 2 (completed in 2020) – Reviewed the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children.

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for Foster Care* (2003).

How we inspect

As part of this inspection, inspectors spoke to the relevant managers, child care professionals, children, their birth families and foster carers. Inspectors reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data submitted by the area
- interviews with:
    - the service director together with the regional manager for quality, risk and service improvement
    - the area manager
    - the principal social worker for alternative care
    - the independent chair of the foster care committee
    - the regional performance and quality assurance monitor
- focus groups with:
    - social work team leaders and the aftercare manager
    - representatives of frontline staff teams
    - foster carers
    - external stakeholder representatives from two advocacy agencies and children's Guardians-ad-Litem (GAL's)
- the review of:
    - local policies and procedures, minutes of various management meetings, staff supervision files, audits and service plans
    - staff and foster care committee (FCC) personnel files
    - a sample of 18 children's and 13 foster carer records
- individual phone conversations with:
    - 10 children, two parents and 12 foster carers.

Acknowledgements
HIQA wishes to thank parents, children, foster carers and external stakeholders that spoke with inspectors during the course of this inspection in addition to staff and managers of the service for their cooperation.

Profile of the foster care service

The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children, Equality, Disability, Integration and Youth. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency has responsibility for a range of services, including:

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

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the national director of services and integration, who is a member of the national management team.

Foster care services provided by Tusla are inspected by HIQA in each of the 17 Tusla service areas. Tusla also places children in non-statutory foster care agencies and has specific responsibility for the quality of care these children receive.

Service area

The Sligo, Leitrim, West Cavan (SLWC) service area had 23,554 children between the ages of 0-17 years living in the area in 2016.[1] SLWC is one of five Tusla service areas within the West region. The region is led by a service director and the service area is managed by an area manager. A principal social worker for alternative care services directly reports to the area manager. He has line management responsibility for the long-term children in care team, foster care resources team and the leaving care and aftercare team. The children in care, fostering and aftercare services are based in Sligo town. Child protection and welfare teams also hold case responsibility for children from the point of their entry to care until they are transferred to the long-term children in care team. These teams are based in Carrick on Shannon, Tubbercurry and Sligo.

[1] Source: Health Atlas via CSO Year 2016, sourced from Area Manager report 2020

The alternative care service management team comprised a principal social worker and three team leaders. The child in care team included a senior practitioner, five social workers and four social care workers. All vacant posts had been appointed to. The foster care resources team had five social worker posts, but had experienced lengthy absence, with only three social workers in post at the time of this inspection. There were five social care leader posts in the leaving care and aftercare team. All posts were filled.

The area had 65 general foster carer households, including one approved to provide respite care only. There were 17 relative foster carer households, and 14 non-statutory foster care households approved by the area's foster care committee (FCC). Of the 106 children in foster care, 78 were placed with general foster carers (three within non-statutory foster care placements) and 26 children were placed with relative foster carers. Two children were placed with their family under a Care Order with the agreement of the district court. A total of five children were placed in relative foster care settings outside the service area.

At the time of this inspection, the area had capacity to offer up to five emergency placements and one long-term placement. Six foster care households had more than two unrelated children placed together. During 2020, five children's placements had been disrupted, with one child experiencing two placement changes.

The service area did not have any special foster care arrangements.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant,** or **non-compliant** with the standards. These are defined as follows:

Compliant	**Substantially Compliant**	**Moderate Non-Compliant**	**Major Non-Compliant**
A judgment of compliant means that no action is required as the service has fully met or has exceeded the standard.	A judgment of substantially compliant means that some action is needed in order to meet the standard. The action taken will mitigate the non-compliance and ensure the safety, and health and welfare of the children using the service.	A judgment of moderate non-compliant means that substantive action is required by the service to fully meet the standard. **Priority action** is required by the provider to mitigate the non-compliance and ensure the safety, and health and welfare of children using the service.	A judgment of major non-compliant means that the services has not met the standard and may be putting children in risk of harm. **Urgent action** is required by the provider to mitigate the non-compliance and ensure the safety, and health and welfare of children using the service.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
17 May 2021	14.00-15.30 (Remote)	Sue Talbot	Inspector
17 May 2021	10.00-15.00 (Remote)	Caroline Browne	Inspector
26 July 2021	09.00-17.00	Sue Talbot	Inspector
26 July 2021	09.30-17.30	Sabine Buschmann	Inspector
26 July 2021	09.30-17.30	Leanne Crowe	Inspector
26 July 2021	09.30-16.00 (Remote)	Caroline Browne	Inspector
27 July 2021	09.00- 17.00	Sue Talbot	Inspector
27 July 2021	09.30-17.30	Sabine Buschmann	Inspector
27 July 2021	09.30-17.30	Leanne Crowe	Inspector
27 July 2021	09.30-16.00 (Remote)	Caroline Browne	Inspector
28 July 2021	09.00- 17.00	Sue Talbot	Inspector
28 July 2021	09.30-17.30	Sabine Buschmann	Inspector
28 July 2021	09.30-17.30	Leanne Crowe	Inspector
28 July 2021	09.30-16.00 (Remote)	Caroline Browne	Inspector
29 July 2021	09.00-16.00	Sue Talbot	Inspector
29 July 2021	09.30-17.30	Sabine Buschmann	Inspector
29 July 2021	09.30-17.30	Leanne Crowe	Inspector
29 July 2021	09.00-16.00 (Remote)	Caroline Browne	Inspector

Background to this inspection

This thematic programme is focused on assessing the efficacy of governance arrangements across foster care services and the impact these arrangements have for children in receipt of foster care. It is the third and final phase of a 3-phased schedule of inspection programmes monitoring foster care services. The previous two inspection programmes were as follows:

- Phase 1 (completed in this area in April 2017) – Assessed the efficacy of recruitment procedures, foster carer supervision, and assessment of foster carers.
- Phase 2 (completed in this area in January 2019) – Reviewed the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children.

Summary of the Findings from Phase 1 and 2

Of the eight standards assessed in Phase 1:

- two standards were substantially compliant
- three standards were non-compliant moderate
- three standards were non-compliant major.

The Phase 1 inspection found that child protection concerns and allegations about foster carers were not appropriately investigated, managed or monitored. Supervision and support for foster carers was not always sufficient. There were gaps in the frequency and quality of foster carer reviews. There were not enough foster carers to meet the growing and diverse needs of children brought into care. Recruitment checks, assessment timeframes and oversight of children placed with foster carers, including in an emergency; required improvement. Training provided to foster carers was limited, and there was variable levels of take up. Good practice was identified in the support provided to carers of children with complex needs. The foster care committee (FCC) was found to be well-established and managed.

