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:	Louth Meath
Name of provider:	Tusla
Type of inspection:	Thematic
Date of inspection:	24 – 27 January 2022
Fieldwork ID:	0035208

About this inspection

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

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

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

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

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

How we inspect

As part of this inspection, inspectors met with the relevant managers, child care professionals and with foster carers. Inspectors observed practices and reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data submitted by the area
- interviews with:
  - the region's chief officer
  - the area manager
  - the chairperson of the foster care committee
  - the quality risk service improvement officer
  - the aftercare coordinator
- focus groups with:
  - principal social workers for children in care, foster care, aftercare and child protection and welfare
  - social work team leaders
  - frontline staff
  - 12 foster carers
  - seven external stakeholder representatives from family and youth services, and advocacy services
- observations of:
  - foster carer committee meeting
  - child-in-care review meeting
  - governance meeting
- the review of:
  - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
  - staff personnel files
  - a sample of 18 children's files and 19 foster carer files
- separate phone conversations with:
  - a sample of four parents, two children and nine foster carers and one guardian ad litem and one psychotherapist.

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 privately run foster care agencies and has specific responsibility for the quality of care these children in privately provided services receive.

Service area

Louth Meath is situated in North Leinster, on the east coast of Ireland and in close proximity to Dublin and is part of North South Axis. While Louth is the smallest county in Ireland, it has a high population density composed of the first and third largest urban areas (Drogheda and Dundalk) outside of designated cities. The Louth Meath area is a large geographical area with distances of 115kms at its broadest which has an impact on accessing resources and responding to need.

The total population (Census 2016) of Louth Meath is 323,928. The Population was 307,032 in 2011 and 274,090 in 2006. This indicates a population surge of a 5% (increase since 2011 and a 15% (49,838) increase since 2006. It comprises three of the largest and fastest growing towns in Ireland. Three towns in the area are in the top five most populated towns in Ireland –

1. Drogheda - 40,956 +6.2%
3. Dundalk - 39,004 +3.1%
5. Navan - 30,153 +5.7%).

Louth Meath has a population of 93,093 children and young people which is the 5th highest child population per Tusla area and representing 28.47% of DNE's Population. Children aged less than 18 years represents 28.47% of the area's total population. This includes 29.3% of Meath's population (57,134) and 27.2% of Louth's population (35,046). The number of children (0-17yrs) increased by 6%, from 87,562 to 93,093. It is clear that Louth Meath's population is still increasing and that there is likely to be an increased demand for children's and young people's services over the next decade.

At the time of this inspection, there were 225 Tusla foster care households in the area comprising of 150 general foster care households and 75 relative foster care households. There were 382 children in care living in foster care households. This included 261 children in general foster care, 101 children living in relative foster care and 20 children in private foster care.

Compliance classifications

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

Compliant	**Substantially Compliant**	**Moderate Non-Compliant**	**Major Non-Compliant**
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
24 January 2022	09:00hrs – 17:00hrs (onsite)	Jane Mc Carroll	Inspector
	09:30hrs – 16:30hrs (onsite)	Una Coloe	Inspector
	10:30hrs – 17:00hrs (onsite)	Niamh Greevy	Inspector
	12:00hrs – 17:00hrs (onsite)	Sabine Buschmann	Inspector
	09:00hrs – 16:00hrs (remote)	Pauline Clarke Orohoe	Inspector
25 January 2022	09:00hrs – 17:00hrs (onsite)	Jane Mc Carroll	Inspector
	09:30hrs – 16:30hrs (onsite)	Una Coloe	Inspector
	09:00hrs – 17:00hrs (onsite)	Niamh Greevy	Inspector
	09:00hrs – 17:00hrs (onsite)	Sabine Buschmann	Inspector
	09:00hrs – 16:00hrs (remote)	Pauline Clarke Orohoe	Inspector
26 January 2022	09:00hrs – 17:00hrs (onsite)	Jane Mc Carroll	Inspector
	09:30hrs – 16:30hrs (onsite)	Una Coloe	Inspector
	09:00hrs – 17:00hrs (onsite)	Niamh Greevy	Inspector
	09:00hrs – 17:00hrs (onsite)	Sabine Buschmann	Inspector
	09:00hrs – 16:00hrs (remote)	Pauline Clarke Orohoe	Inspector
27 January 2022	09:00hrs – 15:45hrs (onsite)	Jane Mc Carroll	Inspector
	09:30hrs – 15:45hrs (onsite)	Una Coloe	Inspector
	09:00hrs – 15:45hrs (onsite)	Niamh Greevy	Inspector
	09:00hrs – 14:00hrs (onsite)	Sabine Buschmann	Inspector
	09:00hrs – 16:00hrs (remote)	Pauline Clarke Orohoe	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 03/2017) – Assessed the efficacy of the recruitment procedures, foster care supervision, and the assessment of foster carers.
- Phase 2 (completed in this area in 09/2020) – Reviewed the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children.

Summary of the Findings from Phase 1

Of the eight standards assessed in phase 1:

- one standard was judged compliant
- six standards were judged substantially compliant
- one standard was judged major non-compliant.

The area had been proactive in recruiting foster carers in the year prior to inspection. However, managers and staff continued to identify that they did not have a sufficient range of foster carers to meet the demands of the service. Safe practices and processes were in place in relation to the assessment and approval of both relative and general foster carers. Concerns and allegations received an appropriate response to ensure the safety and welfare of children. Over half of foster carers in the area had not had a foster carer review in over three years. While the area had a schedule in place for the remaining foster carer reviews, inspectors sought written assurances for more timely completion of all reviews. Furthermore, training needs analysis and the development of a training strategy for foster carers was required.

Summary of the Findings from Phase 2

Of the six standards assessed in phase 2:

- three standards were judged compliant
- three standards were judged substantially compliant.

The area was providing a safe and effective service. Governance and management structures were effective. Areas identified for continued service improvement and compliance with standards included increased management oversight of statutory visits, improvement in recording information in children's files, improvement in recording managerial oversight on children's files and timely investigations of allegations of abuse.

Self- Assessment information and what Tusla said about the service

Prior to the announcement of the inspection, a self-assessment questionnaire (SAQ) was submitted to HIQA by the service area's management team in March 2022. The SAQ is part of the methodology for this inspection and it required the management team to assess their own performance against the eight standards relating to governance which in turn identified where improvements were required.

The service rated its performance as substantially compliant against six standards and moderate non-compliant against two standards. The information they provided described strong governance management and oversight of the service overall and effective leadership and vision to drive improvement. In addition, the service recognised gaps in the service provision which were reviewed and monitored through management systems and service planning. The service rated its performance as non-compliant against the standards for the recruitment and retention of an appropriate range of foster carers and the management and the placement of children through non-statutory agencies.

While recognising strong leadership and vision for the service, coupled with well-developed governance structures, this inspection found that management systems could not ensure the delivery of a consistently high quality foster care service in line with relevant policy, procedure, regulations and standards. Three standards were rated as non-compliant moderate by inspectors and these were effective policies, management and monitoring of the foster care services and the recruitment and retention of an appropriate range of foster carers. Inspectors agreed with the area's judgement in four of the eight standards and increased the level of compliance to substantially compliant for standard 24.

