Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation and Monitoring of Social Care Services

Overview Report on the Governance of the Child and Family Agency (Tusla) Child Protection and Welfare and Foster Care Services

January 2025

Safer Better Care

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About the Health Information and Quality Authority (HIQA)

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

Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

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

Executive summary

Regulation and monitoring promotes and protects the wellbeing and quality for children and young people in care, and plays an important role in driving continual improvement.

The Health Information and Quality Authority (HIQA) is responsible for monitoring the Child and Family Agency's (Tusla's) child protection and foster care services. HIQA fulfils its statutory obligations set out in the Health Act 2007 (as amended) through the Chief Inspector of Social Services.

This report sets out the findings from a specific risk-based monitoring programme examining Tusla's governance arrangements in child protection and welfare and or foster care services in 10 service areas.

This monitoring programme was established in 2023 in response to a large number of children who did not have an allocated social worker. This issue had been exacerbated by a number of factors, including:

- lack of reliable data
- inadequate resources
- staffing vacancies
- ineffective quality assurance mechanisms and monitoring and oversight systems
- inability to meet service demands.

The risk-based monitoring programme aimed to assess the effectiveness of Tusla's national service improvement plan (SIP) developed in response to the cases awaiting allocation, for child protection and welfare and foster care services in order to reduce unallocated cases to under 25% by the end of 2024. It also aimed to improve compliance against the relevant national standards so as to support the delivery of a timely, safe and effective service for children and families. It also set out to establish how effective national governance arrangements were being implemented at local and regional level. Tusla provided updates to HIQA on the national service improvement plan at monthly provider meetings.

Summary of the risk-based monitoring programme

HIQA identified 10 Tusla service areas across the country where at least 25% of children had not been allocated a social worker in child protection and welfare and or foster care services. Inspections were carried out in these 10 service areas from February to May 2024.

Inspectors also spoke with children, their families and foster carers to hear their views about the service they were receiving. In addition, inspectors met and spoke with front-line practitioners, including social workers, as well as middle, senior and executive managers within Tusla.

Summary of findings

HIQA identified a number of challenges across service areas which were impacting on the delivery of timely, consistent care and support to children. Each service area was significantly challenged by resourcing and staffing issues, including staff turnover which impacted on the delivery of services to children. This was further impacted by the significant increase in the demand for foster care and child protection and welfare services.

Inspectors found that Tusla was more effective at managing unallocated children in foster care than children waiting for a child protection and welfare service. Generally, when children were allocated a social worker, the quality of services provided to them or for their benefit was good.

Inspectors observed examples of good practice and support being provided to some unallocated children, and also identified areas that required improvement, especially in the completion of preliminary enquiries and the timely assessment of children.

In the services reviewed as part of this monitoring programme, there were significant delays in children receiving a social work service, including from the management of new referrals through to providing statutory services to children in foster care. Improvements were required to ensure services were consistently implementing Children First (2017) and adhering to Tusla's standard business processes particularly in relation to the completion of initial checks, preliminary enquiries and initial assessments. In some areas, there were significant time delays in establishing that a safety plan was required for children who were on waiting lists from the point of referral to initial assessment.

Due to the findings arising from seven inspections, HIQA escalated risks to individual children to the respective area managers. Assurances were sought from these area managers regarding the review of the risks and the protective measures taken or planned for these children. The assurances provided included visits to children, the creation of safety plans[1] for children and the progression of assessment of child protection concerns. HIQA were satisfied with the assurances provided.

[1] Safety plan: This plan is formulated after the completion of an initial assessment, which has an outcome that a child is at ongoing risk of harm. The safety plan is an agreed set of rules, based on concerns identified that will show how the family and the network will keep the child safe, even when the danger, or risk is present.

Over the course of this programme, HIQA also identified a number of systems risks - for example, some service areas included in this monitoring programme were not able to consistently fulfil their responsibilities to all children referred to the child protection and welfare service or placed in foster care due to increasing volume of new referrals and staffing capacity issues.

Systems risks were escalated to the regional chief officers in eight of the 10 service areas. In two service areas, Cork and Dublin South Central, the responses to escalation at regional level did not provide the necessary assurances to HIQA, therefore, these risks were escalated to Tusla's CEO and executive management team.

Inspections found that, overall, the full impact of Tusla's national service improvement plan and associated actions was not evident due to the different degrees of implementation of actions across the services at the time of the inspections. Improvements are required at an operational level to ensure that effective governance and supports are in place at regional and local levels.

Identified risks during inspection fieldwork

Child protection and welfare services or foster care services are not subject to regulation in Ireland; instead they are monitored by HIQA. This means that while HIQA has the mandate to monitor and inspect these services, the regulatory framework does not include any enforcement powers such as cancellation of the service, where there are serious or immediate risks or where a service is poor or unsafe. When risks are identified in these services, HIQA's only recourse is to escalate the situation to Tusla's executive team and to the Department of Children, Equality, Disability, Integration and Youth. HIQA also publishes its inspection reports on HIQA's website.

Where inspectors identified a specific issue of significant concern or systems risk that presented an immediate and or serious risk to the health or welfare of children, these risks were escalated to the relevant local Tusla manager during the inspection, and to the regional chief officer and area manager following inspection.

In total, seven of the 10 service areas included in this programme were escalated and Tusla area managers were asked to provide written assurances that the cases referred to were being reviewed, with appropriate protective measures being put in place.

For each identified or potential risk in all of the escalated cases, appropriate written responses were received from the respective area managers. Over the course of the inspections, these systems risks were escalated to the regional chief officers. The

responses to these escalations were provided by the Regional Chief Officers at the monthly provider meetings with HIQA. Where assurances provided to HIQA were not sufficiently adequate, as such not acceptable, these risks were escalated to the CEO for a response.

Individual case escalations

During the course of the 10 inspections, 107 individual children's cases were escalated to the respective area managers in seven service areas. In the Donegal area, five of 10 cases escalated during the inspection required social workers to visit those children the same day. There were no individual case escalations for three service areas: Carlow Kilkenny South Tipperary, Waterford Wexford and the Mid West. The majority of the escalated cases related to cases at all the stages in the management of child protection and welfare referrals and were unallocated but also included a number of cases that were assigned or allocated to either a social care practitioner or a social worker team leader. It demonstrated that not all children at actual or potential risk were being assessed in a timely manner and where necessary, protected by Tusla in a timely and effective manner.

For each identified or potential risk in all of the escalated cases, appropriate written responses were received from the respective area managers outlining the steps that had been taken or were planned to be taken to progress each individual escalated case.

These areas are explored further under the quality and safety dimension section of this report.

Systems risks

During inspections, HIQA review a sample of cases to determine if the systems which Tusla have in place to manage child protection referrals are effective and in line with national policy, standards, legislation and their own internal processes. Systems risks are identified where failures in these processes or adhering to processes may mean that children have remained at potential risk – a situation which is unacceptable to HIQA.

Within the child protection and welfare and foster care services, omitting, or not fully completing any stage in the management of referrals and the management and oversight of cases, significantly impacts on the adequacy or timeliness of any intervention put in place to mitigate risk to vulnerable children. For example, a large number of referrals awaiting allocation at the various stages of the process presents a systemic risk because the service does not have the capacity to carry out these

processes in a timely way. These systemic risks pose further risk to children who are already vulnerable.

Of the 10 service areas inspected, systems risks were escalated in eight areas to the respective regional chief officers (See Table 1). Examples of these identified systems risks fall within the following categories:

- Governance
- Information governance
- Workforce
- Referral pathways
- Resources
- Notifications to An Garda Síochána (Ireland's national police service)
- Child Protection Notification System (CPNS[2])
- Cumulative harm[3]

Significant improvements are required to mitigate these risks and ensure the safety and welfare of children at actual or potential risk. The responses to these escalations were provided by Tusla at the monthly provider meetings with HIQA. These risks are explored further under the capacity and capability and quality and safety dimensions later in the report.

Escalations to Tusla Chief Executive Officer (CEO)

In two service areas, Cork and Dublin South Central, the responses to escalation at regional level did not provide the necessary assurances to HIQA, therefore, these risks were escalated to the Executive and the CEO of Tusla. These risks are explored further in this report.

[2] A national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern, resulting in each child being the subject of a child protection plan.

[3] Cumulative Harm: is the outcome of multiple episodes of abuse or neglect experienced by a child. It refers to the effects of patterns of circumstances and events in a child's life which diminish a child's sense of safety, stability and wellbeing.

Table 1. Risk escalations per service area

Tusla service Area	Tusla regional operational area	Number of individual cases escalated	Systems risks escalated	Escalations to Tusla CEO
Dublin South Central	Dublin Mid Leinster	21 (28.7%)	Yes (12)	Yes
Dublin South West Kildare West Wicklow		11 (15%)	Yes (3)	No
Dublin South East Wicklow		17 (31%)	Yes (3)	No
Carlow Kilkenny South Tipperary	South East	0	No	N/A
Waterford Wexford		0	No	N/A
Cork	South West	11 (14%)	Yes (4)	Yes
Louth Meath	Dublin North East	21 (22.5%)	Yes (3)	No
Dublin North City		9 (13%)	Yes (11)	No
Mid West	Mid West	0	Yes (2)	No
Donegal	West North West	17 (26.5%)	Yes (2)	No

Conclusion

All children have a right to be safe and to have access to services and supports which enable their growth and development. It is essential, that children have access to the right services at the right time which are child-centred, and that leadership of those services are working together to achieve the best possible outcome for each child. Tusla should assure itself, people using its services, and the public, that it is consistently meeting national standards in order to provide timely, safe and effective services.

While there were examples of good practice in some areas, this monitoring programme found that some children are being left at potential risk due to failures at operational level to consistently implement Tusla's national policies and business processes. Individual cases and systems risks were required to be escalated to ensure immediate and urgent action was taken by Tusla to provide children with a safe and timely service. The findings from this programme demonstrated that Tusla is required to take action to ensure that it can consistently fulfil its statutory responsibility for the delivery of children's services and improve outcomes for children in participating service areas as there were variations in adherence levels with Children First (2017) and national standards to protect children and promote their welfare. Tusla local and regional services were not consistently adhering to Tusla's standard business processes, policies and procedures. The risks identified primarily related to the child protection and welfare services, in that there were more effective measures in place to manage unallocated children in foster care.

Tusla has embarked on an ambitious programme of reform over the next two years which aims to ensure timely, equitable, integrated and consistent practice across the service areas. Due to resourcing issues and an increased demand on its services, Tusla is currently challenged to deliver the 'right service at the right time' to children and their families.

The findings of this risk-based monitoring programme highlight concerns about Tusla's capacity to consistently meet its statutory requirements and adequately safeguard children in the participating services. In some cases, these failings led to a significant impact on some children, the details of which are outlined further under the capacity and capability and quality and safety sections of the report, and will continue to impact children in the future, unless the systemic risks are effectively responded to. Furthermore, HIQA was also not assured by Tusla's slow response to implement actions in response to the high levels of risk in the Dublin South Central child protection and welfare service, due to sustained high vacancies, high referral rates and complex cases. Despite these risks being recorded on the local risk register for prolonged periods of time and also being escalated internally, the risks remained.

Governance and oversight of risk management, performance management, information governance and quality assurance systems required strengthening. Significant efforts and initiatives have been put in place by Tusla to recruit and retain staff, and at the end of the monitoring programme, Tusla was close to having all budgeted posts filled. However, this will not resolve Tusla's capacity issues and an inter-departmental approach is required to strategically plan for the resourcing and delivery of children's services into the future.

Tusla are required to devise a compliance plan to further strengthen its adherence to the *National Standards for the Protection and Welfare of Children* and *National Standards for Foster Care*. HIQA will monitor Tusla's delivery of its compliance plan through inspections of individual service areas to establish the effectiveness of Tusla's actions in reducing the number of children waiting for a service.

Acknowledgements

HIQA extends its thanks to the children, parents, guardians and foster carers that spoke with inspectors during the course of these inspections, in addition to staff and managers of the services and other professionals for their cooperation.

1. Introduction

The Health Information and Quality Authority (HIQA) is responsible for monitoring the Child and Family Agency's (Tusla) child protection and foster care services. HIQA fulfils its statutory obligations set out in the Health Act 2007 (as amended) through the Chief Inspector of Social Services.

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act 1991 and the Child and Family Act 2013. The Children First Act 2015 aimed to make further and better provision for the care and protection of children by making it mandatory for key professionals to report concerns about children and by improving child safeguarding arrangements in organisations providing services to children. The Child Care Act 1991 (as amended) is the primary legislation governing child care in Ireland. This legislation imposes a duty on Tusla to identify and promote the welfare of children who are not receiving adequate care and protection. In order to meet its statutory obligations, Tusla developed and increased its range of services and interventions to support families to adequately care for their children. However, there will always be some children who will need to be protected from the risk of serious harm.

The regulatory framework

Child protection and welfare services are monitored under Section 8(1) c of the Health Act 2007 (as amended) and *National Standards for the Protection and Welfare of Children* (HIQA, 2012). Foster care services are regulated and monitored under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 Child Care Act, 1991, as amended Child Care (Placement of Children in Foster Care) Regulations, 1995 Child Care (Placement of Children with Relatives) Regulations, 1995 National Standards for Foster Care (Department of Health and Children, 2003).

HIQA uses a standardised monitoring and inspection approach that promotes consistency. We call this the 'Authority Monitoring Approach' (AMA). All inspectors adhere to this approach and to any associated procedures and protocols.

Applying AMA and using this assessment-judgment framework ensures that each provider is treated fairly and that the assessment of compliance is timely, consistent, proportionate and responsive to risk identified within the child protection and welfare services and foster care services. It also provides transparency to providers and the public on how HIQA assesses and makes judgments of compliance and non-compliance.

The framework sets out the lines of enquiry to be explored by inspectors in order to assess compliance with the national standards being monitored or assessed. It also outlines the compliance descriptors of:

Compliant	A judgment of compliant means the service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.
Compliant: Substantially compliant	A judgment of substantially compliant means the service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.
Not compliant	A judgment of not compliant means the service has not complied with a standard and that considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk-rated red (high risk) and the inspector will identify the date by which the provider must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of children using the service, it is risk-rated orange (moderate risk) and the provider must take action within a reasonable time frame to come into compliance.

Once a judgment on compliance is made, inspectors will review the risk to children of the non-compliance. Inspectors will report on this risk as:

- green: there is no risk
- yellow: there is low risk associated with the non-compliance
- orange: there is moderate risk associated with the non-compliance
- red: there is high risk associated with the non-compliance.