Of the six standards assessed in Phase 2:

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

The Phase 2 inspection found that allegations made by children were not assessed and investigated in line with *Children First: National Guidance for the Protection and Welfare of Children* (2017). Management oversight of visits to children, the standards of recording practice, care planning and review required improvement. Good practice was evidenced in the work of the leaving care and aftercare team. Children and young

people spoke positively about the help they received and their relationships with foster carers, social workers and aftercare workers.

Following Phase 1 of the inspection programme, the service director for the West established a new governance structure with task and finish groups to promote a targeted, joined-up system for promoting service improvement at regional and area levels. This inspection reviewed the focus, effectiveness and impact of work undertaken since then in the Sligo, Leitrim, West Cavan (SLWC) service area.

Self-Assessment information and what Tusla said about the service
Prior to the announcement of the inspection, the service area submitted a self-assessment questionnaire (SAQ) to HIQA which provided an overview of areas for further improvement against each of the standards relating to governance. The SAQ is part of the methodology of this inspection.

The service area rated its performance as compliant against one standard which inspectors agreed with. The service area judged themselves substantially compliant against five standards and non-compliant moderate against two standards. Inspectors found that one of these standards, standard 25, Representations and complaints, evidenced full compliance, therefore judged this to also be compliant. In recognising the under-development of national strategy and guidance in relation to two standards, standard 22, Special foster care and standard 24, Placement of children through non-statutory agencies, although the area judged these to be moderate non-compliant, inspectors found that in both standards the area was substantially compliant, and the deficits related specifically to the lack of a national strategy to address these non-compliances. This inspection found levels of compliance were not as high as those assessed by the area under two standards, and inspectors have therefore rated standard 19, Management and monitoring for foster care services and standard 21, Recruitment and retention of an appropriate range of foster carers, to be moderate non-compliant. The reasons for this are outlined in the report below, and specifically relate to the lack of adequate staffing resources in the service, as well as the shortage of foster care placements. The SAQ indicated the area overall had effective management and governance systems in place and clearly outlined the actions it was taking to drive service improvement.

This inspection took place in what has been a challenging time nationally for children in care and their families, foster carers and local social work teams arising from the COVID-19 pandemic. In addition, this inspection initially planned for May 2021, had to be postponed due to the cyber-attack on Ireland's HSE ICT systems, which also impacted Tusla's systems. In this context, HIQA acknowledges that services have had to adapt their service delivery in order ensure continuity of essential services to

children in care and their foster carers. These issues, and how they have been managed, are reviewed within the overall assessment of local governance.

Children's experience of the foster care service

Children's experiences were established through speaking with a sample of children, parents, foster carers and external advocates and professionals. The review of case files, complaints and management and supervision records also provided evidence of the experience of children in foster care.

Inspectors spoke with a total of 10 children and young people individually over the phone. This included children selected from the sample of records reviewed and some young people who were involved in the area's 'FORA'- the young person's participation groups. Most reported good experiences of foster care and valued the support and opportunities they had been given.

Children's comments about their social workers and the aftercare service were mainly positive and included:

- *'My social worker listens to me, has helped me to get through things, and I am now very happy where I am'.*
- *'My reviews are all about me. They listen to what I want'.*
- *'Support from the Aftercare Service is absolutely fantastic- it's a brilliant service. They help us get housing, further education and training'*.

Children also expressed concerns about the turnover of their social workers:

- *'You get to know and trust your social worker, and then you have to start all over again'.*

Children also said:

- *'I am very happy in my foster home. It's perfect- could not be better'.*
- *'I get to do lots of fun things.'*

When asked what they would like to change, some children said they would like to see their siblings or parents more often, and to have less changes of social worker.

The parents of children said:

- *'The children's social worker is very fair, respectful and supportive'.*
- *'I am kept informed about my children's care plans and reviews, and am able to give my views'.*

Foster carers overall were positive about the help and support they received, although few had seen their link worker face-to-face over the previous 18 months. They valued

the 'check-ins' and support given, including additional help provided for the children placed with them. Comments made by foster carers included:

- *'The child is at the centre of everything they do. All decisions are discussed with the foster carer, child and their birth family'.*
- `*His social worker is very good- she really cares. She recognises our wider family relationships and stresses'.*
- *'They asked personal questions sensitively as part of the foster care assessment. I am treated with respect'.*
- *'My link social worker is very supportive and will explain anything I do not understand. Nothing is too much trouble'.*

A few foster carers highlighted gaps in the area's respite care provision:

- *'I have asked for respite, but it is not available'.*

External agencies spoke about high quality, child-centred support undertaken by the children's social workers. They were described as *'skilled and well-tuned into children's needs and experiences'*. Children's social workers were seen to be effective partners in working with them to ensure their best interests were recognised and met. The impact of staff turnover on relationships and the ongoing availability of a suitable range of appropriately skilled foster carers were flagged as concerns. They also highlighted gaps and delays in access to some specialist assessments and services in SLWC compared to what they perceived to be available in other Tusla service areas.

Case records provided an adequate picture overall of contact with children and foster carers; with some examples of exemplary recording and a high standard of child-centred practice. Overall, children's records indicated case holders and managers paid good attention to exploring the views and wishes of children and of foster carers. The voice of children, including their wishes and feelings; was carefully considered within statutory visits, care plan meetings, child in care and foster carer reviews; and helped inform matching decisions for long-term care. However, assurances of the quality of care and safety of children were largely dependent on practitioner self-audit; with gaps in the quality and continuity of records when children or their foster carers were unallocated or managed 'on duty'.

Overall, most children and young people felt they were listened to, had good care and positive relationships with their foster carers and social workers. Foster carers were generally satisfied, but some would welcome additional support in meeting children's needs. Addressing risks in relation to staffing capacity; expanding the range of skilled foster carers; with timely access to specialist support for all children who required this; would assist in further improving the experiences and outcomes of children.

Governance and Management

Leadership and management overall in Sligo, Leitrim, West Cavan (SLWC) was effective and was delivered within a clear framework of organisational systems, structures and processes. These arrangements detailed manager and frontline practitioner accountabilities for ensuring foster care services were safe, effectively addressed children's needs, and supported the delivery of a high quality service. However, attaining a consistently high standard of service delivery required ongoing workforce capacity issues to be addressed. The allocation of social workers to all children and foster carers was critical in driving further improvements in service quality. In addition, the recruitment and timely assessment and approval of a sufficient supply of foster carers equipped to meet the diverse and complex needs of children; was central to the future effectiveness and sustainability of its foster care services. These issues had been well-recognised by the alternative care services management team, and were clearly reflected in the area's risk register and its service improvement plans.

The service area overall had strong and stable leadership. However, over the past 12 months, the capacity of frontline teams had been impacted by vacancies and absences. Although the service area reported relatively low staff turnover overall (4.16%); the length of time it had taken to address these issues, and the impact on what were relatively small teams, was clearly evident.