This inspection took place in what has been a challenging time nationally for social work teams and children and families engaging in the services, due to the risks and public health restrictions associated with the COVID-19 pandemic. Furthermore, Tusla had been the target of a major cyber-attack in 2021, which compromised their national child care information system (NCCIS) for several months prior to the inspection. In addition, the Louth Meath service area was one of four areas operating from a separate email software system to the majority of the organisation, and they were one of the first Tusla service areas to move to the new Tusla email system, which came with its own sets of challenges. Staff did not have access to old emails or information on shared email accounts predating the cyber-attack up until the end of 2021. In this context, HIQA acknowledges that the Louth Meath service area had to adapt their service delivery in order ensure continuity of essential services to children and families. These issues, and how they have been managed, were 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 feedback also provided evidence on the experience of children in foster care.

Inspectors spoke to two children individually over the phone. They reported positive experiences of foster care and of their social workers. They said they were happy where they lived and described many aspects of their lives that brought them joy, such as playing with friends and family, going swimming and playing football. The children were appropriately supported to understand why they lived there. Children and their foster carers told inspectors about the sensitive ways information was shared with them such as through storytelling and collecting memorabilia.

Children's experiences were positive and their comments included the following;

"My social worker listens to me."
"She (social worker) is good."
"My social worker asks me about school and what are my feelings."
"She (social worker) brings colours and I colour on the page."
"My social worker asks me if I have friends and if I am happy."

Inspectors spoke to four parents individually over the phone. Overall, parents described that their experience of the service was good but they identified areas for improvements. Positively, they said that their children were happy and doing well in foster care. Two parents said it had been difficult at times to speak to a social worker and they said that their views were not always heard. Parents said that the service was under staffed.

Some comments from parents included;

"The social worker is a nice woman, she is very open and I can go to her whenever...."
"Everything is going well but it can be difficult to get a hold of a social worker."
"The team leader has been really good but they are under staffed and they are trying to do their best."
"The child gets on well with their social worker."

Inspectors spoke to foster carers through a focus group and with nine foster carers individually over the phone. Inspectors heard a range of experiences and feedback from foster carers about the service. Some described their experiences as outstanding while others had mixed reviews and identified areas for improvement.

Some foster carers told inspectors that they received an outstanding service. They provided examples of this, such as receiving timely and appropriate support and response from the service at times of need and experiencing consistency of approach and practice with the same social worker for children and foster carers for a long period of time. They said that the service promoted children's rights and children's cultural identity and that care planning was effective as a means of ensuring that short to long-term needs of children were met in a comprehensive way. These foster carers felt supported by the service.

Foster carers positive comments to inspectors included;

"They (social workers) keep us updated, they are really diligent."
"I feel supported."
"The social worker knew everything about the child, I have a really good rapport with her."

"The social care worker was excellent."

"The service works well to keep children safe."
"The children's views are taken on board and the social worker is aware of their feelings."

Other foster carers told inspectors that there were gaps in the service provided to them. While some foster carers experienced continuity in the support and interventions provided to them by allocated social workers, other foster carers did not have this experience. Some foster carers said that there was a lack of continuity of social worker for them and for the children in their care. They said that children were experiencing significant changes in social workers and this had a negative impact on their care planning and access to services. They told inspectors that the service was under-resourced and there was not enough staff to provide the service. In addition, some foster carers said that they did not receive enough support from the foster care service to access additional services and they experienced delay in access to respite care.

Other comments included;

"I don't feel that they work to meet her needs, it is a battle to get what is needed."
"I don't think the (social work) teams have enough people to do the job."
"The new social worker called and did not know anything about the child."
"Some social workers come and only listen in the moment….I feel like they are just ticking boxes."
"There is not enough done to mark appreciation."

Foster carers said that they had the opportunity to provide feedback on the service through social work visits, review meetings, and telephone calls. They said they knew how to make a complaint and could speak to managers if required. A small proportion of foster carers were not satisfied with the responses they had received to their representations to the service.

External professionals told inspectors that the foster care service had good management and oversight of commissioned services providing direct work and intervention to children in foster care and their foster carers. They said that the working culture and ethos of the service was child centred and the area strived to be innovative and responsive to the needs of children and foster carers. They gave examples of innovative practices such as the commissioning of psychotherapy support and intervention for children and foster carers which they said will improve the quality of care provided and outcomes for children.

External professionals also said that while the area strived to respond to the needs of foster carers and children in care, there were gaps in the resources available to meet the needs of children and foster carers in the area. They said that there were staffing shortages on social worker teams. They said that there was a lack of consistency of social worker for children in care and this was destabilising for children. While they said that managers endeavoured to ensure that all children needs were identified, decisions about some children were delayed. In addition, they said that there was

variation in the level of support afforded to foster carers by the service. For example, inspectors heard from an external service that some foster carers were seeking additional support, advice and time from them, beyond their remit, particularly during the COVID-19 pandemic. They said that it was their impression that these foster carers were not getting the support they needed.

External professional raised concerns about the lack of foster care placements for children in the area. They said that children could not be matched to foster carers on the basis of need and suitability. They said that this meant there was increasing need for specialist training and support for foster carers in order to sustain children's placements and minimise disruption.

Case records reviewed on inspection demonstrated mixed quality in relation to overall service being provided to children and foster carer. Positively, children's records indicated that their wellbeing and safety was proactively monitored. In most cases, social workers and managers paid good attention to identifying children's needs to inform dynamic child-centred care planning. Social workers allocated to children got to know them well and this was evidenced in the recording of children views and their unique needs. But children were not always placed where their needs could be best met due to insufficient choice of placements and this increased the likelihood of placement breakdown.

Foster carer records demonstrated overall mixed quality in relation the support and supervision provided to them. There was good quality support and supervision provided to foster cares, such as high levels of support when placements were at risk of disruption, increased visits to children and foster carers at times of need and access to additional supports and interventions from commissioned services.

In other cases visits to support foster carers were not frequent enough. Records showed that when foster carers did not have an allocated social worker, the quality of supervision and support was affected, such as delays in access to additional supports or infrequent support and supervision visits outside of the regulatory requirements. Some foster carers were caring for children outside of their approval status and in overcrowded placements which placed excessive demands on them.

Governance and Management

The area had clear and developed governance structures in place to manage the foster care service but persistent challenges impacted upon the quality and safety of service being provided. Inspectors found that the foster care service did not have the capacity to provide a responsive and consistent service to all children and foster carers. There were good practices found, but overall, improvement was required in the management and oversight of service delivery. Whilst there was evidence of service improvement across many aspects of the foster care service, other service improvement objectives intended for 2021 were difficult to achieve and sustain whilst ongoing workforce and foster care capacity issues placed considerable strain on the service. These findings are outlined in more detail in the body of the report.

The service area benefitted from having a strong, stable and experienced management team who knew the area and community well. The management team had high expectations for the service being delivered and they were committed to raising standards in the service for children and young people. There was a working culture underpinned by learning, support and improvement and this ethos was shared by staff and commended by external stakeholders who spoke to inspectors.