Tusla organisational structure

The board of Tusla

The board is the governing body of Tusla as outlined in Section 19 of the *Child and Family Agency Act*, 2013, with the legal authority to perform all functions of Tusla. The board nor the Chief Executive Officer (CEO) can exercise the wide range of statutory functions personally. A formal system of delegations is provided for under Sections 21 and 30 of the 2013 Act. It consists of a chairperson, a deputy chairperson and eight ordinary members appointed by the Minister for Children, Equality, Disability, Integration and Youth. The board of Tusla delegates specific functions to the CEO as specified in *The Child and Family Agency Act, 2013*, to be undertaken in accordance with all relevant policies, protocols, care standards, directions, circulars, guidelines and documents of a similar nature specified by the board or that has issued or may issue from time to time by Tusla or any government department.

Tusla executive

In 2022, a new executive management team was appointed, together with the appointment of six regional chief officers (new grade of staff), to enable devolved governance and accountability within Tusla.

Tusla's executive management team has statutory responsibility for delivering children's services and providing corporate leadership to champion the needs and improved outcomes for children. The executive has a crucial role to ensure that service areas are supported to fulfil their role and responsibilities, however, during the course of this risk-based monitoring programme, it was apparent that, despite the efforts at all levels of the organisation, Tusla was challenged to fulfil its statutory responsibilities to all children, particularly those referred to the participating child protection and welfare services.

The CEO is responsible for carrying on, managing and controlling generally the administration and business of Tusla and for the performance of functions delegated to the CEO by the board. The CEO can delegate these functions to a specified Tusla employee and can further authorise the sub-delegation of any of all of the delegated functions to or by such employees.

Tusla's executive management team reports directly to the CEO and is comprised of:

- Interim National Director of Services and Integration (Deputy CEO)
- National Director of Quality and Regulation

- National Director of People and Change
- National Director of Finance and Corporate services
- Chief Information Officer. (See Figure 1)

In order to assure the CEO about the quality and safety of Tusla's child protection and welfare services and foster care services, reporting arrangements between the Interim National Director for Services and Integration and regional chief officers and service area managers were in place.

Tusla regional and service area management

At the time of the commencement of this risk-based monitoring programme in September 2023, Tusla had six regional operational areas in place:

☐ Dublin North East ☐ South East

☐ Dublin Mid Leinster ☐ South West

☐ Mid West ☐ West North West

A regional chief officer (RCO) was responsible for each region who reported to and was accountable to Tusla's Interim Director of Services and Integration for the delivery and performance of services in their region. The delegated responsibilities of the regional chief officers includes full responsibility and accountability for the delivery of all specified Tusla services and functions within their region. Each RCO has a designated number of area managers, and a wider regional management team, including dedicated finance manager, people and change manager, quality risk and service improvement manager, professional support managers, regional therapeutic manager, PPFS[4] manager, executive business manager and communications lead to support them.

Area managers were primarily accountable for the delivery of integrated services that are provided by Tusla. Their main duties and responsibilities were extensive, some of which included, governance, staff management and leadership, risk management, resource management, building capacity, and developing networks to identify opportunities for collaboration and co-operation across organisational and functional boundaries. They were required to deliver services in line with national and regional performance targets and standards.

The six regional operational areas comprised of 17 service areas which were

[4] PPFS: Prevention, Partnership and Family Support – early intervention and preventative services undertaken by Tusla and its partner agencies. The aim of the PPFS is to prevent risks to children and young people arising or escalating through early intervention and family support.

managed by area managers. There are over 5,000 staff working in Tusla across its range of services. (Figure 2)

Figure 1. Tusla's organisational structure

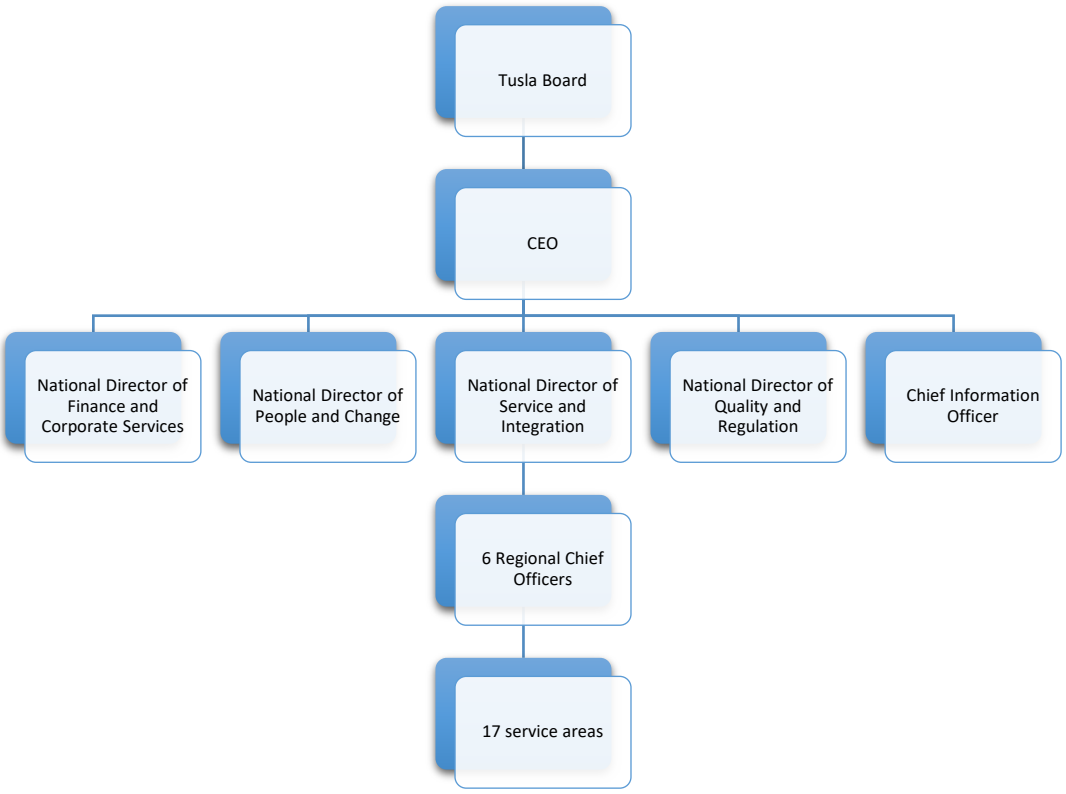
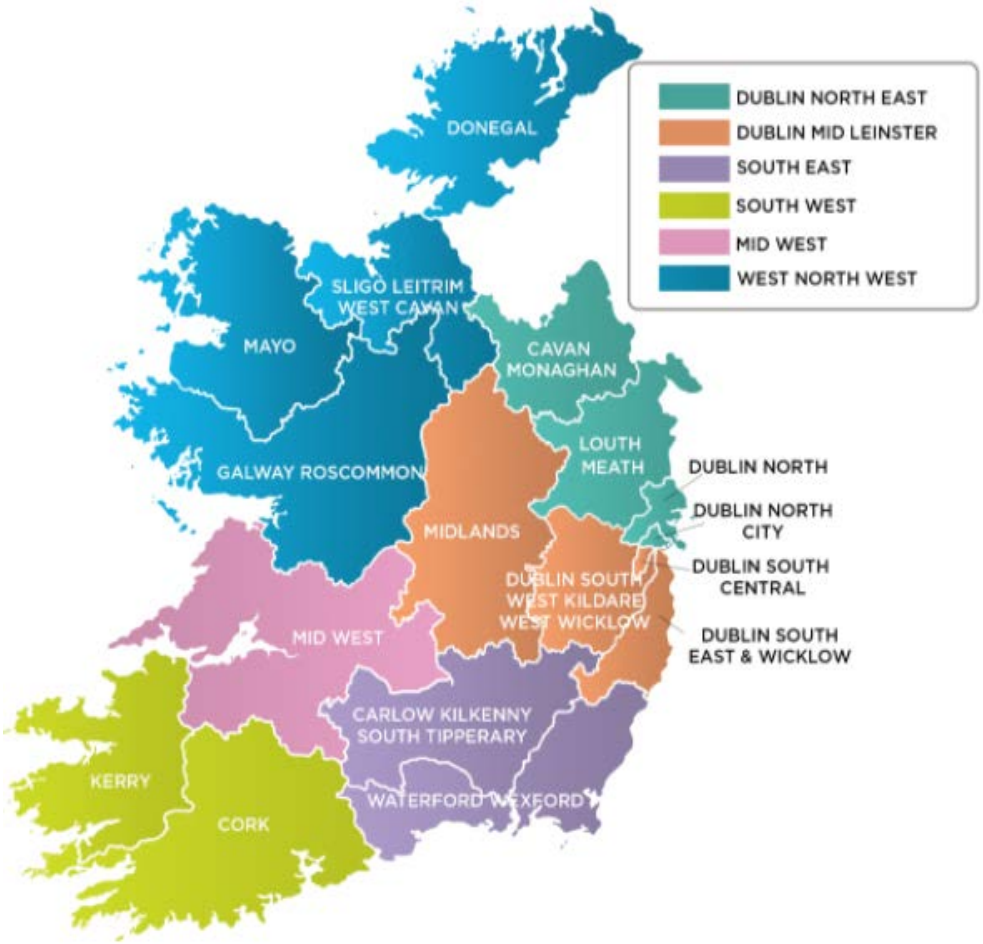


Figure 2. Tusla's service areas*



*Map source: Tusla website https://www.tusla.ie/

Overview of regulatory activity

HIQA has been conducting inspections of child protection and welfare and foster care services provided by Tusla since 2014. Inspection findings have consistently identified a recurrence of a number of common issues of concern across multiple service areas since that time. In 2017, HIQA also began implementing risk-based inspections in these areas.

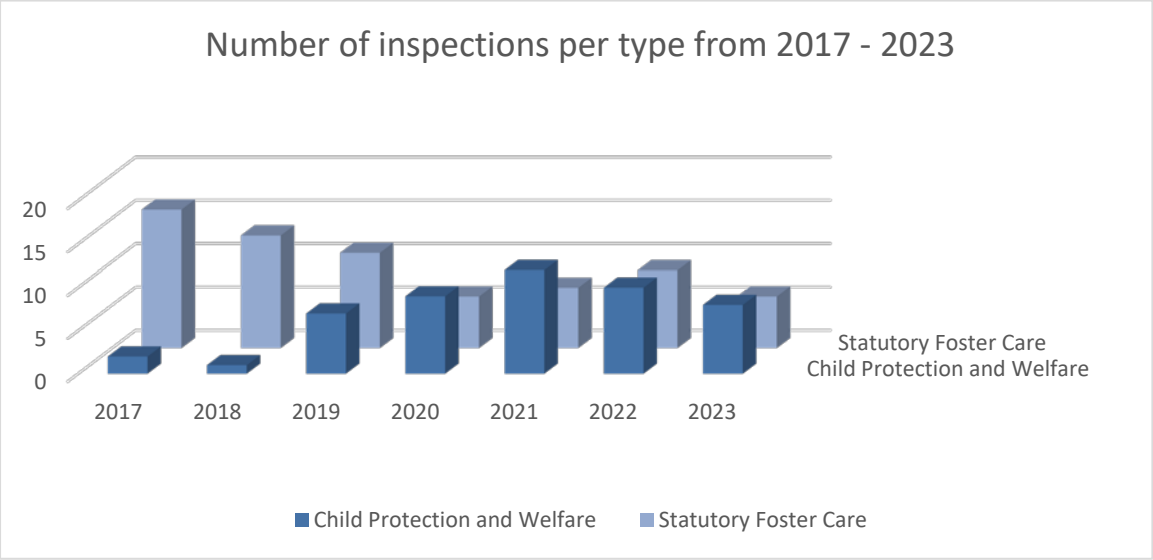
Since 2017, HIQA has undertaken 49 inspections of child protection and welfare services and 68 inspections of statutory foster care services (Figure 3.) Throughout that time, HIQA identified aspects of these services which were delivered well, in a child-centred way, and evidence of service improvements. However, HIQA was concerned about aspects of the services which impacted on Tusla's capacity to deliver safe, equitable and high-quality services to children and families on a national basis. HIQA inspections reported on a lack of sustained improvement in compliance with both the *National Standards for the Protection and Welfare of Children* 2012 and the *National Standards for Foster Care* 2003.

Notwithstanding the positive findings and service improvements identified during this time period, the number of children unallocated a social worker across both child protection and welfare and foster care services continues to be of concern. Despite significant efforts the recruitment and retention of social work staff remains a challenge. Other concerning findings included:

- lack of reliable data
- inadequate resources
- staffing vacancies
- ineffective quality assurance mechanisms and monitoring and oversight systems
- inability to meet service demands.

Despite these challenges, good leadership, governance and management at all levels is essential for building resilience in services and its staff, and ensures the prioritisation of its work based on the resources it has available at any given time – in tandem with making plans for its future capacity and capability. This was not always evident in the services inspected.

Figure 3. Number of inspections by type from 2017 – 2023



Targeted regulatory programme

Given these ongoing findings and concerns, the Chief Inspector developed a national risk-based monitoring programme focused on Tusla's governance and management of child protection and welfare and foster care services.

The purpose of the risk-based monitoring programme was to assess the effectiveness of the provider's governance arrangements in the management of unallocated cases, so as to support the delivery of a timely, safe and effective service for children and families. It aimed to improve compliance against the *National Foster Care Standards* and the *National Standards for the Protection and Welfare of Children* and reduce waiting lists for children. It also aimed to establish how effective national governance arrangements were being implemented at local and regional level.

This programme included any service area where there were greater than 25% unallocated children in child protection and welfare and foster care services.