Leaders provided effective challenge and support, enabling and encouraging ongoing change and improvement in service planning and organisational learning. The area manager and principal social worker for alternative care services worked closely with their frontline teams, regional peers and other agencies to continuously improve organisational performance in line with regulations, policies, standards and best practice. The regional 'task and finish' groups which involved the workforce at all levels; provided a well-focused and structured approach to the sharing of learning; ensuring local systems, processes and practice tools were fit for purpose.

Findings from HIQA's phase 1 and 2 inspections had actively informed the service area's strategic and operational improvement plans, with evidence of good progress having been made in a number of areas. The service area also made effective use of the findings of Tusla's thematic audits to support continuous improvement in practice.

Service and team plans overall provided clear direction, measurable actions and milestones to support continuous improvement. Plans were dynamic, clearly reflected organisational capacity and capability gaps, and promoted organisational values and behaviours. They provided a comprehensive framework for connecting local targets, practice standards and service plans with national objectives and targets.
Governance of service delivery was well-managed, with appropriate systems in place to provide assurance and continuous review of performance trends, progress made,

and of areas of escalating risk. Management trackers were widely used, and provided good business intelligence about the quality of services. Systems developed since the previous HIQA inspection ensured strong management oversight of allegations, serious concerns and complaints to prevent drift or delay. However, the service area still had a few legacy appeals and associated foster carer reviews that had taken a long time to be addressed. These still needed to be concluded, with learning shared to prevent recurrence.

There remained areas of ongoing organisational risk and challenge that were impacting on the service area's capabilities to provide a consistently high standard of safe, effective and child-centred foster care services. At the time of this inspection, the foster care resources team had 16 foster care households that were unallocated who were being supported on a duty cover basis; and there were delays in the completion of foster carer assessments. There were also four children in foster care who did not have an allocated social worker; although this represented significant improvement from the position 12 months previously. The service area had implemented contingency plans for dealing with such capacity challenges; however, it had yet to achieve the levels of stability and continuity required of a high quality foster care service.

The service area also did not have sufficient, suitably experienced foster carers to meet the diverse and complex needs of children entering care. There were specific deficits in the availability of respite care; estimated at 26 'unmet' requests in 2020. The service area had limited capacity to provide long-term placements, with just one placement available at the time of this inspection. Two children had been waiting for over a year for a suitable long-term placement. The area also had very limited capacity to place siblings together. These organisational gaps had been clearly recognised by the service area; with evidence of work in progress to explore alternative models of provision; including actions to strengthen its relative foster care capacity.

Partnership working was underpinned by effective governance and the implementation of joint protocols. The area's leadership and support for the work of the Aftercare Committee, HSE disability planning meetings and liaison with the An Garda Síochána was good. The availability of specialist resources for some children with complex needs, however, was insufficient. The service area was working to expand its expertise and service provision for children with complex emotional or behavioural needs. A substantial programme of service development was in progress to up-skill frontline staff and foster carers to help address the impacts of earlier childhood trauma and enhance the range of support available to children and their foster carers.
At a national level, there were gaps in Tusla's governance arrangements for the provision of 'special foster care' and oversight of the work of non-statutory foster care agencies. Tusla did not have an agreed approach for the development of 'special foster

carers' in line with the National Standards for Foster Care (2003). Practice development and resourcing needed to be addressed to support the service area in taking forward new models of foster care for children who required intensive or specialist support. Tusla's national approach for the placement of children through non-statutory agencies also had not been agreed to inform local governance arrangements. This meant that the service area was not adequately supported in the discharge of its accountabilities for the children it had placed in non-statutory foster care.

Systems for managing and reviewing organisational risk, overall, were well-developed. Risks were clearly identified; logged and regularly reviewed by the area's management team. The risk register had clearly mapped the unsustainability of delays in children being transferred from the child protection and welfare teams due to lack of capacity in the child in care team. It also flagged risk when children were unallocated and did not receive regular contact and support. Concerns were also highlighted about the foster care resources team's growing inability to meet its statutory obligations and keep pace with an increasing volume of work.

Systems and accountabilities for escalation to the area manager, service and national director were clearly defined; with evidence of timely, appropriately challenging and supportive responses from senior managers in seeking to jointly achieve an effective and sustainable solution. The area manager prepared a bi-monthly performance report for regional senior management meetings. This provided the service director with assurances of progress against specific targets and enabled comparison with other service areas in the region. Tusla's published metrics for the service area in March 2021 indicated there were eight children in care without an allocated social worker, and two children without an up-to-date care plan.

Governance of service operations was effectively carried out through six weekly area-based quality, risk and service improvement (QRSI) meetings. This approach ensured good management oversight in areas such as managing allegations, serious concerns and complaints. The work was underpinned by a strong organisational learning culture that actively informed service planning and workforce development priorities. Service area and team meetings were regularly held, and ensured ongoing scrutiny of performance in line with statutory requirements and standards.

Senior managers promoted an open and supportive organisational culture where the safety and best interests of children was at the heart of management decision-making. Foster carers spoke to inspectors about what they perceived to be a positive recent shift in organisational culture; with teams and managers seen to be more approachable and listening to them. A monthly alternative care discussion group had been established that enabled practitioners and managers to explore organisational

barriers and cases that were 'stuck'. This approach encouraged reflection where there were differing opinions about the best way forward. Managers were open to learning from their mistakes and used peer or external review to provide challenge and reflection on their management of complex work. This approach, together with managers' open door policy was reported as supportive and valued by frontline staff.

Managers had effective systems and trackers in place to ensure staff employed to work with children were professionally qualified and suitably trained. Inspectors' review of staff personnel records indicated that overall, the process was well-managed. Staff employed to work with children and young people, their families and foster carers held relevant professional qualifications. Each service department maintained a record of CORU registration and ensured social workers' registration was updated on an annual basis.

The service area's workforce development plans were effectively aligned with local and regional priorities for service improvement. The training and development needs of the workforce were clearly identified through the annual performance development and review process (PDR). Learning needs were also identified through governance reviews and practice reflection events. Mandatory training was strongly promoted, with management checks of coverage. Managers had undertaken research and learned from advanced practice in other areas to support its implementation of new ways of working. Learning and development priorities included work to build the expertise of the foster care resources team in undertaking assessments and reviews where decisions about risk, suitability and viability of placements were complex.

Managers and frontline staff clearly recognised their responsibilities for ensuring service delivery adhered to the standards set out in legislation, regulations and best practice guidance. Practice templates were widely used and promoted consistency of approach. Supervision templates had checks for the timeliness of statutory visits, care plans and reviews and enabled ongoing discussion about any changes needed to safety plans, safe care and risk management plans. Placement plans were embedded within children's individual support arrangements, and these were monitored by managers. A new family-friendly venue for child-in-care reviews had been secured. These are some examples of improvements made by the service area since the last inspection to strengthen child-centred practice.