Strategic management systems were well developed. There was an integrated approach to service planning. The area had a service plan for 2021 appropriately aligned to Tusla's own corporate and business plan objectives. The service plan was ambitious and was part of a five year strategic plan, led out by the area manager, to ensure the best possible outcomes for children and young people using the service. However, inspectors found the pace of overall service improvement in 2021, was compromised by persistent shortfalls in the capacity of the service to meet demands. The service plan did not effectively identify and target some of the unique challenges and risks for this foster care service in the previous 12 months.

Senior management meetings and governance meetings facilitated oversight of areas of escalating risk and areas of progress for the service and included representation from each service pillar, as well as the area manager, business support manager, the Foster Care Committee (FCC) chairperson, principal social workers and others. Standing agenda items included the review of performance and activity data to 'measure the pressure' regarding the capacity and capability of the service, as well as complaints, compliments, incidents and risks. Inspectors observed a governance meeting and found that while there was good analysis of business intelligence, reports, audits and reviews to inform senior managers about the quality of the service, immediate actions could not always be taken to address all known risks. For example, a strategy could not be identified to mitigate against escalated capacity issues on the

fostering social work team resulting from three staff members on maternity leave and the imminent departure of a further staff member.

In addition to senior management meetings, individual team meetings were regularly held to ensure ongoing monitoring of performance against policies, procedures, statutory requirements and standards, but inspectors found that oversight and monitoring of aspects of service delivery by social work teams required improvement. For example, the local procedure for the management of unallocated cases was not effectively implemented or standardised across all teams. Inspectors found inconsistent practice in the implementation of Tusla's standard business processes for the management of allegations by children. This is outlined further on in this report.

There were line management structures and clear accountabilities with staff at all levels which were mostly effective but managerial oversight and supervision of social care staff required improvement. Staff who spoke to inspectors were clear about their role and the expectations that the organisation placed upon them and their colleagues across the service. Inspectors found that there were good communication systems in the area and established working relationships between managers and staff. Supervision of social workers and managers had improved. However, inspectors found inconsistent practice in managerial oversight and supervision provided to social care workers allocated to cases in the absence of an allocated social worker. Whilst records reviewed demonstrated high levels of support, contact, and engagement from social care workers to children in care, supervision practices were not consistent and at times absent. This required improvement to ensure effective management oversight of these cases.

Staffing levels across the fostering service required improvement. There were staffing shortages across children in care and foster care social work teams, with 13 whole time equivalent posts unfilled at the time of this inspection due to vacancies as well as leave and absence. The service was not successful in accessing agency staff to back fill posts. The impact on social work teams was significant. There was evidence of work to progress these capacity challenges in the area, such as a comprehensive workforce analysis and plan for 2022 to 2023, which set out a strategy for restructuring resources, with identified requirements for additional staff and the need for an alternative national model to provide effective cover arrangements for leave and long term absence. There was engagement between the area manager and Tusla's national HR directorate in this regard and a bespoke recruitment campaign for the area commenced in January 2022. In addition, the area had developed a social work graduate programme with a local university to enhance interest and appeal for student social workers to seek employment opportunities with the Child and Family Agency. However, at the time of this inspection, ongoing workforce capacity issues placed

considerable strain on the service and the impact, on what were relatively small teams, was clearly evident.

Managers worked hard to retain their workforce and promote staff wellbeing in response to these challenges. The area had a staff wellbeing and retention strategy which included procedures in relation to caseload management and supervision of staff as well as team building and wellbeing initiatives. Staff told inspectors that they felt supported in their roles but that they were overstretched in their capacity to provide a consistent service.

At the time of the inspection, there were 27 foster carers (9%) without an allocated link social worker and fostering assessments were delayed. In addition, there were 82 children in foster care (21%) without an allocated social worker. There was a duty system for the management of unallocated cases but this did not ensure consistent and responsive support, intervention and supervision of children and foster carers in line with national standards. In the last 12 months, the service area had implemented contingency plans for dealing with such capacity challenges but these measures had not been effective in systematically reducing these delays and gaps in service provision.

The availability of foster care placements to best serve children's needs in the area was inadequate and this posed risks to children due to increasing potential for placement breakdown and further disruption in their lives. The lack of placements to meet the needs of children in the area was regularly risk escalated and considered at the highest risk level for the area. Children were not always placed where their needs could be best met due to insufficient choice and at times, this resulted in poor matching. The service worked in partnership with the Regional Assessment Fostering Team (RAFT) through 2020 and 2021 who had the delegated responsibility for the recruitment and assessment of general foster carers for the Dublin North East Tusla region, including the Louth Meath service area. This meant that there was no scope locally for recruitment of general foster carers until permission was obtained at the end of 2021, to develop and implement a local area foster care recruitment plan.

Inspectors found that that there was a systemic crisis response to identifying and sourcing foster care placements for children in the area by the fostering team and the resource implications of this were evident. During the inspection, there was evidence of work in progress to explore alternative models of provision, such as a new local area strategy for the recruitment and assessment of foster carers and the service had increased the capacity of relative foster care in the last 12 months.

Whilst the current situation in the service meant that a significant focus was on managing risks, improvement plans were designed and implemented to achieve

compliance with national standards and this was the expectation of senior managers for service delivery. In addition to the area service plan, other improvement plans for the foster care service, such as their HIQA quality improvement plan and a foster care committee improvement plan arising from Tusla's thematic audit, were monitored, tracked and reviewed at management meetings, in conjunction with performance and activity data and reports. Inspectors found that the senior management team had achieved and sustained good practice and good levels of compliance in some standards assessed and judged in this inspection, which clearly indicated strong leadership and vision for the service.

The area complied with Tusla's national policies and procedures for risk management. Inspectors found that the identification and classification of risk was comprehensive. Risks recorded on the service's risk register were subject to regular quality review and scrutiny. For the majority of risks, mitigating controls had been effective at reducing and or stabilising the impact on service delivery. For example, the service effectively managed risks which presented throughout 2020 and 2021 as a result of COVID-19 as well as the cyber-attack on Tusla in May of 2021. Responsive and creative solutions were identified for ensuring that families and children were supported and safe during the pandemic. There was a comprehensive recovery plan to ensure that information management systems were restored in the aftermath of the cyber-attack

However, the service did not have the capacity to implement all existing controls and some risks to the service persisted. Risks in relation to staffing capacity, unallocated cases, and lack of placements to meet the needs of children in the area were regularly risk escalated but the risk management response from a regional and national level, had not been effective. In addition, control measures put in place by the fostering service for the management of risk associated with unallocated cases were not fully implemented. For example, children most in need and deemed high priority were not always allocated a social worker in line with identified risk controls. Data provided to inspectors at the time of the inspection showed that there were 82 children in care unallocated, 43 of whom were deemed high priority and 37 of whom were deemed medium priority.