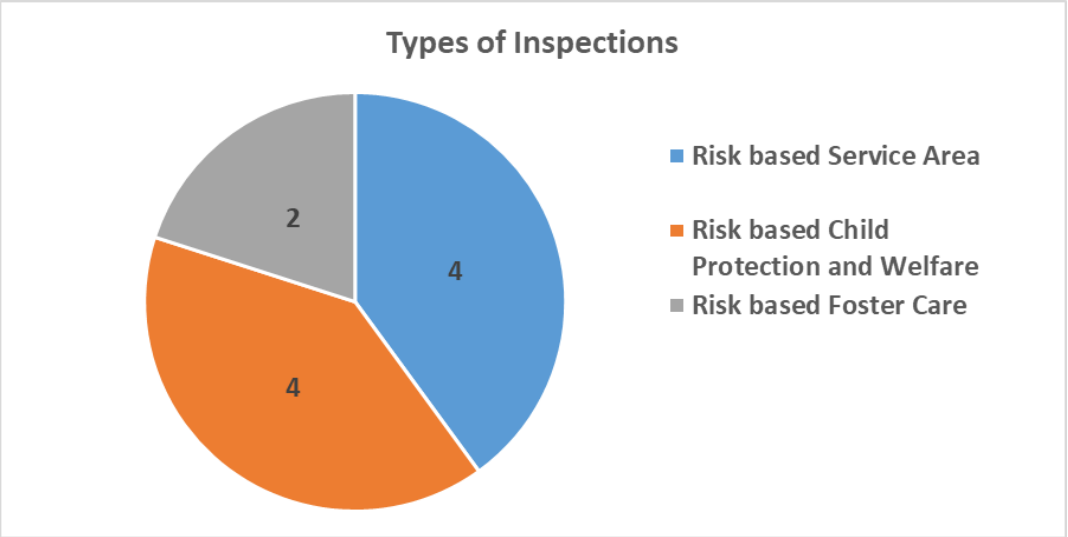
The programme commenced in September 2023 with a meeting with Tusla. Key data and information requested of Tusla was submitted on 27 October 2023. Eight out of 17 Tusla service areas were initially identified for inspection. This increased to 10 service areas by February 2024 when Tusla submitted its end-of-year data for 2023. The following service areas were included in the programme:

Table 1. Areas included in the programme

Service type	Areas included
Foster care	Mid West
	Carlow Kilkenny South Tipperary
Child protection and welfare	Cork
	Donegal
	Dublin South East Wicklow
	Dublin North City
Both foster care and child protection and welfare	Dublin South West Kildare West Wicklow
	Louth Meath
	Dublin South Central
	Waterford Wexford

HIQA carried out 10 inspections in the 10 identified services as part of the monitoring programme between February and May 2024 (Figure 4). In addition, inspectors met with and spoke with middle, senior and executive managers within Tusla.

Figure 4. Types of inspection undertaken



(*Note: A risk-based service area inspection included both child protection and welfare services and foster care services*)

Tusla's National Service Improvement Plan

In response to the cases awaiting allocation, Tusla developed a national service improvement plan (SIP) for child protection and welfare and foster care services (unallocated cases) November 2023 – December 2024 which set out the plan at local, regional and national level to reduce unallocated cases to under 25% by the end of 2024. The findings in relation to this are discussed further on in the report.

Under the SIP, there were four overarching actions with identified actions and time frames to ensure:

- a clear national policy position for the consistent management of cases awaiting allocation and an effective mechanism to understand the complexity of the factors at local level
- effective leadership, management and oversight in achieving effective reduction in cases awaiting allocation
- implementation of all agreed actions in support of performance, recruitment and retention as set out in Tusla's reform programme and the People and Change Strategy
- the design and implementation of a new network operating model inclusive of an integrated front door[5] and local integrated teams.

[5] The front door service was where staff responded to initial contacts made by professionals who were

Under these four overarching actions, the SIP outlined a total of 18 national actions with associated regional and area actions. The plan also included the expected impact these actions would have once implemented. The SIP was endorsed at executive level with each action owned by an assigned member of Tusla's executive management team. Tusla used a project management approach to track progress toward achieving the overall actions with a monthly progress report to report on progress and identify any risks or issues. The progress reports were reviewed at Tusla's eight-weekly internal governance meetings which were chaired by the Interim Director of Services and Integration. Risks were brought to the attention of the executive management team. Tusla presented progress on a monthly basis to HIQA, and provided assurances where required in relation to risks.

By July 2024, Tusla reported that it had implemented the majority of actions set out in its SIP; however, during the inspections, inspectors found that these actions were at different degrees of implementation and the full impact of the SIP was not evident. Tusla's proposed allocation framework was not yet approved, and its reform programme was designed and in the primary stages of implementation. This is explored further under the capacity and capability section of the report.

concerned about a child.

2. Methodology

As part of this risk-based monitoring programme, the following standards were identified to assess the overall effectiveness of Tusla's governance and oversight arrangements for its child protection and welfare and or foster care services:

National Standards for the Protection and Welfare of Children 2012	
2.1	Children are protected and their welfare is promoted through the consistent implementation of Children First.
3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.
4.1	Resources are effectively planned, deployed and managed to protect children and promote their welfare.
5.2	Staff have the required skills and experience to manage and deliver effective services to children.

National Standards for Foster Care 2003	
5	The child and family social worker.
7	Care planning and review.
10	Safeguarding and child protection.
18	Effective policies.
19	Management and monitoring of foster care services.

Inspectors met with social work managers and staff, and interviewed relevant senior managers in the service areas and regions. Inspectors reviewed a range of performance-related service improvement and management plans and reports, relevant policies and procedures and other administrative records. Inspectors observed social work practice, relevant meetings and spoke with children, parents, and foster carers. They also sampled children's files and assessed the quality of care practices and systems in place for identifying and managing risk.

The key activities of this programme included:

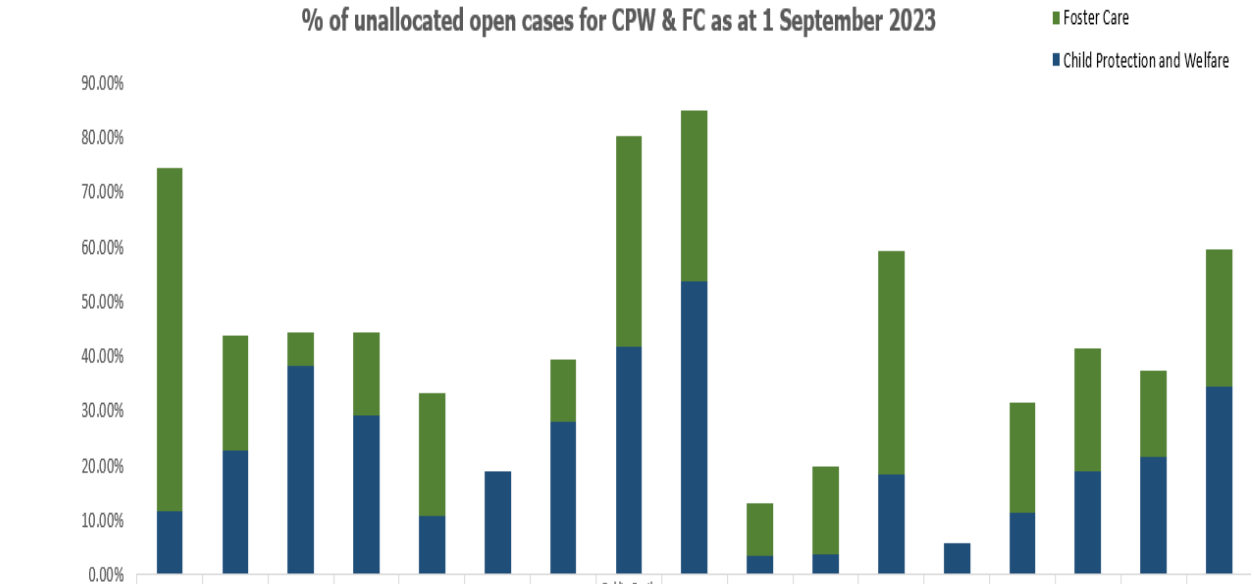
- analysis of a range of Tusla's performance data, targets and trends
- inspections of 10 services
- interviews with Tusla executive management team
- interviews with six regional chief officers
- interviews with 10 area managers
- interviews with 43 other relevant Tusla personnel, such as information officers, quality assurance personnel, business support managers and leads for other commissioned services
- focus groups with principal social workers and social work team leaders
- meetings with frontline staff, including social workers and social care staff
- review of a range of governance and management documentation including:
    - progress made against all service improvement and compliance plans
    - relevant policies and procedures
    - minutes of relevant governance, management and team meetings
    - actions taken to strengthen Tusla's workforce and organisational learning
    - the review of 155 staff supervision records
    - management trackers and audits in driving improvement activity across teams and social work departments
    - the review of 682 children's case files, of which 467 were child protection and welfare case files and 215 were foster care case files.

Inspectors also considered the views of children, parents and guardians and foster carers as an essential aspect of the monitoring programme.

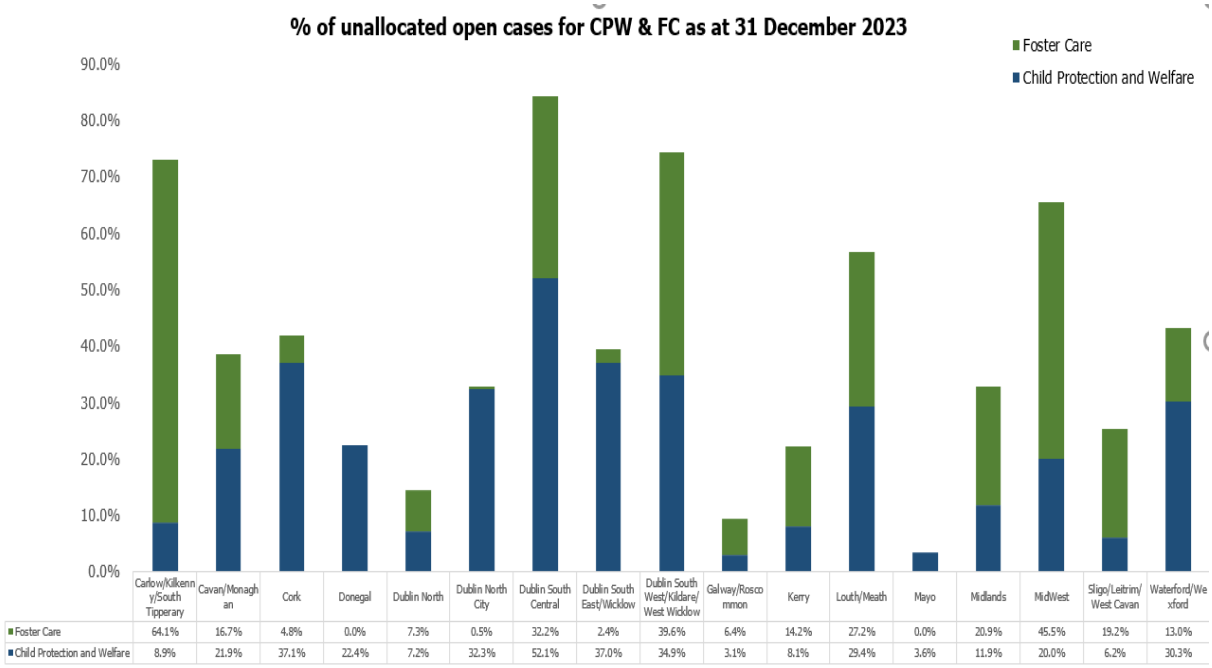
Tusla's key performance data

Tusla publishes reports on its performance and activity on a monthly and quarterly basis. The monthly performance and activity dashboard and the quarterly service performance and activity reports are structured on key measurements listed in Tusla's Annual Business Plan. The data is published on its website and is managed by Tusla's National Manager for performance reporting. (Appendix 1)

In 2023, Tusla experienced a significant increase in demand for its child protection and welfare service. As outlined in its 2023 Annual Report, Tusla experienced an 11% increase in referrals to child protection and welfare services, with 91,924 referrals received. This represented an additional 9,069 referrals when compared with 2022. At the end of 2023, there were 4,276 child protection and welfare cases awaiting allocation to a social worker. The number of cases open to the child protection and welfare services was 22,752, which was an increase of 719 cases compared to 2022. The term 'open cases' refers to the number of children about whom referrals were received by the service and which were identified as requiring a child protection social work assessment or intervention. In each of these open cases, children were receiving a social work service or were waiting for a service.



	CKST	Cavan Monaghan	Cork	Donegal	Dublin North	Dublin North City	Dublin South East Wicklow	Dublin South West Kildare/WW	Dublin South Central	Galway/Roscommon	Kerry	Louth/Meath	Mayo	Midlands	Mid-West	Sligo/Leitrim	Waterford/Wexford
Foster Care	62.70%	21.20%	5.90%	15.20%	22.60%	0%	11.30%	38.40%	31.30%	9.50%	16.10%	40.90%	0%	20%	22.60%	15.80%	25.20%
Child Protection and Welfare	11.60%	22.60%	38.30%	29.20%	10.60%	19%	28%	41.70%	53.50%	3.50%	3.80%	18.29%	5.80%	11.30%	18.80%	21.50%	34.30%



Based on data provided to HIQA by Tusla in October 2023, eight out of 17 Tusla service areas were initially identified for inspection, which included five of the six service areas outlined above. This increased to 10 service areas by February 2024 when Tusla submitted its end-of-year data for 2023.

Inspections of the 10 service areas commenced in February 2024 and were completed by June 2024 (Table 2).

Table 2. Tusla service area and types of inspection and interviews held between February and June 2024

Tusla service Area	Tusla regional operational area	Type of inspection	Date of on-site fieldwork
Dublin South Central	Dublin Mid Leinster	Risk-based service area[6]	6 – 9 February 2024
Carlow Kilkenny South Tipperary	South East	Risk-based foster care	13 – 15 February 2024
Dublin South West Kildare West Wicklow	Dublin Mid Leinster	Risk-based service area	26 – 29 February 2024

[6] Included both child protection and welfare services and foster care services.

Waterford Wexford	South East	Risk-based service area	5 – 8 March 2024
Dublin South East Wicklow	Dublin Mid Leinster	Risk based child protection and welfare	19 – 21 March 2024
Cork	South West	Risk-based child protection and welfare	9 – 11 April 2024
Louth Meath	Dublin North East	Risk-based service area	22 – 25 March 2024
Dublin North City	Dublin North East	Risk-based child protection and welfare	30 April – 2 May 2024
Mid West	Mid West	Risk-based foster care	14 – 17 May 2024
Donegal	West North West	Risk-based child protection and welfare	28 – 30 May 2024

Interviews with key senior and executive managers were also included in the programme and included:

Interview Schedule		
Regional Chief Officer	Dublin Mid Leinster	10 June 2024
Regional Chief Officer	Dublin North East	11 June 2024
Regional Chief Officer	West North West	11 June 2024
Regional Chief Officer	South East	11 June 2024
Regional Chief Officer	South West	12 June 2024
Regional Chief Officer	Mid West	12 June 2024
Tusla Executive Management Team		18 June 2024

3. Views of people who use the service

Children's experiences were established through speaking with a sample of children, parents, foster carers and professionals. The review of case files also provided evidence on the experience of children referred to the child protection and welfare service or in foster care.

Inspectors primarily sought the views of foster carers, children and parents from the selected children's files to be reviewed. The views of children who were unallocated and where there was evidence of gaps in service within their case file were prioritised for conversation with a member of the inspection team. Given the sensitive nature of cases that were open to the services, there were occasions where inspectors did not proceed in speaking with a parent or foster carer or seeking consent to talk to children. Due to the levels of crisis or presenting risks in certain cases identified on inspection, it was not appropriate to talk to a number of children waiting for a service, as some children and their families may not be aware that they were waiting for a service from Tusla. For these children, it was determined that a review of their case files would provide insight into their experiences and not contribute to any further distress for them.