The service area, however, had not yet embedded its approach to undertaking audits of case records to provide effective review and analysis of the quality of casework in line with its protocol. Whilst inspectors' reviews of children's records indicated high priority was given to statutory work; there remained ongoing variability in the standards of recording and file management practice. Senior managers recognised further work was needed to develop a suitable departmental file audit tool or system.

Managers knew their population of children in care and foster carers well. The area manager and principal social worker had good oversight of the work of the foster care committee (FCC) and its independent chairperson. Together, they ensured their statutory responsibilities, service planning and quality assurance processes were aligned to provide a whole systems, integrated approach to driving continuous improvement.

Performance reports from the child-in-care review and FCC independent chairpersons ensured effective analysis of the sufficiency of services and impact for children. Such reports enabled wider organisational learning and evaluation of the quality and effectiveness of its assessment, care planning, review and appeals processes. Although the service area did not prepare an '*Annual Adequacy of the Child Care and Family Services'* report as set out within the National Standards for Foster Care (2003), the FCC annual report satisfactorily covered the key areas to inform the future development of services. Levels of unmet needs were routinely captured and reported on, with monthly matching meetings highlighting areas of ongoing risk to the safety and wellbeing of children and the quality and continuity of their placements. Key ongoing gaps in service provision included the adequacy of respite foster carers and permanent care placements, capacity to place teenagers and larger groups of siblings together, and recruiting carers from other ethnic backgrounds.

The FCC was well-led. Its membership included individuals and agencies with a broad and relevant range of experience, knowledge and expertise. Meetings were well-planned and co-ordinated, and its members had continued to regularly meet over the past 18 months. The FCC properly discharged its role and accountabilities for making recommendations about the suitability of foster care applicants, including re-approval following review. There was evidence of good challenge and recognition of the suitability of foster carers to provide long-term care for specific children. FCC records viewed by inspectors provided a clear rationale for decision-making and of areas for further review. Work flow processes clearly set out key steps and timelines to inform practitioners' submission of relevant reports. The annual report of placement disruptions prepared by the independent chair of child-in-care reviews provided important feedback on service gaps and areas where the learning needs of foster carers required further attention.

FCC members sought to promote a culture of openness and continuous improvement in the way it conducted its business. Members, and those presenting reports were encouraged to voice any concerns, ask questions, and appropriately challenge each other. This approach aimed to ensure that foster carers accepted onto the local area's panel had suitable personal attributes, space, capabilities and skills to meet the needs of the children placed with them. Conditions of approval, where they were stipulated; were clearly recorded and followed up to ensure that any matters outstanding had been addressed. Review and re-approval arrangements provided scrutiny of foster carers'

achievements and track record in working alongside frontline practitioners to help improve outcomes for children. Recommendations made by the FCC concerning the learning and development needs of foster carers, however, would benefit from clearer definition to further enhance their knowledge and competencies.

Recruitment of foster carers was recognised as an important strategic priority in both expanding the local panel and attracting a wider range and diversity of applicants. The area had a well-developed and targeted recruitment campaign for general foster carers that was inclusive of representatives of the local foster carer panel. Management attention had also been given to enhancing systems for timely identification and support for prospective relative foster carers. These approaches however, had not yet resulted in an adequate number of foster carers to meet current levels of need and replace foster carers leaving the service. The service area recognised work was required to further review and evaluate its recruitment strategy, campaigns and approvals processes to provide better data and feedback about service effectiveness and impact.

Recruitment processes had been adapted in line with COVID-19 social distancing requirements; with most preliminary work taking place virtually, including the '*Foundations for Fostering'* training. The timescales from enquiry to approval of relative foster carers were lengthy in some cases and did not support compliance with Tusla's standard business processes or best practice. Although essential checks had been completed; with evidence of regular contact with and visits to see the children; the assessment process was well outside the expected timeframes for children who had been placed with relative foster carers for more than 12 weeks. The reduced capacity of the foster care resources team meant that although efforts had been made to ensure enquiries were promptly followed up; with all enquiries acknowledged within a week in line with Tusla's standard business processes; follow-on work such as screening and completion of assessments, was taking too long. A management tracker had recently been introduced to provide stronger governance and management oversight of the end-to-end process from enquiry to approval. This was starting to provide better performance information about the rationale for management decisions, potential risks, and of the areas where additional capacity was needed.

Service managers gave high priority to the management of complaints, and also sought to identify learning from the compliments its staff received. Complaints management was effectively led and reviewed to ensure ongoing analysis of trends and review of organisational risk. The service area was supported in the management of complex complaints by the regional complaints lead. The use of trackers, together with follow up discussion within QRSI meetings, ensured complaints were investigated in a timely manner and supported open communication and local resolution. The service area had relevant policies, guidance and information leaflets to promote awareness of how to make a complaint or give feedback on the quality of services.

Children, foster carers and parents that inspectors spoke to, had a good awareness of their right to complain and what to do to ensure their voice was heard.

The service area rated its performance as compliant against one standard, substantially compliant against five standards, and non-compliant moderate against two standards. The SAQ indicated the area overall had effective management and governance systems in place and clearly outlined actions it was taking to drive service improvement. Inspectors agreed with the service area's assessment of its performance in three out of the eight standards assessed. While recognising key gaps in national strategy and guidance for two standards; inspectors considered the performance of the service area as substantially compliant. Two standards rated substantially compliant by the service area, were rated as moderate non-complaint by inspectors. For the fifth standard, inspectors considered that the evidence indicated a judgment of compliance.

Standard 18 : Effective Policies

Health boards have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.

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

The service area's policies, procedures and guidance for the delivery of foster care services was informed by relevant child care legislation, regulations and standards. Managers sought to ensure consistent and fair application of organisational policies and procedures across its care delivery, workforce and resource management arrangements. They sought peer review and external advice in complex cases where there were differing views about interpretation of policies or the best way to proceed. The area's self-assessment (SAQ) recognised improvements could be made through strengthening the inclusion of parents and providing additional training for staff in the management of allegations and serious concerns.

The area's annual plan provided a clear focus on its priorities for service improvement and was aligned to wider regional and national objectives and targets. Service plans aimed to place children close to their families and their social and community networks wherever possible. Priorities were clearly identified and informed by analysis and review of the needs and risks to children across the age range, including young people leaving care. Gaps in the capacity of the foster carer panel were clearly identified and regularly reviewed.

The area management team ensured policies and procedures supported the delivery of safe, child-centred services. COVID-19 related procedures and risk management had

been implemented and reviewed in line with national guidance. Regular management briefings ensured timely communication about changes to policy and practice in line with public health guidance. The service area recognised its duties to children and families from other cultural or ethnic backgrounds and ensured interpreting and translation support was provided as required. Efforts were made to produce policies and information leaflets in accessible, child-friendly formats.