There was a 'need to know' (NTK) reporting mechanism in line with Tusla's national incident management system and this was used to notify Tusla's national office of serious incidents and adverse events in relation to children in care. There were 44 such notifications in total made to the national office in 2021, and the majority related to incidents and risks associated with COVID-19. Inspectors reviewed the area's NTK log and found there was appropriate follow up and further review that provided assurances to the safety of children or staff. In practice, this reporting systems was also used to escalate risks associated with the lack of placements for individual children who required foster care. But there was also a cohort of children in foster care

who needed to move to a more suitable placement, and these moves were sometimes delayed. While these cases were individually risk assessed in order to establish additional supports and actions required to meet children's needs, the overarching measurement of the impact of these risks for children in care and indeed for the service were not analysed and assessed on aggregate.

The response and learning from incidents, complaints and representations to the service was good. The area maintained a register of compliments and complaints and this was a standing agenda item on governance and senior management team meetings which supported ongoing organisational learning, quality improvement, and appropriate identification and reflection on what was working well. There was a complaints and compliments casebook for 2021 which detailed learning from a sample of cases across the service area. However, further improvements were needed to share learning across all staff grades.

The area routinely collected and used information to enhance the quality of care and the performance of the service. Tusla's National Child in Care Information System (NCCIS) was used to monitor service provision and gather appropriate data about the service to support service planning and delivery. Information was used to enhance the quality of care and the performance of the service. These related to statutory requirements, such as, up-to-date care plans, child-in-care reviews, foster carer reviews and Garda vetting checks which were monitored and tracked on the child in care and foster care register. However, the service's SAQ identified that information systems required improving in retrieving key data intelligence from NCCIS such as levels of unmet need or foster care breakdown as these reports could not be generated on the current national system.

The area had a well-functioning foster care committee (FCC) with an independent chairperson. The foster care committee was guided by the standards and national policy, procedure and best practice guidance on FCCs. The FCC was well governed and there were good systems in place to monitor its effectiveness and address areas of improvement both for the FCC and for the fostering service. Its membership included individuals with a broad and relevant range of experience, knowledge and expertise.

To conclude, while recognising strong leadership and vision for the service, coupled with well-developed governance structures, this inspection found that management systems could not ensure the delivery of a consistently high quality foster care service in line with relevant policy, procedure, regulations and standards. There was a significant shortfall in capacity to meet the service demands. Risks relating to staffing capacity, unallocated cases, and lack of placements to meet the needs of children in the area required more substantial action to effectively reduce the impact on service

delivery. Improvement was required in the management and oversight of aspects of service delivery.

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 did not agree and judged the area as non-compliant moderate.

In general, policies, procedures and guidance were in place to ensure the effective and safe delivery of foster care services. Strategic management systems were well developed and supported an integrated approach to service planning. The implementation of some policies required better monitoring and greater oversight to ensure that they were consistently implemented.

Inspectors found that planning and development of the service was underpinned by analysis of the services' performance, risks and areas for improvement, changing needs, new research, inspection findings and practice developments. The service had sufficient plans for the delivery and development of the fostering service. There was an integrated approach to service planning. The area had a service plan for 2021 appropriately aligned to Tusla's own corporate and business plan objectives. While the service plan did not did effectively identify and target some of the unique challenges and risks for this foster care service in the previous 12 months, complimentary service improvement planning and development was evident, such as the area's workforce analysis and plan for 2022 to 2023 and the FCC improvement plan 2021 arising from Tusla's thematic audit.

There were policies and procedures to promote a partnership approach to the care of children including them, their foster carers, families and other stakeholders in the development and delivery of services. The fostering service in Louth Meath were proud of their learning culture and this ethos underpinned the service's value on partnership working.

The area had adopted the motto “nothing about us, without us” which defined their strategy on child participation and partnership working. Examples of good practice included the ‘We Need You’ project which provided feedback to the service on children’s views of social work services. There was a project lead who coordinated local youth participation projects in the area, such as a youth participation forum.
There were formal arrangements to support a partnership approach to care with other services and stakeholders. Forums were in place for the service to engage and collaborate with external stakeholders, to develop joint working and to advocate for the needs of children in foster care where appropriate. Such meetings included engagement with local housing directors, joint working with the Health Service Executive (HSE), Garda liaison meetings and aftercare steering groups amongst others. In addition, external stakeholders were included in the development and delivery of the service through the commissioning processes, which informed service planning.

A new initiative called Creative Community Alternatives (CCA) had provided dynamic and practical support to placements at risk of breakdown in the service. There was a clear referral pathway for access to commissioned services through the CCA project and project lead with delegated responsibility for oversight, review and approval of all referrals.

In the last 12 months, formal arrangements with other agencies were not all effective in facilitating effective joint working of specific cases of children as required. There were individual meetings and involvement of the HSE in care planning for some children as required. However, monthly meetings with HSE, in line with the joint protocol requirements had been cancelled by the HSE at the beginning of COVID 19 pandemic and had not reinstated despite requests from the area for same. In the previous 12 months, gaps in accessing specialist services, such as psychology, disability services and mental health supports, had been identified and considered at the highest level of risk for the area. When required, individual cases were escalated for involvement of the senior management team and Tusla’s national office. At the time of this inspection, the area manager was assured that there was evidence of progress to reinstate joint protocol meetings.

Information was sought from foster carers to inform service planning and delivery. For example, foster carers were consulted on the development of a programme of training for the service. Their complaints and compliments were monitored and reviewed to inform learning and improvement. Foster carers were invited to take part in exit interviews when they left the service and the area had conducted an analysis of the findings from these interviews in order to identify areas of learning for service improvement. In addition, there was a service level agreement with a local branch of a foster care advocacy group and joint working was evident.

The area maintained a register of the panel of persons approved to act as foster carers in each county in order to comply with the Child Care (Placement of Children in Foster Care) Regulations 1995. The register included approved foster carers working for private non-statutory foster care agencies. The register in the Louth Meath service area was kept up to date. It included a list of approved foster carers, their address, contact details, their assessment type, their allocated fostering social worker, the date of their approval and whether they were active, inactive, on hold or exiting the service. In 2021, the area manager conducted an analysis of the profile and circumstances of children placed in care in previous 12 months to compare the needs in the area with the existing panel of foster carers, and to inform future service need. This analysis led to the identification of areas that required improvement in relation to foster carer recruitment, retention and training.

The service had national policies, procedures and guidance documents for the delivery of foster care services which were aligned to relevant legislation, regulations and national standards but the implementation of some policies required better monitoring and greater oversight. In addition, the service developed practice guidance, standard operating procedures and practice tools to enhance the quality of the service provided to children, foster carers and other stakeholders. Staff were aware of the policies and procedures underpinning their work. Records showed that children and foster carers received information including polices, national standards and procedures for mandating reporting in line with Children First: 2017, as appropriate.

Inspectors found examples of good practice which adhered to policies and guidance. By way of example, records showed high levels of support being provided to children and foster carers when placements were at risk of disruption, including increased visits to children and foster carers, access to psychotherapy support and multi-agency meetings to coordinate the best response.

In addition, there were detailed and comprehensive social work records for visits, reviews and care plans that captured the views of children and reflected their unique circumstances, talents and interests. Children's concerns and needs were recorded and monitored through good care planning. Children were supported to maintain their relationships with their family. For example, inspectors saw photograph postcards which were made for children to share with their family.