As part of this monitoring programme, inspectors engaged with a total of 20 children, including nine children receiving a Tusla child protection and welfare service and 11 children in foster care. The following section outlines the information we received from children, families and carers we spoke with.

Child protection and welfare service

Children's views

Children's views were obtained by inspectors when possible and appropriate to do so. Children spoke with inspectors about their positive experiences of the service as well as areas which required improvement. In addition, a review of case records provided evidence on the experience of children referred to the child protection and welfare.

In the main, the immediate needs of children were responded to, despite Tusla's capacity to respond consistently to all children. The capacity of the service to respond appropriately to all children was negatively impacted by the large numbers of children being referred to the service and staffing capacity difficulties. Children classified as high priority received an appropriate response with the safety of those children being the primary concern.

A review of case files showed that some children who were allocated a social worker, were listened to and had their views taken into consideration when decisions were made about the service they received.

The majority of children who had an allocated social worker spoke positively about the service they received. They were satisfied with their level of contact with their social worker, and the support they received. They had no concerns and said they can say what they want at meetings. They told inspectors that their social workers would help if they asked for anything and everything was going well for them. Some other comments made by children about their social workers included:

- "She is there for me", "meeting my needs"
- "She is perfect, she does everything I need."
- "The social worker is very nice, I could speak to her if I was worried or if there was something that I needed".
- (Social worker) "Comes visit school, phone calls, go out for tea. Going out is much better, there is no rush."
- "I can really talk about what is going on and if I need any help".

The review of case files showed that overall the child protection and welfare service received by children was not adequate or timely. Children prioritised as at medium and low risk did not always receive the right support at the right time. The level of risk or safety was not always established by Tusla before children were placed on waiting lists for long periods of time. Children who were placed on the waiting list for assessment and support did not have the opportunity to have their views heard. Therefore, their views were not taken into consideration when decisions were made to allocate their case or keep their case on the waiting list for support. When children were awaiting allocation in the child protection service, there was limited contact with them.

In some cases, referrals were made by schools and other professionals due to concerns. While the service areas were aware of this information, some families had yet to be informed about referrals, often months after they were received. This also had an impact on children and their families receiving the right support to address issues at the right time.

Where inspectors did speak with children, their feedback included:

- A child told the inspector they had a social worker but said "I don't really know what it is they do, I don't understand what they are there for."
- A child indicated that what they needed was "extra support and counselling. I have waited a long time and I am getting sick of waiting."

Overall, the majority of areas did not have the capacity to provide a timely service and this posed a significant risk to children. For example, inspectors escalated cases of children who made allegations of abuse or where there were concerns in relation to their welfare, weeks and months prior to the inspection and who had not been met with or an adequate safety plan put in place by the time of the inspections.

Parents' views

Parents' views were obtained by inspectors when possible and appropriate to do so. Parents spoke with inspectors about their positive experiences of the service as well as areas which required improvement in the child protection and welfare service.

Positive feedback from parents included that their children received an appropriate and good quality service, which in their view promoted the rights of children and met their family's needs in a timely manner. They told inspectors that social workers and social care leaders were providing good supports to the families and that they were meeting children and young people on a regular basis as well as checking how the family was managing.

Parents told inspectors there was good communication with social workers. They said that they could call the social worker when they had any concerns and that they got a quick response from the social worker or someone on the social work team. Parents spoke about how changes to social workers allocated to their family was explained to them, and said that their children's voices had been heard. They felt involved in the decision-making process and that the social workers provided all the information they needed to understand the process of initial assessments, safety planning and professional meetings.

They told inspectors about supports put in place by social workers and being provided with support for specific tasks relevant to the child's care. Parents also said that while there had been delays in the past, the service had improved and they were receiving good support from a social worker and a social care leader. Other comments from parents included:

- The (social care leader) "is brilliant and provides a safe space"
- "I don't know what we would have done without Tusla"
- "We have been very lucky to have the worker in the child's life"
- "They (social care leader) respect (the child's) rights"
- "They (social workers) are very good at their job and well-trained"
- "They (social workers) are good at explaining things"
- Social workers were "very nice and supported me very well"
- "I saw them every week and they came to my house"
- "I am finished working with social workers now, but I would be happy to call

them in the future if I needed help".

While the majority of parents viewed their experience of being involved with Tusla as positive, a number of parents expressed some dissatisfaction with the service they had received. For example, parents told inspectors they were waiting for their children to be allocated a social worker. One parent told inspectors that although there was a safety plan in place to maintain safety for their child, this safety plan was not implemented and staff were not aware of this due to lack of monitoring. Some parents told inspectors that they got no help or support. Some of their comments in relation to social worker involvement included:

- "I have had so many, and built up relationships with them- then they are gone. It's hard, and gets tiring"
- "It has never been explained to me why there is no social worker. There were months and months when my child had no social worker. I did not know who was over the case and I found it difficult to get information. I received a letter in the past few weeks stating the social care worker was the person to contact. I had not been told this before"
- "Children don't have a social worker as far as I am aware", that they were "awaiting a social worker from (name of Tusla office) for the last two years."
- "My children don't have a social worker, the last one left last year. They keep chopping and changing so much."

Front-line practitioners

Inspectors spoke with 123 child protection and welfare front-line professionals (social workers and social care staff) to obtain their views about the services. Mixed feedback was received. Overall, they were child centred in their practice and areas for improvement mainly focussed on increasing resources and systems to ensure children receive a good quality service.

Front-line practitioners also shared their concerns with inspectors. For example, they expressed concern in relation to children being placed on waiting lists with no allocated social worker or being in receipt of an active social work service. Other areas for improvement identified were about ensuring children received appropriate support in a timely manner, the impact of staffing shortages and turnover and lack of support by management.

Staff expressed the view that placing children on waiting lists was 'bad practice' and meant that children and their families did not receive a social work service when they needed one. While staff told inspectors they knew children who were at immediate risk of harm were responded to appropriately, they also acknowledged

and voiced concern about children who were deemed to be a either low or medium priority.

Staff also talked about waiting lists for children and families to access essential support services such as mental health services, disability support services and therapeutic services and how that impacts on families waiting to receive these services. It must be noted that some of these services were outside of the remit of Tusla. They said that when children and families have to wait for services, there is a tendency for issues to escalate and that timely services and early intervention can prevent this.

Staff identified the inability to transfer children's cases to other teams internally within their own service area and externally to other service areas, as a barrier to providing an effective service. This meant that children who had been assessed as requiring an ongoing social work service were not transferred to the most appropriate team to ensure their needs were met in a timely manner. This caused delays in providing a child with an allocated social worker.

Staff also spoke about the pressure on them due to staff shortages and the overall lack of opportunities for career advancement. Front-line practitioners spoke about the high volume of existing caseloads were often not considered during allocation of new cases and that needs to be addressed. Consequently, this meant that they could not provide the level of support they would like to the children allocated to them. While the majority of staff reported positively on the level of induction, additional training, support and guidance they received, some staff did not feel supported by their managers. They said that staff were leaving to move to other services for better career options and a less stressful work environment.

Foster care service

Six of the 10 inspections completed as part of this programme inspected foster care service provision. Inspectors spoke with 11 children in foster care.

Children's views

Overall, the children who spoke with inspectors were generally positive about their experiences of the social work service.

Some children who spoke with inspectors did not have an allocated social worker and did not appear to notice any difference when a social care leader or social care worker was allocated to support them. They benefited from having regular visits in most cases, and reported good relationships with their current workers.

For the majority of Tusla foster care services, children's case records provided a clear picture of children's needs and what was important to them – their relationships, activities, achievements, worries and wishes for the future. Children were encouraged and actively supported to contribute to their child-in-care reviews, and inspectors found an increased level of participation by children over the past year. Child-in-care review booklets completed by children also provided important feedback about children's thoughts and feelings. While some children attended their child-in-care reviews, others chose not to attend those meetings. They told inspectors they were informed of the decisions made at meetings by either their social worker or foster carer and were made aware of their care plans.

Children that spoke to the inspectors described their positive experiences of social workers and other frontline workers as:

- "easy to ask social worker if I need anything"
- "I like my social care worker and I see her about once a month. I am happy now, and I would tell her if I had any worries"
- "listens and makes things happen"
- "doing a good job, would give social worker a 10 out of 10"
- "The social care leader is good. She is kind and pretty. She asks me questions about my mammy, daddy and foster carer"
- "I have contact with my family. I know my foster carer will get in touch with my social worker if they need to speak to them"
- "I don't go to that (child-in-care review), I don't want to go".

Children in foster care also spoke with inspectors about their negative experiences of the service which meant there were areas of the service that required improvement based on children's feedback.

While some children had an allocated social worker, others were placed on a waiting list. Children who did not have an allocated social worker had their cases managed through various systems in different areas. This was due to the lack of a national approach to provide consistency to children requiring a social work intervention. For the service received by a child was dependent on where they lived and what was available locally to support families.

There were negative impacts for many children when they did not have an allocated social worker or were not receiving an active social work service. This meant that children who were deemed at risk and requiring a social work service were not adequately supervised to ensure the care they were receiving was safe and meeting their care needs. This is an unsafe practice. For example, child-in-care reviews were not always completed in line with the timeframes set out in the *Child Care*

(Placement of Children in Foster Care) Regulations, 1995, which led to delays in children receiving the supports they needed at the right time. Another impact was that some children told inspectors that they had not been given information about who to contact should they be worried about anything in their lives. Some children spoke about having experienced "a good few social workers". Other comments included:

- "didn't see care plan"
- "not sure if I have a social worker or not at the moment".

Parents' views

Parents said they were mostly satisfied with the help and support they received from Tusla and that recently they had felt better-informed about their children's progress and care arrangements. Parents told inspectors that they were invited to attend child-in-care reviews and that everyone was provided with an opportunity to have a voice.

Parents spoke positively about the work of front-line practitioners, including social workers and social care staff. They said that staff were easy to talk to, followed through on what needed to happen for children, they had good relationships with them and they were kept up to date with what was happening for their children in foster care. They also told inspectors:

- "my new worker helped me understand the reason why my child is on a care order. The worker we now have is lovely".
- "getting on really well"
- "I am included in plans about my children and know how the children feel about the plan"
- "they are second to none – five stars"
- "they are very understanding. I am very happy where my child is placed"
- "I have trust in them".
- "I am helped to be involved in meetings for my child. The social work team leader understands my first language is not English and will use plain and simple words to explain things."

Other parents expressed disappointment with the foster care service. They spoke about the change in social workers for their families and gaps in specialist services for children with high and complex needs. Feedback in relation to their experience of the service included:

- "there were months and months when my child had no social worker… I found it difficult to get information"

- "I have looked for my child's care plan previously but never got a copy"
- "children don't have a social worker as far as I am aware"
- "everything is seen as someone else's responsibility. We are passed from one department to another. What is happening for my child is not good enough"
- "the social worker is great- I can ring them anytime- but getting the right therapeutic help is slow".

Foster carers' views

Foster carers in some areas told inspectors that they felt listened to and were involved in discussions in relation to child-in-care reviews and care plans. Foster carers spoke about the importance of children having a consistent primary worker, being either a social worker or social care practitioner. Other feedback from foster carers included:

- "we have had the same social care practitioner for a couple of years, we see her about once a month and she is good at following up on anything we need"
- "although we have lost a lot of social workers over the years, the children have continued to get the support they need"
- "we are very happy with everything- we have had great support from the children's social workers and my fostering social workers over the years"
- "any child that does not have a social worker should be high priority"
- "our fostering social worker is brilliant- we are blessed in having her. However there has been a serious turnover of staff which has led to delays in our plans to adopt"
- "everyone is trying to help, but there is not the right kind of support available which makes aftercare planning very difficult".

Some foster carers spoke about their negative experiences with the social work departments. These comments mostly related to children who did not have an allocated social worker. This led to delays in service provision for children in some instances, and children being expected to develop relationships with new social workers continuously. They told inspectors:

- it is "hard for the child to have had so many social workers"
- "it is hard to get decisions made for the child without a social worker in place"
- "we know things are difficult for Tusla at the moment and the children placed with us do not have a social worker. What has been put in place – a social care leader and team leader is not ideal"
- the child has "not had a social worker for the last two years"
- "for them every couple of months introducing them to someone new, gaining

trust in someone, then they are gone, children don't know where they are"
- "Nothing bad to say about social workers, (they) just don't stay too long"
- "the system is failing children because there is not enough social workers".

Overall, while the majority of foster carers were satisfied with the role of the social care worker, they were not satisfied that children in their care were waiting for long period of time to be allocated to a social worker. Foster carers raised concerns in relation to the frequent changes in social work allocation and the lack of consistency for children during their time in care.

Front-line practitioners

Inspectors spoke with 76 front-line professionals working in foster care services (49 social workers and 27 social care staff) to obtain their views about what was working well in regard to the governance of the service, as well as which areas required improvement.

It was clear to inspectors that front-line practitioners were regarded as respected members of the children-in-care teams across all areas. Their contribution in ensuring children were safe and had their needs effectively met was seen to complement the wider statutory social work service. These arrangements, although they were not in line with the *National Standards for Foster Care* (2003), provided a good level of consistency for children, enabling them to increasingly shape their future care arrangements and feedback on their experience of foster care.

Overall, front-line staff praised the leadership of the service. Most staff reported positively on their induction, additional training and management oversight of their work. They also said their workloads were very busy and that sometimes there were not enough hours to complete all required activity leading to their completing work out of hours. As more children have become unallocated, pressure increases from the courts to allocate a social worker to children in foster care, leading to the need for further review and re-organisation of workloads of front-line staff. They recognised while every effort was made to ensure essential statutory work was covered, children sometimes did not have a consistent worker to carry out key tasks. Most staff reported a positive teamwork and child-centred practice; despite the significant social work capacity challenges throughout Tusla.

Front-line practitioners told inspectors that more staff were required to enable a more timely quality service for children. Some staff were aware of the suggested restructuring for service areas proposed by Tusla's executive and expressed some concerns. HIQA was informed by the executive team that meetings were taking place in each area to address the concerns of staff. There were varying levels of awareness among staff of Tusla's National Service Improvement Plan.

Staff told inspectors that cases were complex and a huge challenge was the lack of placements for children coming into care.

In relation to support services for families, staff told inspectors that they were heavily reliant on services commissioned by Tusla to provide services to children and their families. These services were brilliant they said but acknowledged that there are waiting lists for some services. This meant that sometimes there was no service to refer children to and other children had to wait to receive the support and therapy services they needed.