Children and foster carers told inspectors they felt well-informed about policies and procedures, such as their right to complain and how to report child protection concerns. The provision of annual policy updates to foster carers ensured they were aware of any changes to policies and procedures. The area's young person's fora were making an effective contribution to policy and practice development through providing feedback on services and developing information leaflets that informed children about their rights.

Practitioners' awareness of key policies and plans was well-supported through discussion in regional 'task and finish' groups, local quality, risk and service improvement (QRSI) meetings, team meetings and individual supervision. Inspectors' review of records indicated a strong management drive to ensure consistent application of policies and procedures. The recent audits of children in voluntary care (January 2021) and children with disabilities (November 2020) identified some areas for improvement in implementing national policies and guidance. These had been largely addressed at the time of this inspection, with additional management checks in place to ensure ongoing compliance.

Partnership working had been strengthened, with appropriate forums in place to identify children with complex needs. Joint working with the Health Services Executive (HSE) had been strengthened in line with the joint protocol for children with disabilities. However, there remained gaps in the availability of specialist services for some children which required further attention within joint agency forums. These included play therapy, occupational therapy, cognitive behaviour therapy and autism assessments.

Inter-area transfers of children in care were appropriately planned, with good oversight of the process. Practice reviewed by inspectors indicated managers carefully considered the best interests of children, their care status and the most appropriate time to hand over case responsibility. Appropriate action was taken to review and update the foster care panel when a foster carer moved into the area. Records also indicated good communication with other areas in planning for the safety of children moving to live in the area.

Overall, inspectors found managers provided good leadership and support in ensuring policies and plans were in place and properly implemented to deliver a high quality, child-centred foster care service. However, there remained a few areas where policy development or service planning required further development. These included work with birth parents, enhancing the confidence and skills of the workforce in managing allegations and the provision of specialist services for some children that required a stronger multi-agency response.

Judgment: Substantially Compliant

Standard 19 : Management and monitoring of foster care services

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

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

Management roles and accountabilities for the performance of the service area were clearly defined; with strong governance and oversight of the area's operations by the service director and area manager. Alternative care services were managed by an experienced principal social worker; with clear reporting lines to the area manager and from team leaders responsible for the long term children in care, foster care resources team and the leaving care and aftercare teams.

The service area had clear and effective management and governance structures in place that enabled regular feedback and review of organisational capacity and capabilities. Service development activity led by the region's task and finish groups was aligned and complemented area-based service improvement activity. The area manager and principal social worker ensured good oversight of service delivery through their management reporting systems; with effective use made of performance trackers to check for trends, progress and risks. The FCC and independent review chairpersons provided additional challenge and feedback on what was working well and areas that required improvement. Taken together, these approaches provided a clear shared focus on the service area's performance and of the impact of management actions taken to secure continuous service improvement.

Gaps in the capacity of the foster care resources team had increased in recent months. Organisational performance was impacted by periods of staff absence when there was insufficient capacity to provide the levels of support and continuity to children and foster carers in line with expected standards of practice. Management action had led to improvements in filling of vacancies in the child in care team; however, there remained four children who did not have an allocated social worker at the time of this inspection. Steady progress had been made from the point in April 2020 when 17 children were unallocated and 15 children were awaiting transfer to the child in care team. The capacity of the foster care resources team remained insufficient, with only three of the five post holder's available; with reduced levels of support for foster carers and growing delay in completing foster carer assessments. At the time of this inspection,

16 foster care households were unallocated and were being supported on a 'duty system'. Workload pressures were growing in relation to the team's capacity to undertake foster care reviews or contribute to long-term planning assessments. Whilst contingency plans had been put in place that prioritised urgent work, including plans to secure external capacity to help reduce delays in foster carer assessments; it had taken a long time for these matters to be resolved.

Service managers carefully handled the lengthy and challenging restrictions imposed by the COVID-19 pandemic through enhancing levels of support available to frontline staff and ensuring regular updates and reporting of the impact for children and their foster carers. This initially involved holding daily and weekly meetings to monitor the wellbeing of children and foster carers, the stability of placements and workforce capacity to meet escalating risks.

Managers in the service area had identified a clear programme of work to strengthen organisational capacity and capabilities in its service and team plans. They prioritised and regularly monitored progress against priority actions identified in HIQA's previous inspections and Tusla's thematic audits. The area's self-assessment questionnaire (SAQ), however, did not adequately explore the impact of its ongoing workforce capacity challenges on service operations and the experience of children and foster carers.

Senior managers demonstrated an openness and commitment to learning from things that had gone wrong, including where practice had not reached the required standards. They ensured lessons were learned from their management of complaints and foster carer allegations and had taken action to build the confidence and knowledge of its workforce. The recent development of an alternative care complex cases forum sought to strengthen inter-team working and enable open discussion about differences of professional opinion or management decisions. Managers had sought to learn from other service areas and jurisdictions about evidence-based approaches to meeting the complex needs of children, and the potential of other models of foster care; including the specialist skills and back-up support needed.

The service area's risk register provided a clear, succinct and up-to-date overview of gaps in organisational capacity and of the measures the area manager had been put in place for managing risk. It clearly highlighted issues that had been escalated to the service director, agreed strategies for reducing risk, and timescales for review. The service area's '*Need to Know*[2] system was well-managed; with appropriate follow-up and further review that provided assurances of the safety of children or staff. Review of these records indicated good partnership working with An Garda Síochána in the management of incidents in line with the joint protocol.

[2] Tusla's internal reporting system for bringing serious concerns and risks to the attention of senior managers

Managers actively monitored the service area's performance in its service review, improvement plans and individual supervision activity. Systems to support the collection of data to inform analysis of organisational risk and performance were well-developed. Trackers were used for monitoring complaints and compliments and serious concerns and allegations against foster carers which strengthened management oversight of timeframes and investigation outcomes. Trackers were also used to support checks of compliance with statutory work such as visits to children in care, reviews and care plans to inform the collection of performance data against Tusla's metrics and targets. New trackers had been introduced to enable monitoring of the experiences of the support needs of children whose placements had been disrupted/broken down. Stronger oversight of foster care processes from initial enquiry to approval aimed to identify and prevent delays; and assist in targeting areas where additional capacity was required.

The service area had expanded its use of the National Child in Care System (NCCIS) to include electronic case management of the records of foster carers. This enabled managers to have oversight of the needs and experiences of children alongside levels of support provided and feedback from foster carers on a whole household basis. The service area used NCCIS to inform the management and updating of its child in care register. Tighter oversight of practitioner's performance and activity, however, was required to ensure information was routinely kept up-to-date in relation to changes in children's legal status. Inspectors identified one case where the NCCIS legal status of a children had not been updated. This was promptly addressed when brought to manager's attention. The recent audit of children with a disability had led to improvements in the recording of the specific disabilities/complex health needs of children on the register. The need for managers to make better use of the information held within the register to assist with future service planning was recognised in the service area's SAQ.