There were examples of staff adhering to procedures associated with COVID-19. For example, inspectors saw individual COVID-19 risk assessments on file identifying specific risks relating to the spread of infection in fostering households for children with compromised immunity. These assessments were accompanied by mitigating actions.

The service followed Tusla's national transfer policy in relation to children placed inside and outside the Louth Meath service area. While there was significant resource implications for the area in holding case responsibility of children in care from other service areas, the area has accepted transfer of children where there has been significant need.

There was inconsistent implementation of other policies. The local procedure for the management of unallocated cases was not effectively implemented or standardised across all teams with relevant case responsibility. Risk assessments to determine the priority of cases unallocated and to identify actions required, were not routinely evident on individual files. Hard copies held in folders by social workers managers were not accessible enough for the monitoring and management of these risks. The application of the risk assessment was not always timely and when concerns about children in care increased, cases of high priority were not always allocated.

Inspectors found inconsistent practice in managerial oversight and supervision provided to social care workers allocated to cases in the absence of an allocated social worker. Whilst records reviewed demonstrated high levels of engagement, contact and support from social care workers provided to children in care, supervision practices were not consistent and at times absent. This required improvement to ensure effective management oversight of these cases.

Inspectors found inconsistent practice in the implementation of Tusla's standard business processes for the management of allegations by children. Inspectors looked at seven child protection and welfare concerns for children in foster care and found that all seven were delayed and did not adhere to Tusla's own timelines within standard business processes. In addition, the launching of child protection and welfare concerns and referrals through NCCIS was not in line with standard business process.

In three cases, allegations of abuse and concerns for the protection and welfare of children were not launched on Tusla's national information systems in a timely manner and these reports were not screened in line with Tusla's own standard business process to determine threshold, priority and response. Inspectors found that immediate safety concerns were addressed in these three cases and notifications were sent to An Garda Siochana as required.

In one of these three cases, where a child protection and welfare concern arose from an allegation made against a child in care, practice was not in line with Children First: 2017. Inspectors found that while immediate safety concerns were addressed, a decision was made to defer the social work assessment pending other external investigations. But this meant that child protection and welfare concerns, including the impact of the allegation for other children in the foster care household remained unassessed.

Overall, this standard is assessed as non-compliant moderate due to the lack of effective and consistent implementation of the local procedure for the management of unallocated cases, and inconsistent practice in the implementation of Tusla's standard business processes for the management of allegations by children.

Judgment: Non- Compliant Moderate

Standard 19 : Management and monitoring of foster care services

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

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

Management structures were well established in this service but their effectiveness varied due to persistent risks which compromised the quality and safety of the service being provided. Following this inspection, HIQA requested the area to complete a provider assurance report to seek assurances against this standard in relation to identified gaps in the management and monitoring of the foster care service. This is outlined further on in this section of the report.

There were clear line management structures in place but their effectiveness varied. Qualified and experienced managers provided leadership to staff. The area was under the direction of the regional chief officer for the Dublin North East Tusla region and the service was managed by an area manager. There were clear reporting lines to the area manager from principal social workers managing the foster care social work teams and children in care social work teams. There were clear accountabilities, with staff at all levels understanding where and by whom decisions should be made.

The management team comprised of one principal social worker for children in care, and one principal social worker for the fostering team and aftercare. There was evidence of good working relationships between teams. Managers and staff reported a positive culture across the service with strong joint working relationships. Staff said they were supported in the delivery of care to children and their families but capacity challenges meant that the service was considerably stretched and this was unsustainable.

Management and monitoring systems were developed and this supported accurate review and analysis of organisational capacity and capabilities. There was appropriate identification of risks and challenges to the service. Management reporting systems provided the area manager and principal social workers with oversight of service delivery but inspectors found that oversight and monitoring of aspects of service delivery by social work teams required improvement such as the management of child protection and welfare concerns (for children in foster care), and the management of unallocated cases of children in care and foster care.

The senior management team persistently balanced competing demands of managing significant and serious risks to the service as well as driving improvement. Records showed that managers continuously took decisive action to adapt and modify their actions in response to increasing challenges and emerging needs across the service, for example reconfiguring teams, expanding individual roles and responsibilities and the commissioning of extra resources to support frontline service delivery. Decisions were guided by priority in all instances to address the highest risk and while this was appropriate in the circumstance, it meant that there was less capacity to address lower level risks and drive improvement in line with the service's vision and ethos.

Service led auditing, external monitoring and service plans were incorporated into an overarching service improvement plan which was reviewed and updated at senior management and governance meetings against performance and activity data and reports.

There was a quality risk service improvement (QRSI) officer whose role and remit was effectively integrated across the service. She worked closely with the area manager, senior management team, and regional and service managers to ensure that there were appropriate quality, risk and improvement processes in place. The QRSI officer implemented learning and development initiatives to improve practice, such as supporting staff across all grades in the identification and management of risk. This had added value to the development of a culture of responsive risk management across the service. Inspectors found that social workers responded to immediate risk to children.

Social work and management supervision had improved following a Tusla national thematic audit and implementation of effective actions by managers. Supervision records demonstrated high levels of practitioner knowledge regarding individual case work, including the effective identification of risks and needs for children and foster carers. Records showed good case discussion and clear management direction provided to staff. There was oversight and monitoring of practice which noted the tracking of key statutory requirements such as statutory visits, foster care reviews, and garda vetting. However, case management actions were not always time bound or recorded and evidenced as being reviewed.

Inspectors found inconsistent practice in the supervision provided to social care workers allocated to cases in the absence of an allocated social worker. Whilst records reviewed demonstrated high levels of engagement, contact and support from social care workers provided to children in care, supervision practices were not consistent and at times absent. This required improvement to ensure effective management oversight of these cases.

The service area maintained a child-in-care register in compliance with statutory requirements and there were arrangements in place to ensure it was updated and accurate. Although the service did not prepare an annual 'Adequacy of the Child Care and Family Support Services' report, end of year reports such as workforce planning, annual reports and service plans provided comprehensive analysis of the capacity and capability of the service in order to inform the development of the service.

In the review of individual case records for children, inspectors found that children's records on NCCIS were mostly good and in the majority of cases information was up to date. While key records in relation to statutory requirements were evident, some of the work being completed by social workers was not consistently reflected, as not all information was recorded or uploaded to the system in a timely manner. Inspectors found that mechanisms for recording individual case management oversight needed to improve as this was not routinely placed on children's files. Naming conventions were not always used which made it difficult to track social work case management. This was identified by managers and was being addressed at the time of the inspection.

The service's SAQ identified that information systems required improving for compliance with this standard. The area manager identified gaps in retrieving key data intelligence from NCCIS such as levels of unmet need, foster care breakdown or most up-to-date population characteristics.

The identification and classification of risk was comprehensive but the service did not have the capacity to implement all existing controls to mitigate against certain risks and some risks to the service persisted. Risks in relation to staffing capacity, unallocated cases, and lack of placements to meet the needs of children in the area were regularly risk escalated but the risk management response from a regional and national level, had not been effective.