A big concern was staff shortages and the awareness that cases were on waiting lists and those cases could become high priority. Similar to child protection and welfare services, staff were satisfied that where there was immediate risk, children and families received an immediate response but planned duties were cancelled as a result and they expressed concern that this sends the wrong message to children.

An area of good practice but not consistent across all areas was Tusla's national initiative of youth participation forums for children-in-care that provided a platform for children to have a voice and to be part of service improvement and planning. The aim of the forum was to ensure that any change or decision made in relation to services provided to children that directly affected them, that their views were taken into consideration as part of the process. This promoted a child-centred approach to working with children and created a children's-right based approach to service delivery. This approach was in line with Tusla's 'Child and Youth Participation Strategy 2019 – 2023'.

4. Capacity and Capability

National Standards for the Protection and Welfare of Children (2012)
Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
Judgment: Not compliant
Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.
Judgment: Not compliant
Standard 4.1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.
Judgment: Not compliant
Standard 5.2 Staff have the required skills and experiences to manage and deliver effective services to children.
Judgment: Not compliant

National Standards for Foster Care (2003)
Standard 18 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.
Judgment: Substantially compliant
Standard 19 Health boards have effective structures in place for the management and monitoring of foster care services.
Judgment: Not compliant

In a well-governed service, the service provider ensures that overall accountability for the service is clearly defined and the governance arrangements ensure safe, sustainable services are delivered. While Tusla had a risk management system in place it had not been able to mitigate the risks in the service areas included in this programme. As a result, not all children referred to the child protection and welfare service or placed in foster care received a timely and consistent service. In addition, Tusla services participating in this risk-based monitoring programme were not consistently adhering to their approved standard business process and were not fully implementing Children First (2017).

Regional and service area management teams were not able to reduce all risks to a level that was safe and effective. Concerns remained in relation to the ability of service areas to achieve the national targets set out in the national service improvement plan and their ability to sustain improvements. Tusla executive management team informed HIQA that they had completed a human resource exercise in July 2024 which validated staff vacancies across the service.

Service areas participating in this monitoring programme demonstrated an understanding of the needs of children and families, and sought to make effective use of commissioning and partnership working with external agencies, community and voluntary sector providers to help fill service gaps, promote innovative working and make best use of shared resources. All participating service areas inspected had relevant commissioning arrangements in place with a range of services which diverted children and their families to appropriate family support services when they did not meet the threshold for a social work intervention. Some areas were more heavily reliant on these services than other areas. The availability of commissioned support services was not consistent within some service areas. This meant that on occasion, there was no service to refer children to and other children had to wait to receive the support or therapeutic service they needed.

There were inconsistencies across regions in relation to the allocation of cases to other grades of staff. Tusla was in the early stages of developing a National Allocation Framework. In the absence of such a framework, individual areas had differing arrangements in place.

Service Improvement Plans

As outlined earlier in the report a key action for each service area under the national plan was to develop a specific service improvement plan (SIP) or rapid service enhancement plan for reducing unallocated cases. This was to be implemented by 30 January 2024, and was to be informed by practice assurance audits and associated action plans, policy implementation plans and other local plans.

At the time of the inspections, the Waterford Wexford, Dublin South East Wicklow, Dublin North City, Mid West, Louth Meath and Donegal service areas had a local rapid service improvement plan in place, of which five were aligned to the national service improvement plan. While the Louth Meath service area had a SIP which outlined the steps taken by the area to seek to reduce unallocated cases, it was not aligned to the national service improvement plan and did not identify key performance indicators to show the effectiveness of the plan in achieving the national target of under 25% children awaiting allocation in December 2024.

The Dublin South Central and Carlow Kilkenny South Tipperary service areas at the time of inspection, had drafted their rapid service improvement plans and some aspects were in the early stages of implementation and had not yet defined key targets to support incremental achievement of the required national target. As such, these service improvement plans could not be adequately assessed in terms of their effectiveness in reducing the number of unallocated cases. The Cork and Dublin South West Kildare West Wicklow service areas at the time of the inspection, did not have a rapid service enhancement plan for reducing unallocated cases, they either

had a range of, or had included the target as a service objective in their existing service improvement or strategic plans or as part of its implementation of required actions in its compliance plan following inspection of the service.

Local plans were aligned to the national and regional service improvement plans so as to improve outcomes and experiences for all children across the services. While managers and staff were working towards the national target of reducing the number of unallocated children to 25% or less, concerns remained about their ability to achieve the target and to sustain improvements. Managers and staff told inspectors that the service improvement plans could not be effectively implemented as a result of the significant staffing challenges. Monthly progress update reports were made to the regional chief officers on progress, risks and mitigations based on the area's devised rapid enhancement plan or existing service improvement plan to reduce unallocated cases. Some service areas were more confident than others that they would achieve the 25% target.

Another action under the national service improvement plan was to ensure that areas and regions were monitoring key performance data and mitigating risks within their control. Where risks that were not within the control of local or regional areas were identified, they were to be escalated to Tusla's National Operations Risk Management and Service Improvement Committee (NORMSIC) which meets on a quarterly basis, and was chaired by the Interim National Director for Services and Integration. NORMSIC also oversees engagement and coordination of all service improvement and audit activity between Tusla's quality and risk directorate and national operations. In addition to ensuring oversight of risk management and supporting service improvement within operations, one of the key functions of NORMSIC is to drive consistency in, and learnings from, audits and HIQA inspections to improve compliance levels across services. This was underpinned by the Regional Operations Risk Management and Service Improvement Committee (RORMSIC) structures whose remit is to maintain a quarterly review of current area data and assurance reports and identify learnings and additional regional service improvement actions required. RORMSIC structures were in place across each participating service area.

At the monthly provider meetings, Tusla provided updates to HIQA on the national service improvement plan. An action under the national service improvement plan was to ensure there was effective leadership, management and oversight in achieving effective reduction in unallocated cases. Regional and area level actions were also outlined so as to align to the national actions. While regional chief officers were delegated full responsibility and accountability of all children and family services in their region, the board and the CEO also retain responsibility for all delegated functions. At executive level, this included eight-weekly reviews of the

service area's regional assurance reports, the development of an agreed performance dashboard associated with unallocated cases, quarterly reviews through existing NORMSIC structures to identify learnings and additional national service improvement actions as required. It also included performance conferences with each regional chief officer (RCO). In November 2023, a regional data overview session took place. This session was dedicated to discussions in relation to child protection and welfare referrals, open cases that were allocated and cases awaiting allocation, fostering data and assessments as well as potential actions to address these items.

The CEO outlined that in order to further strengthen oversight and support to RCOs in fulfilling their responsibilities, three additional processes were initiated in 2023:

- executive management team meeting with RCO's as a group, every 12 weeks, which provided an opportunity for information sharing and discussion on strategic actions required to improve intractable risks such as staffing, budget allocation, leadership capacity, digital enablement and other relevant areas executive management team meeting with RCO's and special emergency arrangement[7] (SEA) team, on a weekly and then bi-weekly basis to provide robust and integrated oversight of the changes being implemented to strengthen governance and oversight of these arrangements across the regions
- regular directorate meetings, led by relevant executive management team director, or nominee and relevant regional management team Lead for the purposes of information sharing, and review of specific issues, for example, budget variances.

In line with the national service improvement plan, the executive management team implemented a new approach to integrated performance management in April 2024. Inspectors were informed that these meetings discussed key data in relation to people, (for example, recruitment and retention), finance, information (for example, implementation of an ICT system, quality and risk (for example, risk register) and operations (for example, unallocated cases). These meetings were followed directly with an engagement with the regional management team. During both aspects of these engagements, the RCO or member of the management team had an opportunity to highlight any areas of concern, where they require additional support from the executive management team.

[7] A Special Emergency Arrangement (SEA) refers to emergency settings where a child/young person is accommodated in a non-statutory and/or unregulated placement e.g. Hotel, B&B, Holiday centre, Activity centre, Tusla property or privately leased property. The child is supervised by Tusla staff, or staff provided by a private provider, or community and voluntary provider (or combination of those). The overall responsibility for the child remains with the placing service area and region.

The executive management team met with four RCOs in April 2024 and with the remaining two RCOs in May 2024. The minutes of RCO performance conferences for each region were provided to HIQA. The records were concise and noted the key topics discussed, such as noted above. In relation to unallocated cases, the minutes noted that the reporting of unallocated cases across regions was not consistent and required RCOs to be consistent to ensure that the figures could be relied upon and analysed nationally. The performance meeting records contained limited information as they had no commentary recorded in relation to individual region's performance against the national target of reducing waiting lists to 25% or less, nor did it comment on how regions were adhering to Tusla's own key performance indicators (KPIs) as set out in its standard business processes. The executive acknowledged to HIQA that these records were brief and concise, and that the verbal discussions that took place provided the executive with adequate assurances. They also informed HIQA that they could track performance at an agency wide level for the board through a number of different mechanisms such as dashboards, quality and risk and operational reports.

To further enhance their response to children assigned low and medium priority awaiting a child protection or welfare response, a low harm high need (LHHN) response pathway was initiated in February 2022 to target additional resources to priority regions. Five pilot service areas – Cork, Waterford Wexford, Louth Meath, Dublin South Central and Dublin South West Kildare West Wicklow were identified by Tusla as having the highest number of unallocated cases at the end of 2021. Three of these service areas had fully operational LHHN teams at the time of the inspections. The Dublin South Central service area had received permission to temporarily deviate from the LHHN model prior to the inspection. This meant that while they had a staff team in place, this team diverted cases to commissioned services where children were awaiting initial assessments for a prolonged time frame. The remaining area (Dublin South West Kildare West Wicklow) advised that they were not able to establish their LHHN teams primarily due to recruitment challenges and service priorities.

As part of Tusla's national improvement plan, an assurance review of the implementation of the LHHN response in the areas where it was piloted was undertaken by Tusla's practice assurance and service monitoring team (PASM) from February to May 2024. The review was aligned with an action outlined in a service improvement plan requested by HIQA in November 2023. At that time, a plan was requested based on HIQA's concerns over the persistent challenges in managing a significant volume of unallocated cases within the children in care and child protection and welfare services across Tusla. The review provided insights into the challenges and successes of implementing the response. Each area had implemented

the response pathway at different process stages and in specific geographical locations, and the data collected by the implementation team did not lend itself to effectively measure the impact of the response pathway. PASM made recommendations for consideration at area and team level. Several of these recommendations support the findings of the risk-based monitoring programme, particularly in relation to the capacity of the LHHN staff team to effectively undertake these types of initial assessments and safety planning, given their lack of social work qualifications, training and inexperience in child protection and welfare assessment.

Tusla's Reform Programme and the People and Change Strategy

To address the challenges faced by the agency, Tusla has embarked on an integrated reform programme (2023 – 2026), of which the planning phase had taken place prior to this monitoring programme. Tusla had included actions associated with this reform programme in the national service improvement plan with a time frame for completion noted as 31 December 2023. Updates in relation to this were shared at the provider monthly meetings with HIQA, which demonstrated actions achieved to date and those that were on track for September 2024.

The reform programme aims to transform the delivery of services by:

- improving access to services
- ensuring equity and consistency of services to better meet the changing needs of the children, families and communities they serve
- retain, grow and diversify their workforce
- strengthen trust and public confidence in Tusla.

The CEO outlined that a key pillar of the reform programme was the design and implementation of the Local Integrated Service Delivery Model, so as to review the structure and practice of frontline service delivery. The purpose of this was to ensure that children, young people and families had better access to integrated services, to promote more positive outcomes, to ensure resources were utilised more efficiently and to better support Tusla staff. The CEO provided a copy of the summary report of the reform programme up to July 2024. It outlined the significant progress made in the last 12 months. The new Tusla structure had been approved by the board to be implemented in 2025. Tusla's executive management team were interviewed by the Chief Inspector and Head of Programme – Children's Services as part of this monitoring programme. The executive management team were a relatively new team with a very large brief, of which the regulated and mandatory entities form part of. It was evident that they were committed to putting the necessary structures in place to support the service areas. They acknowledged the challenges faced by Tusla and these are discussed further in the report.

From 2022, and throughout 2023 and 2024, the executive management team and the CEO as a collective, or individually visited all regions (minimum of three times) and all areas (minimum of two times) to hear directly from RCOs, area managers and staff on the challenges and opportunities in the regions and service areas, and the strategic issues that the executive management team and the CEO needed to focus on to better support the regions and areas to fulfil their statutory obligations. All the feedback from these sessions informed the strategic work of the executive in that period and was translated by the executive directors into the development of key strategic programmes of work from 2023-2025, which were on-going. Tusla's People Strategy was included in the national service improvement plan submitted to HIQA.

Tusla's People Strategy 2022 to 2024, led by the national director of people and change sets out its commitment to all staff:

- to be a great place to work
- to provide purposeful work around the care and protection of children
- to be the very best that they can be in caring and protecting children in the State
- to support each other to face whatever challenges that lie ahead.

The aims and objectives set out in the strategy supported enhancement of a positive experience for all employees. As outlined in its Corporate Plan 2024 – 2026, Tusla's ambition is to reform its practice, structure and culture.

One of the overarching actions with identified national and regional actions and time frames within Tusla's national service improvement plan was to ensure the implementation of all agreed actions in support of performance, recruitment and retention as set out in Tusla's reform programme and the People and Change Strategy. These actions were in place and ongoing.

The CEO outlined that significant progress had been made and was ongoing in increasing the supply of social workers for frontline work. The CEO and executive management team, with the support of the Department of Children, Equality, Disability, Integration and Youth, agreed to invest further in the funding of bursary schemes and sponsorship programmes in 2023 and 2024 to expedite the supply of professionally qualified social workers for frontline work in Tusla, particular in areas of high demand and poor recruitment rates.