The service area's structures and systems for assessment, care planning and review of children were clearly set out within its policies, procedures and guidance; and reinforced within the area's practice forum and group supervision. However, achieving a consistently high standard of practice was constrained in some cases, by staff capacity. Inspectors' sampling of some children's records who had been previously unallocated, indicated that this was for six months in one case and four in another. Team managers and/or social care workers often stepped in to undertake high priority work such as statutory visits or court reports when children were unallocated. Inspectors also found instances of drift and delay in relative foster carer assessments being completed; with gaps in support and supervision for some foster carers, and delays in records being written up.

Management capacity to provide regular audit of children's and foster care records was limited. Assurance relied heavily on the individual practitioner undertaking a self-audit of their case records in advance of supervision. Managers had not been able to consistently meet the standards of case auditing set out in their local protocol. This meant the quality of casework of frontline practitioners and managers had not been effectively reviewed to identify areas for continuous improvement in practice.

Supervision was generally undertaken in line with the expected frequency set out in Tusla's policy and guidance. However, not all supervision contracts were reviewed and updated annually. The service area had not undertaken any audits of its supervision arrangements to help benchmark standards and identify areas for improvement.

Overall, the service area had effective management structures and governance arrangements in place to support the delivery of its service improvement plans and manage risk. However, ongoing gaps in the capacity of its workforce had impacted on the quality and continuity of care and support for children and for foster carers. Audits and assurance of the standards of supervision or case recording practice had not been sufficiently implemented or used to support continuous improvement in practice.

Judgment: Moderate Non-Compliant

Standard 20 : Training and qualification

Health boards ensure that the staff employed to work with children and young people, their families and foster carers are professionally qualified and suitably trained.

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

Overall, the service area had recruited professionally qualified and suitably trained staff to enable it to provide high quality foster care services; however due to ongoing staff absences there were insufficient staff at the time of this inspection. The learning and development needs of its workforce had been appropriately identified. Priorities identified supported recognition of the areas for service improvement including complex foster carer assessments and meeting the complex range of needs of children in its care. Social work staff held relevant professional qualifications and their learning and development needs were appropriately identified.

The area had appropriate systems for the recruitment, induction and continuous professional development and supervision of its workforce. An Garda Síochána vetting and CORU registration were up-to-date and reviewed in line with Tusla's policies. A

system of monthly reminders ensured checks were well managed and kept up-to-date. Of the sample of 10 employee records reviewed by inspectors, all essential Garda checks and CORU registrations were in place. There were a few gaps in personnel information in relation to contracts or references. Following the inspection, the area manager provided assurances that these matters had been addressed.

Structures and systems to identify and address the learning and development needs of the area's workforce were well-established and appropriately managed. Training needs analyses were informed by individual needs highlighted in supervision and annual performance development reviews (PDR) combined with analysis of learning from complaints and serious incidents. Training priorities were also aligned to wider organisational development needs and strengthening its capabilities to deliver its service improvement plans. These processes taken together ensured ongoing identification of relevant priorities and resource requirements.

The impact of COVID-19 restrictions meant most training was undertaken as e-learning. There had not been any opportunities for joint training with foster carers involving both child and family social workers and fostering link social workers. Coverage of mandatory training had been prioritised in key areas such as *Children First,* General Data Protection Regulation (GDPR) and complaints management. Inspectors' review of individual supervision records indicated good management recognition of the skills required to support job development or career progression. Mentoring support was provided to new staff following their initial induction, with additional support for new managers.

The area's SAQ identified further work was planned to strengthen its induction programme. The Practice Forum's work enabled ongoing reflection on the experiences of children and foster carers to inform future learning needs. The area had actively promoted the nationally approved model of child participation training to help embed children's rights into organisational culture and practice. Joint learning events such as regional work with chairpersons of foster care committees (FCCs) and annual training events held jointly with another service area ensured effective capture of learning from others' experiences. Service managers encouraged collaboration with other professionals or agencies in promoting the best interests of children, enabling shared learning through consultation and joint review of their behavioural or developmental needs.

The foster care resources team had recognised the need to review and adapt its assessment practice in the light of the changing profile of foster carers and the diversity of children's needs, and to strengthen its practice in the management of foster carer allegations. Members of the FCC sought learning from another region about the management of risk in responding to concerns about foster carers whilst seeking to ensure the safety and continuity of relationships for children already placed. The service area also sought feedback from foster carers to identify their learning and development needs and aimed to further build on this work through the development of a training forum.

Managers clearly recognised the risks and potential impact on staff in delivering care within the context of the COVID-19 pandemic and more recently the cyber-attack; within what has also been a time of capacity challenges in the management of vacancies and staff absences. The safety of staff and their wellbeing was prioritised; with additional support provided as needed including via the employee assistance scheme. The area had developed a 'mindfulness' support session earlier in the year, which had been positively received by staff teams.

The service area had clear systems and processes in place to ensure safe recruitment and the continued growth in the competencies of its workforce. Additional and specialist training had been identified to meet existing gaps in the knowledge and expertise of the workforce.

Judgment: Substantially Compliant

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

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

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

The service area had a clear and well-developed recruitment strategy that actively involved representatives of its local foster carer panel. The service area held an annual recruitment campaign that sought to help it keep pace with local demand for foster care placements. Local recruitment arrangements were also aligned with Tusla's annual nation-wide campaign. However, the service area had not been able to recruit the level of foster carers it needed to continuously grow the service in line with local need and priorities identified. Previous targeted campaigns for foster carers from diverse ethnic backgrounds had not been successful. The service area in its self-assessment questionnaire (SAQ) recognised the need to conduct an evaluation of its approach to inform future recruitment drives.

Monthly foster care committee (FCC) panel meetings promoted a structured approach to matching children on a long-term basis to available foster carers, enabling the principal social worker and FCC chairperson to have oversight of service gaps and changes required to strengthen support to individual children and their foster carers. The capacity of the service area to meet demand for long-term care placements or respite care was limited. This led in a few cases to children remaining in placements that were

not best placed to meet their needs over time, or their being placed in residential care. There had been five placement disruptions in 2020, involving four children; all placed with general foster carers. Five children were placed with relatives outside the local area, and three were placed locally with non-statutory agencies. No foster carer was in receipt of an enhanced payment. The contribution of the Home Youth Liaison Service (HYLS) was valued by foster carers and young people, both in relation to targeted work to prevent placement breakdown as well as programmes of support to help strengthen young people's confidence and independence.