Inspectors found that priority action was required to mitigate the non-compliance and ensure the safety and welfare of children using the service. Following this inspection, HIQA requested the area to complete a provider assurance report to seek assurances against this standard in relation to identified gaps in the management and monitoring of the foster care service. These gaps related to the following inspection findings;

- The service could not ensure that there were sufficient numbers of social workers employed to undertake the duties required of the service.
- The systems in place to ensure that resources were matched to the needs of children who required foster care had not been effective and there was a lack of fostering placements available to children.
- Control measures put in place for the management of risk associated with unallocated cases were not fully implemented nor were they possible to implement.
- The oversight and management of other professionals working with children in care could not provide adequate assurances of the quality and safety of the service being provided to unallocated children in care including children placed in private foster care placements. Supervision arrangements for these staff members, both Tusla and external, were not consistent or standardised and at times absent.

At the time of writing this report, the area provided HIQA with satisfactory assurances in relation to how the service would address these issues. This included a bespoke plan for increasing fostering resources for Louth Meath, approval for additional posts for the service and additional recruitment campaigns to fill new and existing positions. In addition, the area actioned a review of their procedures in relation to the management of unallocated cases in order to amalgamate and standardise process and practice. The area actioned improvement to their mechanisms for managerial oversight and supervision of cases allocated to social care workers and improvement in lines of reporting and oversight of cases of children in private foster worker without an allocated social worker. The area set out to review all unallocated cases and reprioritisation for allocation to a number of additional staff joining the service.

Judgment: Non- Compliant Moderate

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, staff had the capabilities and competence to work with children, young people, their families and foster carers. There was a range of knowledge and experience amongst staff ranging from newly qualified social workers and social care staff to senior practitioners and social work managers with extensive experience and expertise. Social work staff held professional qualifications and professional registration and their learning needs were identified and supported.

Recruitment practices supported the employment of staff who had the qualifications and skills to work with children, their families and foster carers. As part of the recruitment process and the on-boarding of staff to the service, garda vetting disclosures and professional registration were monitored and tracked in the service to ensure timely renewal. Inspectors sampled 10 staff files held centrally, and found that all files held up-to-date garda vetting and up-to-date evidence of professional registration where appropriate. However, seven out of 10 staff files did not contain all required references for staff. One file had no evidence of qualifications on record or an employment contract and this required review.

There were effective communication systems and line management structures across the service which meant that all staff members were clear about their role, and the expectation that the organisation placed upon them and their colleagues. There were established working relationships between staff and managers and information was shared effectively. Collaborative working was clearly evident. There was effective planning for the delivery of training and development, supervision and retention strategies. Formal supervision provided to social workers and managers occurred regularly. Staff described receiving good-quality supervision, including reflective discussion. Supervision records sampled on inspection were detailed and comprehensive and portrayed a high level of practitioner knowledge and diligence regarding individual case work, including the effective identification of risks and needs for children and foster carers. Records showed good case discussion and clear management direction provided to staff. There was oversight and monitoring of practice but case management actions were not always time bound or recorded and evidenced as being reviewed. Personal development planning was identified as a priority for all staff in the service's SAQ and records demonstrated progress in this regard.

Senior managers and staff placed value on learning and development. There was a register to track and monitor completion of mandated training. Training needs analysis occurred on a three yearly basis to inform the regional workforce learning and development planning. The area had a training plan for 2021 which reflected the training needs of staff, and at the time of this inspection, relevant training had been scheduled for 2022. In addition to this, the service monitored the training needs of all staff through supervision and line management reporting.

There was a bespoke induction programme for new and less experienced staff joining the service and specific handbooks and tools designed to guide and support them. Some social workers said that it was difficult to avail of training opportunities due to the demands of service delivery and that some training sessions relevant to their role, was not always accessible to them.

There was a retention and wellbeing plan for the service. Staff wellbeing was promoted through a range of forums including supervision, team building events and supports for self-care. In addition there were other retention initiatives such as academic support for staff who wished to undertake training relevant to their roles.

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 non-compliant moderate with this standard and inspectors agreed with this judgment.

There were not enough foster carers to meet demand. Children were not always placed where their needs could be best met due to insufficient choice and at times, this resulted in poor matching. Inspectors saw examples of overcrowded foster care placements, children under the age of 17 years living in supported lodgings, children not being able to remain with their siblings and or living out of the area away from their social and emotional stabilities. This posed risks to children due to increasing potential for placement breakdown and further disruption in their lives.

The recruitment strategies in the area for 2021, did not sufficiently prioritise placing children in their local community or enhance the availability of a range of general foster care placements for this service. The service worked in partnership with the Regional Assessment Fostering Team (RAFT) through 2020 and 2021 who had the delegated responsibility for the recruitment and assessment of general foster carers for the Dublin North East Tusla region, including the Louth Meath service area. This meant that there was no scope locally for recruitment of general foster carers until permission was obtained at the end of 2021, to develop and implement a Louth Meath foster care recruitment plan.

There was also a regional matching procedure which meant that general foster carers assessed through RAFT were matched with children from other areas. According to the services SAQ in March 2021, the priority for local teams was to place children within their local community, however this was increasingly difficult in many cases as children from all over the region and all over the country, had to be considered within the pool of foster care placements available on a regional level.

The lack of placements to meet the needs of children in the area was regularly risk escalated and considered at the highest risk level for the area, but risk management structures and processes had not been effective in the reduction of this risk for the service in the last 12 months. The area regularly reviewed the existing panel of foster carers, and undertook analysis of admissions to care. They knew the gaps in their service. They identified a chronic shortage of placements for children of all ages but particularly for sibling groups and for children over the age of eight. In June 2021, their recruitment strategy deviated from a solely regional approach in an effort to increase local recruitment of general foster carers and it was decided that all local enquiries generated from regional recruitment campaigns would be dealt with by the Louth Meath fostering service. In addition, in October 2021 Tusla's National Office agreed to forward any enquiries directly to Louth Meath and out of 30 enquiries in Q4 2021, there were seven enquiry visits resulting in one fostering application.

At the time of this inspection, the service had developed a new strategic approach to recruitment of foster carers by reverting back to a local area arrangement for the recruitment, assessment and matching of foster carers. Local recruitment initiatives had commenced in the area with the support of local foster carers. Managers were optimistic about this strategy due to the benefit of the service's established local links in the community which could be utilised to promote local recruitment campaigns and word of mouth publicity. Managers were optimistic about the benefit of developing connections and close working relationships with prospective carers from initial stages of enquiry right through to assessment and approval and they said that this had worked well for the service in the past.

The service had procedures for investigating the availability of relatives as potential carers for each child in need of placement. In the last 12 months, the area had prioritised the assessment and recruitment of relative carers and 26% of children in foster care were living with their relatives. Relatives were always the first option considered for any child placed in care and the social work practice model of signs of safety was used to assist social workers in identifying potential suitable relative carers amongst children's extended family.