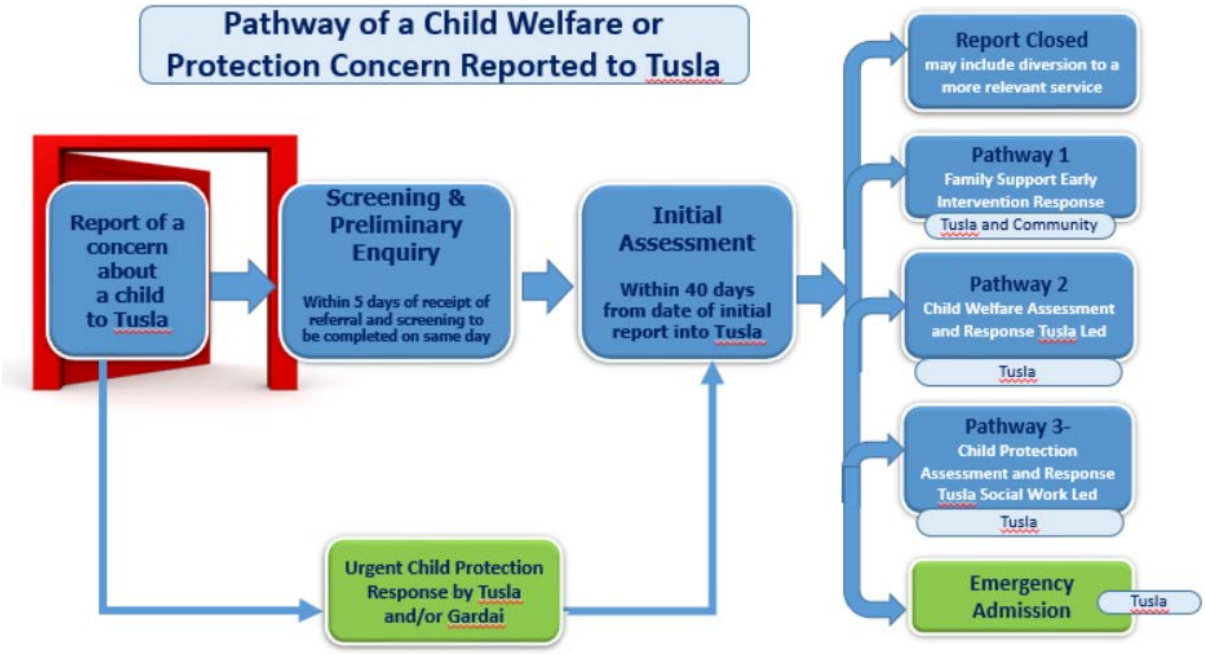
The CEO also reported that significant progress had been made, regarding the funding of staff to gain a social work qualification through additional study, and the launch of the first ever social work apprenticeship scheme. A careers pathway was also implemented as a retention initiative, as well as the appointment of a retention officer in each region. The director of people and change had also worked in collaboration with third level institutions to support the development of additional social work courses.

During the course of this risk-based monitoring programme, HIQA observed that excellent work had been done regarding recruitment and retention of staff, as evidenced in the figures presented during the interviews. This was against the backdrop of an unprecedented demand for the services since 2022 which saw an immediate need to accommodate Ukrainian children arriving as unaccompanied minors and to work with community and voluntary partners to support these children and their families accommodated in communities across the country. There was also a marked increase in the numbers of unaccompanied and separated children seeking international protection originating from countries other than Ukraine, with arrivals mainly from Somalia and Afghanistan. It is evident that as Tusla continues with its reform programme, the findings from these interviews demonstrated that oversight and assurance mechanisms need to be strengthened in areas such as quality improvement, staffing and risk management.

Standard Business Process

Child protection and welfare services throughout Tusla fulfil its statutory responsibilities under the Child Care Act 1991. Tusla had standard business processes in place to standardise the management of child protection referrals from the first point of contact with the service, through to case closure which included any or all of the process and other sub-process stages. Tusla's standard business processes had been reviewed and changes were made to timelines for preliminary enquiries and initial assessments, as well as the removal of the further assessment process to ensure it was aligned with their national approach to practice in June 2020. Inspectors followed Tusla's standard business process in the review of the arrangements in place for the management of child protection and welfare concerns and found that services were not consistently implementing Children First (2017) or adhering to standard business process. Adherence to standard business processes and key performance indicators are essential in order to effectively measure the timelines for the completion of tasks associated with the processing of new referrals of concerns about children through the service.

Figure 5. Tusla's Standard Business Process for Child Protection and Welfare



Risk management

Tusla's internal risk management processes did not fully mitigate the risks for some vulnerable children who required a timely and accessible service to fully meet their needs. The National Operations Risk Management and Service Improvement Committee (NORMSIC) and Regional Operations Risk Management and Service Improvement Committees (RORMSIC) were two committees that were in place to oversee operational risk.

Tusla had a national *'Organisational Risk Management Policy – January 2022' in* place. This was updated in November 2023 and Tusla submitted this version to HIQA. The policy was aligned to the Tusla risk management framework. It set out the systems and processes, including staff's role in them, that are required to ensure that risks are managed consistently across Tusla. Additional components of the risk management process were:

- Tusla's national incident management process, a statutory requirement under the National Treasury Management Agency (Amendment) Act 2000, to report incidents on the National Incident Management System (NIMS), and
- A 'Need to Know' reporting process for incidents which may attract potential media coverage, have Tusla-wide implications, expose Tusla to significant corporate risk or litigation, and involve a number of other government departments or state agencies.

A standard operating procedure for the '*National Corporate Risk Register (NCRR) Notification Process (2023)'* was also in place. It described the steps required in the notification process for risks being added or removed from the NCRR. The Chief Risk Officer (CRO) was the National Director for Quality and Regulation and had overall responsibility for the management of the NCRR, and had direct access to the CEO and the chair of the audit and risk committee in this regard. Risks that are considered to have an impact on a strategic objective are identified and recorded on the NCRR, and required board attention and agency Tusla-wide, cross-directorate response. Each risk on the NCRR was assigned to a relevant executive management team member as the risk owner.

The CEO outlined that the national corporate risk register (NCRR) reflects the risks that are considered to have an impact on the strategic objectives of Tusla, and is reviewed by the executive management team on an ongoing basis and collectively each quarter. This is also submitted to the board, through the audit and risk committee on a quarterly basis. Since the commencement of this risk-based monitoring programme in 2023, a new integrated national risk was appropriately added to the NCRR at the end of 2023, specifically associated with cases awaiting allocation. A risk regarding the demand on services had been appropriately on the NCRR since 2015. The CEO outlined that the NCRR is reviewed by the executive and the board and risks when required were brought to the attention of the Department of Children, Equality, Disability, Integration and Youth (DCEDIY). Tusla alone will not be able to address the risks associated with the demand on services, and will require the continued cross-departmental supports and short to long-term strategies to address their resourcing issues.

A review of the minutes of the NORMSIC and RORMSIC forums relating to the participating services failed to capture the significant risks to children who remained unallocated without a social worker, in some instances for long periods of time. This demonstrated that the necessary systems were not sufficiently strong to ensure that the safety and welfare of children at actual or potential risk were protected by Tusla in a timely and effective manner. Despite risk management mechanisms being in place, Tusla was not effective in addressing these operational risks, even in circumstances where a specific service area had been internally risk escalated to Tusla's executive or by HIQA. For example there was a delay of five months in Tusla implementing elements of its plan to reduce unallocated cases in the Dublin South Central area. HIQA acknowledged that Tusla placed an emphasis on the management of children considered most at risk. Despite the shortcomings of the recorded minutes of NORMSIC and RORMSIC, specific risks had been appropriately placed on the national corporate risk register, however, mitigations of the risk at a regional and local level required further improvement in some services.

During and following the inspection fieldwork component, individual cases and systems risks were escalated by HIQA to the relevant area manager or regional chief officer and in one particular service area, to the CEO. As noted earlier in the report, of the 10 service areas inspected, 107 individual cases (101 child protection and welfare cases and six foster care cases) were escalated to the respective area managers in seven service areas. This related to 101 (24.3%) child protection cases reviewed across the seven service areas, and six (6.5%) foster care cases in two service areas. There were no individual child protection and welfare case escalations in the Waterford Wexford area, nor were there any foster care escalations for the Carlow Kilkenny South Tipperary, Waterford, Wexford and the Mid West service areas. These escalated cases related to the various process stages in the management of child protection and welfare referrals. The majority of the escalated cases were unallocated but also included a number of cases that were assigned or allocated to either a social care practitioner or a social work team leader. Examples of these identified risks included: referrals not screened, preliminary enquiries not appropriately completed, children who required a safety plan not having one in place, cumulative harm not being considered or assessed and poor oversight of referrals. It was a concern for HIQA that some of these risks were not identified at local level, and consequently, control measures in relation to these specific risks were not identified, nor were the areas that exceed the 25% of unallocated cases.

Risks in relation to children placed on the child protection notification system (CPNS) were identified in Dublin South Central, Dublin North City and Donegal service areas and significant risks associated with the use of special emergency arrangements (SEAs) to accommodate very vulnerable children with complex needs were identified in the Cork and Mid West service areas. There was a system risk in the Louth Meath service area as the numbers of children on the CPNS did not correlate with lists provided to the inspectors. However, this was clarified and responded to following the inspection. These areas are explored further under the quality and safety dimension later in the report.

A large number of referrals awaiting allocation at the various stages of the referral process presented an actual systemic risk because the service did not have the capacity to carry out these processes in line with their own timeframes. Of the ten service areas inspected, systems risks were escalated by HIQA in eight areas (see Table 1) to the respective regional chief officers. Examples of identified systems risks fell within the following categories:

- Governance
- Information governance
- Workforce
- Garda notifications

- Cumulative harm
- Child protection notification system (CPNS)
- Resources
- Referral pathways.

The Cork and Dublin South Central service areas could not provide adequate responses to a number of the systems risks identified to assure HIQA in relation to the immediate actions to address some of the issues raised. The following risks were escalated to the CEO in writing:

- children on the CPNS
- absence of effective governance and oversight of unallocated cases, such as cumulative harm not being adequately assessed
- safety planning
- quality assurance mechanisms
- safeguarding visits by social care leaders or social care workers being inappropriately recorded as statutory visits to children in foster care.

These risks were also discussed with the executive management team during interviews on the 18 June 2024. The executive was advised of other risks identified during the monitoring programme, such as delays in the notification of suspected abuse to An Garda Síochána, inconsistencies and inaccuracy in the reporting of data, gaps in supervision and case management and the lack of resources. Tusla's executive management team was given the opportunity to re-submit the escalated plan in relation to Dublin South Central service area.

As part of its ongoing monitoring and validating of this risk-based monitoring programme, HIQA met with Tusla on a monthly basis to discuss progress on the national, regional and service improvement plans and to consider updated data regarding the number of open cases, referrals, allocations, resourcing and responses to identified systems risks from inspection fieldwork. The responses to these systemic risk escalations were provided by regional chief officers at these meetings. The meetings are attended by two nominated representatives of Tusla's executive management team, regional chief officers and area managers, HIQA's head of children's programme, regional managers, programme coordinator, regulatory support staff and inspectors.

The overall findings of the inspections demonstrated that significant improvements were required to ensure that each participating service implemented the national policies and standard business processes consistently. The volume of unallocated

cases and the lack of capacity to meet the demand were well-established and presented longstanding risks both within the service areas and at a national level. The risks associated with not having sufficient organisational capacity to effectively meet the needs of children were clearly recognised by senior managers. Despite these issues being escalated through Tusla's 'Need to Know' reporting process, through supervision and senior management discussions with the regional chief officer, through NORMSIC and RORMSIC forums, these risks continued for children referred for a social work service. Despite these escalation systems and specific risks being appropriately placed on the national corporate risk register, mitigations of the risk at a regional and local level required further strengthening in some participating services.

Management of unallocated cases

Tusla's *'Unallocated Children and Young People National Policy and Guidance'* was approved by Tusla's National Policy and Oversight Committee (NPOC) on 25 January 2024. The timeline for implementation had been extended to 30 March 2024. Some areas had local standard operating procedures aligned to the national policy, while others did not. However, the policy and its implementation was not fully effective. HIQA were informed in May 2024 that the policy was implemented across the regions but that different areas implemented the policy in different ways, as such different safeguards were put in place, and efforts were being made to find a middle ground. While Tusla endeavoured to ensure that all children and families who were assessed as needing a child protection and welfare service and to ensure that all children in care have an allocated worker, increasing numbers of referrals and resource challenges meant that it is was not always possible to allocate a worker immediately. The policy outlined that where a child or young person is awaiting allocation to a worker, this is often referred to as an unallocated case and is defined as: *'An open case which does not have a named dedicated key worker assigned'*.[8] This policy had not taken into account the national standards nor Children First (2017) in its definition – where there are specific tasks which are assigned to social workers.

[8] Definitions agreed in 2016 as part of the Tusla Unallocated Case Project

The Child Protection Notification System (CPNS) is a national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern. The result of which requires each child to be the subject of a child protection plan. Risks in relation to children placed on the child protection notification system (CPNS) were identified in the Dublin South Central, Dublin North City and Donegal service areas. All children placed on the CPNS should have an allocated social worker, as these children are identified as those who are most vulnerable to risk of harm. The inspections found poor governance and management oversight of children active on the CPNS who were awaiting allocation to a social worker. Despite assurances from Tusla, the inspections found in the Dublin South Central service area that 17 children listed on the CPNS did not have an allocated social worker. While they were assigned to a senior manager for oversight, not all of these cases were being actively worked and monitored to ensure children were safe.

In the Donegal service area, 70 children were listed on the CPNS, of which 67 were allocated to a social worker. The remaining three children had been allocated short-term to a social care leader due to unexpected leave and had been actively worked on. These children were subsequently allocated to a social worker following the matter being raised during fieldwork with the principal social worker. In the Dublin North City service area, seven children on the CPNS were allocated to social care staff, and despite the cases being actively worked, this practice was not in line with the national standard operating procedure and was not accurately reflected in the local and national reported and published metrics.

In the Dublin South Central service area, a number of systems risks were escalated which included that 300 children assessed as being at low or medium priority diverted to the 'low harm, high need' (LHHN) team, which as outlined earlier was not fully operational at the time of the inspection, were on a waiting list. Inspectors found that even when children had been allocated to a social care worker on this team, they were not guaranteed an active and timely service or intervention. This was escalated as a systems risk to the respective regional chief officer. The response provided did not adequately assure HIQA in relation to the implementation of immediate actions to address the risk. Consequently, this risk was escalated to the CEO in March 2024. The CEO provided a written response to HIQA on this and other risks identified 12 April 2024. However, the actions outlined to address the risks required further clarification as the plan lacked a clear strategic direction to resolve the issues on a long-term and sustainable basis, including the lack of a long-term plan for cases on this waiting list of 300 children that may require further social work intervention, such as an initial assessment or safety planning. The CEO provided a further written response on 8 May 2024. This plan did not provide sufficient assurances regarding the urgency to address the risk and a further plan was submitted on 2 July 2024. At the time of writing this report, HIQA was informed that a project plan had been developed, but there had been a further delay in cases being transferred over to the unallocated cases project, and an identified social work team leader dedicated to the project was due to commence on the revised date of September 2024.

HIQA had concerns regarding the effective transfer of children's cases to other teams internally within service areas or externally to other service areas. This is an ongoing issue for Tusla. A review of the issue was conducted and Tusla set out its findings in a June 2023 report, '*A compilation of systemic operational barriers or challenges reported as impacting on the efficient and timely transfer of cases between social work areas'*. Similar to HIQA findings, the national review identified that there was widespread inconsistency in the application of the national transfer policy. Responses indicated that some areas adhered to local structures rather than comply with national policy and there was the perception that "some areas accept case transfers, and some do not".