The Foster Care Resource Service Plan (2021) provided clear actions to improve the quality of the service and address gaps in local provision. This included the need for additional training for new and established foster carers to enhance their knowledge and expertise, and increase role satisfaction and retention. The need for stronger joint working between the fostering link and children's social workers was also recognised as an important shared action in identifying risks and providing additional support to help retain foster carers where this was appropriate and in the best interests of children.

Foster carer consultation groups in both Sligo and Leitrim had been re-kindled to promote better communication and networks of support. A foster carer newsletter had been recently developed which aimed to strengthen the profile of and support for foster carers. The area was also working to implement a support group for the children of foster carers as soon as public health restrictions allowed, and to involve care-experienced people more in its development work.

The service area's success in recruiting and approving new foster carers was low in 2020. It had, for the first time, not been able to provide from within its directly managed foster care resources sufficient placements for children newly admitted to care or for children whose placements were disrupted. During 2020, the FCC approved four general foster carers; three of these were from the non-statutory sector. The assessments of three relative carers had also been presented to the FCC, however only one had been approved by the year end. The service was working to expand its relative foster care capacity, and sought potential relative foster carers as the first and preferred placement option where this was in line with children's wishes and their best interests. The service area provided additional support as required to assist them to be able to provide the levels of care needed.

Inspectors sampled records of children already placed with relative foster carers where their assessments were incomplete, and where children had been placed for longer than 12 weeks. Essential safeguards were in place in relation to initial Garda vetting, health and other recruitment checks about suitability. However, it had taken a long time for their assessments to be progressed. In one child's case there had been a delay of 30 months, and for another there was a 19 month delay at the time of this inspection. Although regular contact and visits had been made in the interim to these children and their foster carers, such delays fell well outside Tusla's standard business process

timeframes and best practice. These assessments had been prioritised for urgent action at the time of this inspection.

The area had received 15 enquiries in response to its recent March 2021 recruitment campaign. All had a named fostering link social worker and had been followed up within a week of their expression of interest. At the time of the inspection, seven potential foster care households had been screened out, seven were awaiting a home visit, and one had proceeded to *Foster Care Foundations* training stage. The foster care resource team's assessment workload at the time of this inspection included a total of 11 applicants who were at different stages in the assessment process. The area in its SAQ had recognised the need to take further action to enhance its capacity and address delays in its recruitment and assessment processes. The area had recently implemented a management tracker to enable better oversight of the quality and timeliness of its assessment activity. This management information was beginning to provide better data about barriers to progress and the quality of engagement and assessment work.

The retention of foster carers was recognised by managers as an area of increasing risk to the sustainability of the service and its capacity to match children with foster carers best placed to meet their needs. One foster carer had left the service in 2020, and four had exited by the time of this inspection in 2021. The process for tracking foster carers leaving was appropriately managed, and exit interviews provided useful insights on their reasons for leaving. Areas for further review and learning included the need for additional support when caring for children with disabilities or mental health needs and the availability of staff/quality of relationships with social workers from the children in care and fostering link teams.

Workforce capacity and systems to recruit, assess and retain an appropriate range of foster carers had not yet delivered the level and range of foster carers the local area needed to effectively respond to the diversity of children's needs. The time taken to assess and approve foster carer households was lengthy; impacting on its capacity to strengthen and grow its local panel of foster carers. Support for and the retention of foster carers were areas for further improvement.

Judgment: Moderate non-compliant

Standard 22: Special Foster Care

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

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

Tusla did not have a policy or procedures in place for the provision of special foster care service for children with complex needs, as required by the National Standards for Foster Care (2003). As a result, the service area did not have any special foster carers on its local area panel. This mirrored the lack of development nationally in relation to the need for and specification of the role of multi-skilled specialist foster carers.

Service managers had recognised and sought to provide an appropriate, timely and child-centred response to children with complex emotional or behavioural needs who required high levels of support or supervision to keep them safe. Foster carers of children with complex health conditions or diagnosed disabilities did not receive an enhanced payment; although there was evidence of a range of additional supports provided by the service area, including out of hours supports; to meet their specific needs.

The recent thematic audit completed by Tusla of governance, management and oversight of children in care with a disability (November 2020) identified that all children had an allocated social worker, with evidence of an increase in support from social workers at times of crisis, or risk of placement disruption. The audit found social workers were strong advocates for children and also highlighted additional help foster carers required. They worked in an inclusive and joined up way with other relevant health professionals and agencies. All areas for improvement had been actioned by the time of this inspection.

Gaps in foster carers' knowledge, confidence and expertise in caring for children with high and complex needs were routinely identified within foster carer reviews and supervision and support conversations with their link social worker. Investigations of foster care allegations, serious concerns and complaints also provided analysis of gaps in foster carer knowledge and expertise. One foster carer told inspectors of the importance to them of their bi-monthly discussions and review of their foster child's behaviour management strategies alongside the psychologist, play therapist and their child's social worker and social care worker.

Although the service area had not formally mapped its need for special foster carers, managers were starting to explore its potential value given their awareness of current gaps in local provision for children with specific or complex needs. The service area had not always been able to find suitable or long term care placements for children displaying emotional or behavioural challenges.

The service area had recognised gaps in its provision for children with high or complex needs and was working to address these. However, opportunities for further service improvement were impacted by the lack of a clear and agreed national strategic

direction in exploring the need for and models of special foster carers. This needs to be addressed at a national level.

Judgment: Substantially Compliant

Standard 23: The Foster Care Committee

Health boards have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice.

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

The foster care committee (FCC) was well led by a suitably experienced independent chairperson. Its terms of reference and business operations ensured the best interests of children was at the heart of its decision-making and its analysis of risk. Its members clearly recognised their governance role and discharged their accountabilities to the service area in line with Tusla's FCC's policies, procedures and best practice guidance (2017). The FCC annual and quarterly reports provided good performance information and data to support wider service planning and improvement. Inspectors' review of minutes of FCC meetings indicated effective management of its workload; with appropriate arrangements in place for the approval and ongoing review of relative, general and non-statutory foster carers and for tracking the outcome of foster carer allegations and other serious concerns.

Committee members had a broad and relevant range of knowledge and expertise, including of personal experience of care, or as foster carers. Partner agencies' participation in FCC meetings was good and enabled sharing of expertise and relevant discussion about the needs of children and the suitability and experience of foster carers. Joint development work with other FCC chairs and access to training/peer review with neighbouring service areas supported access to additional advice and expertise as required. FCC meetings had been held on a regular monthly basis over the past year. For the most part, meetings had been conducted virtually. An additional face-to-face meeting had been convened where there was a need to give substantial time to discussing a complex issue in order to reach an agreed strategy for managing the way forward.

Arrangements for checks and reviews of the suitability of FCC members were appropriately undertaken, including Garda vetting. New committee members had an appropriate induction, with follow-up checks for established committee members who continued to serve on the FCC. Its members benefited from joint training with a neighbouring area and additional bespoke training was sourced as required. The FCC

chairperson attended quarterly regional meetings with other FCC chairs, facilitated by the regional quality, risk and service improvement manager. This oversight and support was effective in strengthening good practice and promoting a consistently high standard of performance across the region.