Emergency approval of relatives carers in situations where children needed emergency care were subject to pre-placement checks and approval in line with the regulations but improvement was required to ensure that this practice was consistently robust. Inspectors found an example of emergency checks not completed before the placement of a child in relative foster care in July 2021. In addition, capacity challenges in the service meant that the assessment for approval was delayed and despite these indicators of need and support, the case remained unallocated at the time of this inspection. The practice of unassessed and unapproved relative carers being unallocated is not acceptable, as their capacity to provide safe care, appropriate to the needs of the child, has yet to be determined, and therefore it is important that they are allocated so that oversight and support can be provided.

The systems in place to ensure the timely approval of all relative carers in the area required improvement and gaps in staffing contributed to this delay. At the time of this inspection, there were six relative assessments completed in the previous 12 months and there were 18 assessments outstanding and delayed by an average of 19 weeks. In response to this risk, the service were completing in-depth preliminary assessments for relative carers and these assessments demonstrated good quality.

There were strategies in place for the retention of foster carers in the area. The service did not identify a significant issue regarding the retention of foster carers and many foster carers had remained with the service for a long period of time. The service's retention strategy identified a range of targeted actions. For example, there was a foster care training plan arising from consultation with foster carers and staff. Records showed a comprehensive training programme on each foster carers file. There was correspondence on foster carers' files from the area manager thanking them for their dedication to caring for children and asking them to identify possible carers for their recruitment campaign. Prior to this inspection, foster carers were also invited to meet with the Tusla's director of services and integration and the regional chief officer for the Dublin North East Tusla region, to hear about their experiencing of fostering, as well as their worries and concerns and suggestions regarding service improvement.

Exit interviews were offered to all foster carers leaving the service to gather information about their experiences of the service and to identify learning for service improvement. The Foster Care Committee chairperson undertook an analysis of interviews for the purpose of identifying areas of learning for service improvement. In 2021, 15 approved foster carers left the service but just five agreed to an exit interview. Alternative ways of gathering information, outside of the exit interview process, could enhance and contribute to the analysis of reasons for leaving.

Judgment: Non- Compliant Moderate

Standard 22: Special Foster Care

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

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

There was no national strategy in relation to the provision of a special foster care service for children whose behaviour posed real and substantive risks in line with the criteria set out in the national standards. This service did not have any special foster carers approved as such on their local area panel. Inspectors assessed this standards against the arrangements in place to provide additional supports and resources to children with complex needs and their foster carers.

Data received by HIQA from the service prior to this inspection, identified that there were 87 children residing in 46 foster care households with additional supports to meet a range of complex needs of children. The identification and response to complex needs from the service was dynamic and fluid. Complex needs for children in foster care were identified through initial care planning, social work visits to children and carers, child-in-care reviews, line management supervision, complex case forums and partnership working with other external services and commissioned services.

In addition, multidisciplinary assessments were sought for children and in the event of delays, provisions were made for private assessments. Children's care plans reviewed were mostly comprehensive and detailed a range of care and support needs including treatments and interventions from other services. There was appropriate multidisciplinary and partnership working demonstrated in reviews of care plans for children. This was evident in a child-in-care review meeting observed by inspectors. There was good practice found. There were good levels of multidisciplinary input. The assessment and review of service provision was centred on the child and equally considerate of the child's views. Information was shared well and in addition, professionals were proactive in drawing solutions to improve outcomes for the child and improve support to the foster carers.

The service had arrangements in place to provide additional supports to children with complex needs and their carers through the commissioning of services, partnership working and additional financial supports to meet the needs of children and foster carers. This provided access to supports such as therapeutic supports, home support intervention, enhanced link work support, advocacy with the local authority in respect of housing, supporting carers to attend specialist services in some cases outside of the area.

The area's SAQ reported that respite was offered to all carers as required and based on the child's assessed needs as outlined in their care plan. A new respite policy was in place that allowed for continuation of payment to any foster carer for a child with complex needs who avails of respite. However, records showed that the provision of respite was challenging due to the lack of placements and in some cases, the provision of respite was delayed. As identified in the area's SAQ, when respite was not available, the area had actively recruited a suitable respite carer, which in some cases involved the carers own family being assessed as respite carers and this was evident on records reviewed. This was a really good initiative given the lack of general respite placements available.

The service had not always been able to find suitable or long term care placements for children with emotional or behavioural challenges. The area undertook targeted recruitment campaigns for specific children and while the majority of these were unsuccessful, one very specific placement was found for a child who required additional supports.

This standard is assessed as substantially complaint. It is acknowledged that the area were working to address challenges in its provision for children with high or complex needs. However, opportunities for further service improvement were impacted by a lack of a clear and agreed national strategic approach.

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 substantially compliant with this standard. Inspectors agreed with this judgment.

The Foster Care Committee (FCC) was well governed and its functions were guided by standards and the national policy, procedure and best practice guidance on FCC's. The FCC considered the suitability of applicants to act as foster carers and made recommendations in terms of their approval. There were delays in the processing of foster care reviews but the FCC had systems in place to improve its efficiency and effectiveness. The FCC chairperson reported on relevant matters in relation to the fostering service and made recommendations about quality issues and service improvement.

The FCC was led by a suitably qualified and experienced independent chairperson who was in post since November 2021. There were good communication and reporting structures from the chairperson to the area manager and senior management team. The chairperson provided performance reports to the senior management team and attended senior management meetings. Formal arrangements were in place for committee members to deputise for the chair for Louth committee meetings but not for Meath. The committee had appropriate administrative support from a full time FCC secretary.

The chairperson contributed to service improvement in the area. She completed a FCC annual report in line with national standards and best practice guidance and this contributed to overall annual service planning and development. An audit of FCC was undertaken by Tusla's practice assurance and service monitoring team (PASMT) in 2021 and the chairperson provided reports to the area manager on the implementation and status of actions arising which included the recruitment of new members to the FCC, improved effectiveness of the FCC's use of time and a strategy to address the backlog of reviews, amongst others.

Inspectors found that membership of the committee was in line with regulations and Tusla's own policy guidance. During 2021, the FCC experienced challenges in retaining committee members and establishing stability with regard to the role of the FFC chair. However, all FCC committee meetings went ahead as scheduled and at the time of this inspection a FCC chairperson was in post.

The FCC was successful in recruiting new members which included a wide variety of individual expertise and knowledge to enhance the quality of the committee's collective oversight and decision making in relation to children's placements in foster care. In addition, there was a system in place to seek and record any additional specialist information required. Inspectors observed part of a FCC meeting during the inspection which demonstrated good collective discussion and information sharing. The FCC chairperson facilitated good collective analysis of key risks or issues. There was appropriate challenge, suggestion and scrutiny of information to ensure that decisions were in the best interests of the child and that the placement was suitable to meet their needs. The unique skills, knowledge and experiences of committee members added value to the collective discussion and decisions.

The FCC and foster care service maintained a joint register of foster carers in the area which was updated at each FCC meeting to ensure it was maintained and accurate. The register was monitored and reviewed by the senior management team and foster care committee chairperson and secretary. Key data and information was tracked and analysed as a quality assurance measure, such as the expiry of garda vetting for foster carers, the tracking of assessments of relative carers and the monitoring of serious concerns against foster carers.