HIQA was concerned that children who had been assessed as requiring an ongoing social work service were not transferred to the most appropriate team to ensure their needs were met in a timely manner. There were also delays in providing a child with an allocated social worker. The volume of referrals and blockages in transfer pathways were major issues for some service areas, particularly for cases transferring outside the area. Staffing levels, capacity and workload pressures were also mentioned as barriers to the timely transfer of cases, indicating that this was a national issue. Staff pressures were cited as having led to occasions where the children-in-care teams did not have sufficient capacity to accept timely transfers from the welfare, protection and alternative care teams. Some service areas also identified that barriers existed where a case was before the court in the transferring area and may be unallocated following transfer. This posed challenges where a court direction required the immediate allocation of the case. Some areas had escalated cases where the transfer had not been accepted by another service area to their regional chief officers but escalation had not necessarily accelerated or progressed any of the cases in a timely manner. HIQA were informed in November 2024 that a new transfer policy had been approved by Tusla's national policy and oversight committee and an implementation plan was being developed.

There was also an issue with children that were placed with non-statutory fostering agencies and children placed in statutory placements in other service areas. While it is the responsibility of the service area placing the child to provide services to such children, sometimes these children were in a placement hundreds of kilometres away from the service area. This practice resulted in a significant use of resources when transferring areas had to continue to manage cases involving extensive travel requirements.

An action plan provided by the Tusla CEO included a plan to transfer 38 children in care in Dublin South Central service area by 31 May 2024 as one of the measures to address the crisis in this service area. However, at the July provider monthly meeting with HIQA, this action had still not been completed. HIQA requested that this be brought to the attention of the executive for resolution.

Quality assurance

The purpose of quality assurance is to promote continuous improvement and effective risk management in services for children and families. Tusla's Quality and Regulation Directorate's practice assurance and service monitoring (PASM) team is responsible for undertaking quality assurance reviews and audits[9] of Tusla services.

[9] The term 'audit' is used to describe the process of assessing current activities, processes and systems against explicit standards (for example, legislation, policies, procedures, guidelines, standard business processes, national standards) and other elements put in place to drive quality assurance initiatives, leading to opportunities

The role of the PASM team[10] is to provide assurance that children are safe, services are of a high standard and well managed, and that positive outcomes for children are being achieved. The national review team within PASM contributes to service improvement within Tusla in two ways:

(i) National Reviews of Tusla services: to assess consistency of practice and adherence to policies and procedures nationally and to drive service improvement. It can be conducted across all 17 Tusla service areas, or it may focus on a random sample, depending on the nature of the review. An annual PASM practice audit or review schedule is developed to assure the Tusla Board and the CEO in the discharge of their governance responsibilities. This risk-based planning approach aims to identify auditable areas of practice, so as to provide assurance on the management of key areas of risk.

(ii) Practice Audits: support quality improvement within Tusla. The audits focus on the adequacy and effectiveness of the governance, risk management and internal control systems in place. Practice audits are agreed following requests from services, identified risks, organisational and system changes, management inputs and other factors.

Tusla's PASM team had completed a number of audits in each of the service areas, including the '*National Review of the Management and Oversight of Child Protection and Welfare and Children in Care Cases Awaiting Allocation to a named Social Worker' 2023*. This was conducted at the request of the interim national director for services and integration in relation to an identified action within Tusla's Business Plan 2023.[11] At the time of fieldwork inspections, preliminary findings were shared with HIQA.

The regional quality risk and service improvement (QRSI) arrangements and their functions across the service areas varied, for example, there was no QRSI officer in the Dublin South Central service area at the time of inspection, while there was an established QRSI team in the Waterford Wexford service area. In another service area, the QRSI team were unaware of *Tusla's Quality Improvement Framework* and the governance and oversight of this team was absent.

for learning and development – Tusla Quality assurance Audits – A Guide for Staff, 2016

[10] Quality and Regulation Directorate: National Review Team Standard Operating Procedure for National Reviews & Practice Audits – Process Guide for Services (October 2023)

[11] Tusla Business Plan 2023: Ref# 1.1.(d):Audit of unallocated cases (Child Protection/Children in Care) will take place in 3 of the highest deficit 6 Areas to determine the supports available/oversight arrangements in place to children pending allocation to a Social Worker.

While some audits were put in place nationally in 2023, local audits were also evident. Examples of audits included referrals of child sexual abuse, unallocated cases, care plans, placement disruptions, voluntary care, the foster care service, a special residential arrangement put in place for children with a disability that were taken into care, governance and supervision. Service areas were continuing to work on recommendations from previous HIQA reports on the child protection and welfare and foster care services, as well as PASM audits of their services.

There were mixed findings with respect to the quality and effectiveness of audits and reviews of unallocated cases. While audit and review processes were in place, inspectors found that these were not adequate and there was no capacity to respond to urgent need leading to drift in cases. For example, next steps were not identified, there were inaccuracies in reviews and records demonstrated the length of time that a child was unallocated was not considered. In some cases, recommended actions were not implemented at the time of the inspection.

Reviews of unallocated cases by social work team managers as a quality assurance mechanism were found to be ineffective in some service areas, as actions could not be progressed due to staffing and resource challenges. Managers did not always review cases on waiting lists in line with the frequency outlined in the policy and a stronger focus was required on the impact of these reviews in preventing case drift, improving outcomes and strengthening safety planning for unallocated children. Inspectors also found that these reviews did not always bring about a change in case priority or allocation of a social worker and most children remained on a waiting list. For example, the findings of an audit of unallocated cases completed by a principal social worker in the Dublin South Central service area had resulted in 40 children being re-categorised from medium to high priority due to the length of time on the waiting list. This demonstrated the extent of the pressure on the service given that, although audited, there was still no capacity to allocate.

An example of good quality auditing was evident in the Waterford Wexford service area. An established quality assurance team with a schedule of audits and a tracker to monitor the completion of actions was in place, and this had shown improvement in practice in the latter part of 2023. Oversight of the team was provided by a principal social worker and the area manager who assisted the team in functioning efficiently and ensured that the set processes were followed as anticipated. Inspectors found evidence that a quality assurance plan was developed to guide the completion of quality assurance initiatives. The service area was strengthening its capacity for stronger self-assessment to develop and sustain improvement in service provision. Senior managers were clear that improvement in practice and service delivery was a long-term process that required the consistent application of a long-term strategic plan. The audits were aligned to actions outlined in the area's service improvement plan.

Another good example was found in the Carlow Kilkenny South Tipperary service area. Service area management were actively using learnings from audits to target its areas for continual improvement, including case recording. The business plan also contained key actions and timeframes for addressing the areas for improvement identified in the recent audit of unallocated children in care undertaken by the PASM team. A regional oversight group had been established to help identify the steps required to improve response times for children. This action was in line with the national service improvement plan. The purpose of the group was to strengthen governance and align the emerging national policy and practice changes with implementation at a regional and local level. Meetings involved participation from regional human resources (HR), finance and professional support managers together with area managers and quality assurance managers from the region.

Information governance

In order to effectively manage and deliver child protection and welfare and foster care services, and be assured that they are providing high-quality, timely and safe care, it is fundamental that data is collated, analysed and action taken as necessary. Accurate data has the potential to be used for many important purposes, such as measuring the safety outcomes of people using services, informing decision-making, effective planning of services, and for reporting purposes. Tusla publishes reports on the performance and activity of their child protection and welfare services and children in care on a monthly and quarterly basis, and these are published on its website. Inspectors found that some service areas did not accurately report their performance data in line with Tusla's own requirements. In 2021, Tusla's Case Management[12] (TCM) system was originally developed as a single integrated case

[12] Tusla case management (TCM) provides a single joint up digital and data environment across Tusla

management system across all services. In March 2023, the case management system went live for child protection and alternative care services, replacing the previous National Childcare Information System (NCCIS). The case management system provides a modern, secure and integrated system for the management of social work and care services for Tusla. Over time, the system will be expanded and implemented for all Tusla services to achieve the vision of a single integrated system supporting integrated services and a single view of the child.

Information governance was not sufficiently strong across the service areas included in this monitoring programme. Improvements were required in the management of children's records and the consistent use of information to ensure that relevant documents were uploaded and saved on case files in a consistent and timely way. The inspections found that the integrity of information used for monitoring purposes was compromised due to capacity of staff to update the case management system in a timely manner, and also in respect to the reports being generated for oversight and monitoring purposes. For example in the Dublin North City service area, there was poor management of information related to children placed in special emergency arrangements. HIQA found that the management of records of children placed in these arrangements were not always held on the case management system, therefore, key details of and any ongoing child protection and welfare concerns were not known to the relevant Tusla teams. Management and staff were aware of these gaps and were able to provide inspectors with information that could not always be found on the case management system. They said that staff vacancies and lack of business support staff meant, that information was not always uploaded in a timely manner.

Risks were identified whereby the processing of information related to children's records and decision-making processes were absent from Tusla's case management system. Records were not contemporaneous and readily available, and some records did not accurately reflect the concerns or risks for a particular child due to cloning of referrals on the case management system without updating the information. Other examples of poor information governance included:

- delays in launching safety plans on the case management system and management sign-off of these records
- safeguarding visits to children by social care staff inappropriately recorded as statutory visits

that enables all services to work efficiently, securely and in an integrated way. TCM is designed directly by practitioners through local networks and governance groups across all services and is developed by Tusla's internal ICT team. Almost 4,000 practitioners across 23 services in Tusla now use TCM.

- team leaders not having the appropriate authority on the case management system to access previous referrals on a child from other service areas (however, this was rectified by the end of the monitoring programme)
- poor management of information related to children placed in special emergency arrangements
- dual unallocated[13] cases not identifiable on the case management system – in one service area, 10 children in seven foster care families were dual unallocated.

There was a disparity in the way some areas regarded a child as allocated or not. In some areas, children were deemed allocated when they were allocated to a social worker. However, some areas regarded a child as allocated if they were allocated to a principal social worker or team leader or to another staff member with a social care qualification, which was not in line with the standards. In other service areas, when children were allocated to grades other than a social worker, they were deemed 'secondary allocated. In these instances, it was clear that a child was not allocated to a social worker. Given the disparity in the recorded allocations, the data relied upon at executive level may not be accurate.

Use of Resources

Eight of the 10 inspections assessed compliance of child protection and welfare services with Standard 4.1, and found that these service areas were not adequately resourced to ensure the efficient management of referrals throughout the process from receipt of referral through to completion of assessments. Similarly, six of the 10 inspections of foster care services found insufficient social work capacity to ensure full compliance with statutory requirements and the provision of a safe and consistent service for a child.

A good quality service effectively uses its resources. It has a range of checks and balances in place to ensure that resources are deployed in an effective and transparent way. A good service provider has contingencies in place and responds to resource challenges such as staff vacancies, and uses its resources in an innovative way to respond to these challenges. For example, the provider may relocate staff from one team to another based on service demands and prioritised needs. Local challenges are communicated where appropriate to regional service directors and national directors where appropriate. The provider holds regular meetings with all the agencies that provide services to vulnerable children and families. Clear

[13] Dual unallocated case: this is where neither the child nor the foster carers had an allocated social worker to oversee the placement.

agreements are in place with the support services who receive funding from Tusla.

A key factor to ensuring a sustainable delivery of safe and effective services is workforce planning. Across all 10 participating service areas, there were external and internal factors that negatively impacted on Tusla's ability to ensure it had the staffing levels required to deliver its service objectives. Workforce plans were either not in place or in development across the service areas. Increased demand for Tusla child protection and welfare services resulted in:

- an overreliance on current staff to fill vacancy gaps which was not sustainable
- social care staff without adequate training and experience in child protection and welfare and safety planning
- principal social workers not receiving appropriate supervision in line with policy.

Tusla's recruitment and retention strategy recognised the challenge of recruiting and retaining staff. Some areas had experienced significant turnover of staff in the two years prior to the inspections and staff retention remained an issue for all. Some retention strategies were more effective than others. There was evidence of national, regional and local responses to these issues across the services. Staff retention and support of staff was seen as a high priority in every service area and they reported some success in this regard in that some staff had returned to work having previously been students or having worked in the area in the past. A culture of a 'one area approach' that engaged staff in creating a positive work experience was strong in the Waterford Wexford service area. A pilot of a condensed four-day working week to support staff wellbeing was evident in the Donegal service area. The condensed four-day working week initiative was introduced as an incentive to recruit staff in the Dublin South Central service area, which had been escalated by HIQA due to its high levels of unallocated children and the systems risks that were evident.

At the beginning of this monitoring programme, Tusla was unable to provide the data required in relation to posts in specific service areas. There was a lack of clarity at local level in some areas in regard to the number of vacant posts[14] versus affordable posts. In contrast the executive management team were very clear that each regional chief officer knew their sanctioned staffing numbers. Tusla's executive management team outlined that it had added a new action to the national service improvement plan with regard to the validation of vacancy data being collected. There was a risk identified that the national definition in terms of what a vacant post is, had been interpreted differently across the participating services. The review and validation exercise completed by Tusla in June 2024 and the HR dashboards provided a clear overview of key metrics, annual WTE, workforce demographics, absence and retention rates at national and geographical area levels.

Each service area was significantly challenged which impacted on the delivery of services to children. Some areas experienced significant staff turnover in the previous two years and retention remained an issue for most. Some area managers and regional chief officers referred to having lost posts due to the national definition of a vacant post. Vacancies included social work, social care and key management positions. The Donegal service area had operated without an area manager for a period of six months as well as vacancies in a principal social worker post and four social work team leader posts. These positions were alternated between the two remaining principal social workers, who also had to maintain their own workloads, this led to a drift in the monitoring and oversight of the child protection and welfare service. Ultimately, this meant that the service could not effectively perform key functions in accordance with the required standards.

Staff told inspectors that there was enormous risk related to staffing and systemic challenges. For example, validated metrics provided by Tusla at the end of 2023 demonstrated that there were 16 social work vacancies and four social care vacancies in the Dublin South Central service area, and the Waterford Wexford service area had 26 social work vacancies and six social care vacancies. The impact of staffing concerns on the operation in both service areas was escalated to the respective regional chief officers. In the Waterford Wexford service area, the team were '*under high levels of pressure'* and *'that the service area's ability to run a safe and effective service is impacted'.* However, management of this service area were left reliant on existing staff, across teams and grades, to share resources and take on additional cases which increased their caseloads, reduced their capacity and oversight mechanisms.