Inspectors' review of a sample of FCC records indicated members maintained a strong focus on hearing and understanding the voice and experiences of children to inform the decisions and recommendations they made. Social work reports received by the FCC provided good analysis of children's views and experiences which was effectively used to inform the suitability of their long-term match. The wishes and feelings of children were appropriately threaded through considerations of risk and decisions about the continued suitability of foster carers; including in complex and sensitive areas such as foster carer allegations or reviews. The quality of foster carer assessments was carefully considered to ensure all relevant factors were clearly explored and that assessments provided clear analysis of the strengths, identified risks and areas for knowledge or skill development. On occasion, approval decisions were deferred until sufficient assurance was received. Foster carer reflections of any previous placement endings or disruptions were appropriately considered within their reviews.

The annual FCC report (2020) provided a clear overview of the adequacy of foster care provision and of priorities for improvement. The report had identified a doubling of concerns and allegations (total of nine) compared to the previous year. This led to a programme of learning and further improvement that had informed wider service and team planning and the training needs of the local workforce. The appeals process was adequately managed overall; with external review where needed. However, it had taken a long time to conclude a few foster carer appeals. There was evidence of organisational learning from this, with recent improvements in the timeliness of interventions, and additional offers of support whilst the process was being heard.

Overall, the FCC exercised its governance role well and ensured its practices complied with the standards of performance set out in Tusla's policies, procedures and guidance. Its systems, processes and scrutiny of the suitability and retention of foster carers on the panel was well-managed and driven by an open, challenging and child-centred culture.

Judgment: Compliant

Standard 24: Placement of children through non-statutory agencies

Health boards placing children or young people with a foster carer through a non-statutory agency are responsible for satisfying themselves that the statutory requirements are met and that the children or young people receive a high quality service

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

The service area ensured good scrutiny and support for the safety and wellbeing of children and the quality of foster care services delivered through the non-statutory sector. The service area had three children, placed with two different providers within two households. The rationale for these placements related to gaps in the capacity of Tusla's own provision at the time of their admission to care. All three children had an allocated social worker, and were regularly seen and spoken to. There was evidence of good contact and information-sharing with the respective agency's fostering link social workers and their Guardians ad Litem. However, Tusla's arrangements nationally for the commissioning and contract management of private providers was still in development at the time of this inspection. This meant that there remained no service level agreement in place as required by the standard and local managers were not supported by clear guidance for monitoring and benchmarking their performance.

The foster care committee (FCC) ensured assessment and review arrangements for non-statutory foster care agencies complied with the standards set out in policy, procedure and practice guidelines for the management of its foster care panel. This provided assurance that the same standards of approval and retention were considered in decision-making about suitability. Approvals and reviews of foster carers were well-managed.

Inspector's review of children's records indicated statutory visits, child-in-care and foster carer reviews were undertaken in line with placement regulations. There was evidence of good communication between non-statutory foster carers and other foster carers in maintaining contact between siblings placed elsewhere. Checks of the quality of foster care included recognition of their accountabilities for reporting child protection concerns, promoting children's identity and relationships with their birth family, and maintenance of relevant up-to-date records of the child's progress, development or behaviours. Increased contact and visits were made following notification of concerns or escalation of risk, as was the case for children placed in other foster care settings.

While case management arrangements indicated appropriate oversight of and support for children in the care of non-statutory foster care agencies; governance and assurance processes were hindered by the lack of a clear national framework for commissioning, contracting and benchmarking the quality of provision locally procured.

Judgment: Substantially compliant.

Standard 25: Representation and complaints

Health boards have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including Complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.

The area judged themselves to be substantially compliant with this standard. Inspectors did not agree with this judgment and assessed this standard as compliant.

Local resolution arrangements were effective in resolving the majority of complaints in a timely manner. The area did not have a designated complaints manager. The area manager maintained good oversight of complaints and compliments. The regional complaints officer provided additional support and guidance to senior managers in the investigation and review of complaints. Complaints and compliments were routinely discussed at quality, risk and service improvement meetings (QRSI) to help strengthen analysis of areas for improvement and learning from what was working well. External/peer review of complex complaints was appropriately used on occasion to provide further assurance of an open and fair process, which provided challenge and support for changes to practice and wider organisational learning.

Representations and complaints overall were well-managed and monitored by team and service managers, with complainants routinely advised of the outcome of their complaint in writing. The service area had received eight complaints about its alternative care services in 2020. All were closed, with the expected timescales for investigation adhered to. To date for 2021, the area had received four complaints, two were closed, and factors outside the service area's control had led to delay in the others being concluded. A complaints/compliments tracker had been developed which enabled good ongoing oversight of progress, delay and trends. Key themes in relation to learning from complaints such as the need for consistently good communication with children, birth families and foster carers and addressing gaps in access to services; were being used to review organisational performance and shape service improvement plans.

Children and their foster carers were provided with relevant information on how to make a complaint or give feedback on their experience of services. Children-in-care review arrangements ensured checks were routinely taken of the experiences of children and of anything they would like to see changed. They were encouraged to make suggestions for improvement. Children told inspectors that they had received such information in a way that was easy for them to understand, which had been adapted to their age. Although some children inspectors had spoken to, did not know about advocacy organisations, they said they were helped to have the confidence to speak up and have their opinions heard. Home and statutory visits made by their social worker ensured any concerns the child had were routinely sought and promptly acted

on. Parents were given advice about how to access legal advice and how to complain at key points such as admission and review of children's care which took account of their capacity to understand and their need for interpreting/translation support.

Relevant advice and guidance was also given to foster carers about advocacy organisations they could approach for support, and the work of a national foster care association was promoted. Foster carers told inspectors that when they had made a complaint, their issues had been promptly addressed. The foster care committee (FCC) identified further analysis of the root causes of complaints would also help it in identifying areas for learning in relation to its role and function.

The service area ensured children and foster carers were aware of how to make a complaint; with good systems in place for the management and monitoring of complaints. Complaints were actively used as a key performance indicator to enable the service area to assess progress made in driving organisational improvement and strengthening its understanding of the needs, views and wishes of children, birth families and foster carers.

Judgment: Compliant

Appendix 1: National Standards for Foster Care (2003)

This thematic inspection focused on the following national standards that relate to the governance of foster care services.

Standard 18	Effective policies
Standard 19	Management and monitoring of foster care services
Standard 20	Training and qualification
Standard 21	Recruitment and retention of an appropriate range of foster carers
Standard 22	Special foster care
Standard 23	The Foster Care Committee
Standard 24	Placement of children through non-statutory agencies
Standard 25	Representations and complaints