The FCC chairperson identified that training and development for FCC members was a priority for 2022 so that all members were supported in their role and to develop greater connectivity between the FCC and the fostering service. A comprehensive training and development plan was in place which included, for example, training in relation to access arrangements for children in care and feedback from quality assurance audits and HIQA inspections.

The FCC chairperson maintained a log of committee member's appointments, as well as each members garda vetting, privacy and confidentiality declarations and training. Not all committee members had up-to-date garda vetting due to a change in the criteria for vetting. This was appropriately escalated to the Tusla's national HR directorate for resolution.

There were 30 foster care reviews awaiting approval by the FCC due to a combination of factors including delays in securing a date for presentation to the committee and challenges of the services' social work teams to complete timely reviews. In response, the FCC chairperson had increased the frequency of committee meetings and implemented tools to ensure the most effective use of time at committee meetings. There was a mechanism for social workers to provide a formal update to the FCC, in addition to any fostering review reports which may have been delayed in their presentation to the committee. This meant that the backlog was on target to being addressed by March 2022.

Judgment: Substantially 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 non-compliant moderate with this standard and inspectors did not agree and judged the area as substantially compliant.

At the time of this inspection, a new protocol for the governance arrangements of non-statutory foster care agencies was implemented. The role of governance and oversight of service provision by the non-statutory foster care agencies was delegated to two national managers. The protocol set out Tusla's arrangements nationally for the commissioning and contract management of private providers and local managers were supported by governance structures for monitoring and benchmarking their performance.

The service area ensured good scrutiny of the quality of foster care services delivered through the non-statutory sector. The service area had 20 children, placed with four different providers. The rationale for these placements related to gaps in the capacity of Tusla's own provision at the time of their admission to care. At an operational level there were service level agreements with non-statutory foster care providers for each individual child placed with that provider. In addition, all non-statutory service providers were subject to Tusla's normal monitoring and inspection arrangements though the Alternative Care Monitoring and Inspection Service.

Children in private foster care were reviewed at governance meetings and where appropriate, a decision could be made to review individual cases at the complex case forum. In addition, private foster carers were reviewed through the FCC to ensure that 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 private foster carers reviewed by inspectors were managed well.

All children in private foster care had a care plan and were visited in line with the regulations. The oversight of allegations and serious concerns of children in private foster care were subject to the same level of review and oversight as children in statutory placements. However, not all children living in private foster care agencies had an allocated social worker. There were five children out of a total of 20 children without an allocated social worker. Due to staffing shortages and a lack of capacity to meet service demands, these cases were managed in the same way as other unallocated cases of children in care in the area, with no additional priority for allocation to enhance oversight and scrutiny for the quality of care provided. This meant that the quality of children's care in non-statutory foster homes was not always supervised in accordance with best practice. This required improvement.

Records reviewed on inspection showed an example of poor case supervision provided to a social care worker allocated to a child in private foster care. Equally, there was some good practice found but improvements were required to ensure the service had adequate assurances of the quality and safety of the service being provided to children placed in private foster care placements. Records demonstrated that statutory visits were undertaken in line with regulations and levels of engagement between the social care worker and private fostering link worker were good. In addition, the child in care review was good quality and records showed appropriate implementation of recommendations and actions required to meet the child's needs and promote their safety and welfare. However, there was no case supervision recorded on file and in addition, there were delays in the completion of the child's care plan.

This gap was identified to the service during this inspection and was included in the provider assurance report requested by HIQA to seek assurances against the management and monitoring of the foster care service in relation to standard 19.

Whilst not all children in private foster care had an allocated social worker, gaps in relation to staffing capacity, the management of unallocated cases and the supervision and management oversight of social care workers was assessed and judged against the management and monitoring of the service in standard 19. Furthermore, since the area's SAQ, there was improvement in the governance arrangements for private foster care by way of implementation of Tusla's new protocol for the governance arrangements of non-statutory foster care agencies. In addition, the area had developed systems for good scrutiny of the quality of foster care services delivered through the non-statutory sector. For this reason, this standard has been judged as substantially compliant.

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 agreed with this judgment.

There were systems in place to enable children, young people, their families and foster carers and others, to make representations, including feedback, compliments and complaints about the service provided to them. Managers were responsive to these representations, and valued the opportunity to identify gaps for learning, development and improvement and to acknowledge good practice. However, while all complaints reviewed by inspectors were responded to, inspectors found that not all complaints about the service were processed in line with policies and procedures and the recording and monitoring of outcomes of complaints needed improving.

Children in care were provided with an information pack which included information about providing feedback and making representations or complaints to the service. In addition, the area manager sent individual letters to children over 12 years of age, reminding them of the complaints process and offering further opportunity to hear their feedback. The area manager also said that a child friendly Tusla website containing information about the service was also made known to children in care. Social workers said that they explained the process to children and supported them to make a

complaint or provide feedback but this was not routinely reflected in case records reviewed by inspectors. In addition, foster carers said that were satisfied that they had opportunities to provide formal and informal feedback on the service being provided to them. Their general consensus was that the service was open to hearing and responding to feedback, appropriate challenge and or complaints but not all foster carers were satisfied by the response to their complaints or representations. Foster carers were aware of the national complaints procedure and it was accessible to them. There were arrangements in place for the use of interpreting services to assist social workers to share information regarding complaints and representations as required.

Information regarding external independent advocacy services was available to children, foster carers and parents if required. The area had a service level agreement with a local branch of a foster carer's advocacy group to promote foster carers access to independent advice and representation and children were provided with information about advocacy supports.

There was evidence of creative initiatives to enable children to make representations to the service about their experiences of foster care. For example, there was a peer mentoring group comprising of young people accessing aftercare services and this group were invited to share their experiences of being in care to the FCC.

The area maintained a register of compliments and complaints. They were a standing agenda item on governance and senior management team meetings which supported ongoing organisational learning and quality improvement, and appropriate identification and reflection on what was working well. The area's quality risk and service improvement officer had active oversight of the compliments and complaints register and she promoted implementation of associated procedures by providing support and guidance to staff. There was a complaints and compliments casebook for 2021 which detailed learning from a sample of cases across the service area. However, some social workers said that they social work teams would benefit from a more formal learning approach in relation to learning from complaints.

While there were good oversight and monitoring structures to track compliments and complaints, the process of capturing all complaints in line with the policy and procedure needed improving. Inspectors found examples of verbal complaints made to the service that were not included in the service's tracking system. Inspectors were satisfied that these complaints were addressed and responded to but they needed to be counted and included within management and oversight systems and recorded and included on the Tusla national incident management system (NIMS), in line with policy.

Inspectors reviewed a sample of complaints made to the service in 2021 and found that the service responded to all of the complaints and there was a satisfactory

resolution to most of the complaints. Complainants were provided with information about the management of their complaint including information about the process for appeal.

Data provided by the area indicated that there were no complaints about the service in the last 12 months which were upheld or partly upheld. However, from a sample of complaints reviewed, inspectors saw one example of a complaint, which clearly identified gaps in service provision and was responded to on foot of that determination by the service. The recording of outcomes to complaints required improvement to ensure accurate identification of outcomes and lessons learned from mistakes.

Judgment: Substantially compliant

Appendix 1: National Standards for Foster Care (2003)

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

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