[14] "A vacancy is a funded post (in the current run rate) that is not now filled in any capacity, and where the position had been filled at some point since 1/7/2022. If it was not filled since 1/7/2022 then it is not a valid vacancy, even if previously funded." – Tusla definition

HIQA was concerned that this was not sustainable long-term as some children and families continued to wait for significant periods of time for a service and for supports and interventions to be put in place. During the interview, Tusla executive management advised that they were acutely aware of the staffing issues which was compounded by the increase in demand for their services. As a result, they acknowledged that there was a risk to the safety and well-being of children, young people and families. Turnover figures were low and significant investment had been made in induction training and training for staff to undertake social work training. Tusla also advised that this issue was raised and discussed with the Department of Children, Equality, Disability, Integration and Youth as well. By the time of inspection the Waterford Wexford service area had introduced processes and systems to improve management and oversight, such as the 'stable cases' team referenced in the quality and safety section further on in this report and fortnightly task force forum meetings. Therefore, Tusla were challenged to meet current demand within existing resources, particularly in child protection and welfare services, and were endeavouring to ensure those most at risk were prioritised.

Given the acknowledged significant resource challenges including the retention of staff within Tusla, HIQA continues to have concerns regarding Tusla's ability to implement their national service improvement plan to a target of 25% unallocated cases, as well as their the ability to deliver a safe, consistent and quality service across all participating service areas. However, the results of a national HR validation exercise submitted by the executive management team indicated that in the participating service areas in May 2024, there were 169.51 vacant social work posts. Positively, 140 social work posts were in progress and 13.4 posts were filled by agency staff. Notably, the Dublin South Central service area which was escalated to the CEO had not benefitted to the same degree as other service areas.

One of the impacts of staff shortages was that cases were not transferring to the relevant teams in the participating service areas. This often resulted in children's cases remaining assigned inappropriately to the front door team who could not consistently provide a safe and consistent service. Managers and staff worked beyond their capacity to develop and put actions in place to mitigate the associated risks. In three services, senior managers were filling operational gaps due to vacancies which negatively impacted their monitoring and oversight responsibilities.

In order to manage the risk in relation to children awaiting allocation, some areas assigned cases awaiting allocation to grades of staff other than professionally qualified social workers in an attempt to manage waiting lists. Experienced service managers were drawing on strategies that had been effective in the past to manage vacancies and maximise organisational flexibility. Resources were deployed in attempts to respond to staff vacancies to strive to meet prioritised need. Examples

of this included:

- social care staff deployed to screening and intake in order to reduce waiting lists
- the creation of new posts at principal social worker level which facilitated the creation of new teams thus reducing workloads for managers and increasing oversight
- the active on-duty system for children in care
- creating additional capacity by using access workers
- the diversification of roles into other positions, this included a domestic violence liaison officer on the child protection team in three service areas.

An annual graduate campaign, rolling social work campaign and the social work apprenticeship programme were in place, as part of Tusla's People Strategy. Examples of retention initiatives evident across the participating service areas included:

- linking in with local universities and colleges
- transition year programme providing information to students in Transition Year of school
- summer initiative programme
- staff retention groups and retention officers
- staff mentoring and coaching
- staff newsletters and appreciation days
- wellbeing groups, activities and ambassadors
- funding for further education and for social care leaders to convert their degree to social work and the commencement of the social work apprenticeship programme in September 2024
- access to support services
- employee surveys, 'stay' and 'exit' interviews.

A 'summer initiative' across the services allowed students in on placement, and in some areas the offer to work one to two days a week had commenced. While this was a national initiative, it depended on the local area's budget affordability to offer

it. Tusla's graduate programme was seen as positive. In 2023, Tusla's social work graduate campaign resulted in 126 graduates accepting offers of employment with Tusla. The CEO reported that the 2024 graduate programme resulted in 174 social work graduates successful at interview and placed on a panel. Service areas provided updates at the monthly provider meetings with HIQA in relation to the number of graduates that were taking up posts in their respective areas.

Notwithstanding the creative and innovative ideas that had been put in place, the staffing crisis across all service areas was severe and despite the best efforts of all involved, there was simply not enough staff to meet the levels of need at the time of inspections.

Supervision and support

Supervision and support are key in exploring a staff member's decision-making, wellbeing, professional development, and providing management oversight. Most importantly, supervision helps to achieve the best possible outcomes for children. Inspectors reviewed a sample of 155 staff supervision records including those of frontline practitioners, team leaders and senior managers in all ten participating service areas.

A national supervision policy (2023) was approved, however, it was not consistently implemented to date as Tusla was developing a dashboard to support its implementation. As such, service areas were using both the old and new versions of the policy. This dashboard was delayed as priority was given to the changes required for the unallocated dashboard. The work on it was nearing completion and an expected date was by the end of quarter three 2024. Tusla envisaged that the dashboard would facilitate managers to use supervision more effectively, to ensure a reflective practice element as opposed to a 'tick box' exercise.

Supervision records across the service areas demonstrated mixed findings. While supervision was occurring, it was not always in line with national policy and was not well recorded. Some staff experienced long gaps between their formal supervision sessions with their line managers. For some, supervision did not support staff in their role by monitoring their wellbeing and addressing issues that were affecting their performance or staff development. Discussions regarding a child's progress and decisions made or actions required were not consistently recorded. As such, it was not clear how line managers would track the progress of cases from one supervision to the next. In contrast, others focused on staff welfare and regular checks were made to ensure case holders had sufficient capacity to effectively address their workload priorities. In the Dublin North City service area, the supervision records

reviewed by inspectors showed little or no evidence that action had been taken to support aspects of the role that staff were finding challenging.

Front-line practitioners across the child protection and welfare service and foster care services spoke about the good supports they received from management and peers. They appreciated the level of teamwork and relationships in place to support one another. New staff talked about mentoring systems and protected caseloads and how those measures had assisted them in their learning and development. They spoke positively about supervision, describing it as “oxygen” and “very helpful”. Staff spoke about the number of retention strategies and wellbeing initiatives in place, such as team building days, yoga, good training opportunities, scholarship programmes and the availability of a psychologist to the teams to provide support to staff using a trauma informed model of care. The majority of staff spoke about feeling listened to and being supported by their managers and that issues could be escalated should they arise.

Regular and good quality supervision which included discussions on case management, professional development and support for staff was evident in the Waterford Wexford, Dublin South East Wicklow and Mid West service areas. In the Waterford Wexford service area, the quality and frequency of supervision across teams was good. There was comprehensive recording of discussions and oversight of cases and key data related to children awaiting allocation to a social worker. The impact on the child was clearly considered and recorded in supervision with actions outlined and child focused rationale included. Supervision was centred on the analysis of data to determine the effectiveness of practice within teams and across the service. In the Mid West service area, supervision of staff remained a high priority at all levels in the organisation. The quality of staff supervision overall was generally good, with effective tracking of actions from one supervision meeting to the next. The oversight and governance of unallocated children was a standard agenda item in supervision at all levels in the organisation. The quality of supervision was subject to annual audit, and all relevant staff had received supervision training and had signed a contract outlining mutual expectations.

Commissioning

Where services are not delivered by Tusla, it may commission community and voluntary providers to do so on its behalf. A significant part of Tusla's national service delivery model is responding to welfare referrals and re-directing children and families from social work interventions to community-based supports if appropriate. A good quality service should have service-level agreements[15] (SLAs) in place with externally sourced agencies for commissioned services. These SLAs should be reviewed and amended on a regular basis in order to be in line with the area's service plans and or when required to improve service delivery for children and their families. The provider should ensure that these agreements include the scope of the service provided, resources required to deliver the service, and monitoring and governance arrangements, including compliance with national policy, Children First (2017) and relevant standards.

All participating service areas inspected had relevant commissioning arrangements in place with a range of services which directed children and their families to appropriate family support services when they did not meet the threshold for a social work intervention. Some areas were more heavily reliant on these services than others. The Dublin South Central and Dublin North City service areas had a commissioning contract with an external agency to support the completion of initial assessments for those children who were prioritised as medium on behalf of Tusla. The inspections found that there was overall good governance in place to oversee the monitoring of the various commissioned services across the areas. This comprised of receiving reports on the extent to which these services had acted in accordance with the commissioning plan, along with regular meetings with these service providers to discuss the targets being met and challenges faced. The Waterford Wexford, Cork and Dublin South Central service areas were in the process of, or had just completed a review of the commissioning of service arrangements to identify local needs and reconfigure services to secure better value for money. This was to inform the service area's strategy on how best to spend available resources to improve outcomes for children and their families. There was evidence of service expansion of commissioned services in the Cork service area and the decommissioning of a small number of services which were not delivering the expected standards of performance in the Dublin South Central, Mid West and Cork service areas.

[15] Service level agreement (SLA): sets out the standard terms and conditions upon which funding is granted by Tusla and defines the responsibilities and accountabilities between Tusla and the commissioned service.

From a review of documentation, inspectors found examples of innovative work commissioned from community and voluntary service providers. These included one-to-one social care support, family support, domestic violence services and therapeutic supports to ensure children and families received appropriate interventions as required. Other examples included additional supports for children's reunification, prevention of placement breakdown and a range of activities and experiences for children to help build their personal skills and resilience.

The delivery of Tusla's child protection and welfare and foster care services depends on the availability of a wide range of local and national resources designed to respond to the needs of children and their families. One of the key risks pertaining to resources is the placement of children in a special emergency arrangement (SEA). HIQA remains very concerned about the lack of provision for especially vulnerable children who remain at high risk of harm and are placed in unregulated settings. Following the inspections, HIQA sought and received assurances from the area manager in the Cork service area with respect to two individual cases. In the Cork, Dublin North City and Mid West service areas, the governance and oversight of SEAs was reported as a systems risks to the respective regional chief officers. The Cork service area had been previously requested to submit a provider assurance report in relation to children placed in SEAs in its region. This is discussed further in the quality and safety section of the report. Another example of resource risks relate to Tusla's inability to ensure its resources are adequate and appropriate to meet the needs of all children who require an out-of-home placement in a foster care or regulated setting that effectively meets their diverse and complex needs. Tusla's executive management team outlined that they too, were concerned about children being placed in SEAs and had routinely reviewed information on SEAs up to May 2024. At that point, they were satisfied of the governance arrangements at regional level.

Notwithstanding the good commissioning arrangements in place, a number of service areas were experiencing waiting lists for commissioned services, as these providers also had staffing challenges. The availability of commissioned support services was not consistent within some service areas. This meant that, on occasion, there was no service to refer children to and other children had to wait to receive the support or therapeutic service that they needed.

5. Quality and Safety

National Standards for the Protection and Welfare of Children (2012)
Standard 2.1 Children are protected and their welfare is promoted through the consistent implementation of *Children First.*
Judgment: Not compliant

National Standards for Foster Care (2003)
Standard 5 The child and family social worker There is a designated social worker for each child and young person in foster care.
Judgment: Not compliant
Standard 7: Care planning and review Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.
Judgment: Substantially compliant
Standard 10: Safeguarding and child protection Children and young people in foster care are protected from abuse and neglect.
Judgment: Substantially compliant

Tusla was more effective at managing unallocated children in foster care than children waiting for a child protection and welfare service. Generally, when children were allocated a social worker, the quality of services provided to them or for their benefit was good. The eight participating areas where the child protection and welfare services were assessed were not complaint with Standard 2.1 of the *National Standards for the Protection and Welfare of Children,* 2012.

Improvements were required across the participating service areas included in this monitoring programme to ensure all children were protected and their welfare promoted through the consistent implementation of Children First (2017). In addition

improvements were required to ensure each child in foster care had an allocated social worker in line with the national foster care standards in the six participating services.

While all service areas were committed to promoting children's safety and wellbeing and sought to provide a timely and responsive child protection and welfare service to children and families, Tusla were unable to consistently achieve this. While actions were taken to protect children identified at immediate risk and the majority of children of high priority were receiving a service in the main, children who were prioritised as medium or low priority, and referrals categorised as child welfare generally experienced unacceptable delays and did not receive a timely or appropriate response. Children did not receive an equitable response due to demands within the service areas.

The impact of regional and national governance and service improvement plans should be evident locally. Tusla set out targets in their national service improvement plan 2023 to reduce the percentage of open unallocated cases in all areas to below 25% by the end of 2024. However, progress varied greatly from service area to service area inspected between February and May 2024.

There were significant delays in children receiving a social work service, from the management of new referrals through to providing statutory services to children in foster care. There were variations across the participating service areas in their adherence to Children First (2017) and to Tusla's standard business processes particularly in relation to the completion of initial checks, preliminary enquiries and initial assessments. Some children were placed on waiting lists without adequate safety being established from the point of referral to initial assessment. In some service areas, there was failure to consider cumulative harm and neglect, and these cases were not always considered or assessed in respect of multiple previous referrals received by Tusla. Improvements were required in relation to governance and management oversight of children listed on the Child Protection Notification System (CPNS) in the Dublin South Central, Donegal and Dublin North City service areas who were awaiting allocation to a social worker. For example, service areas were reporting CPNS cases as allocated to professionally qualified social workers, when they were not, and allocated these cases to social care practitioners which was contrary to Tusla's definition.

Furthermore, some children on the CPNS were allocated to social work team leaders or principal social workers with the understanding that they were being 'worked', however, due to the workload of these particular managers – these cases were not being effectively monitored. In some instances, delays in children receiving a social work service varied due to the personal circumstances of children and families who

were unable or unwilling to engage with the social worker or where a social worker was awaiting further information from external services.

Overall, children did not receive an equitable response due to demands within the service areas. With a significant number of children awaiting allocation for social work assessments, it was not within the service area's ability to ensure timely assessments for all children. Therefore, a national response is required to promote children's rights and to assess children's needs in line with Tusla's own timeframes and the *National Standards for the Protection and Welfare of Children*.

In the absence of a professionally qualified social worker, some children were allocated to social care leaders or social care workers, many of whom were relatively new to working in these services and who were undertaking work without adequate child protection and welfare training and without the required skills, knowledge and experience in relation to assessing child protection and welfare referrals. As such, these practitioners may be unable to ensure that there is adequate coverage of all the issues required during a statutory visit and that a child's needs and risks may not be appropriately considered while unallocated.

Of particular concern was the reliability of some reported data to the executive management team. For example, some service areas were reporting that all children on the CPNS had an allocated social worker when this was not the case. All children placed on the CPNS should have an allocated social worker, as these children are identified as those who are most vulnerable to risk of harm. The inspection in the Dublin South Central service area found that 17 children listed on the CPNS did not have an allocated social worker. While they were assigned to a senior manager for oversight, not all of these cases were being actively worked and monitored to ensure children were safe. In the Donegal service area, 70 children were listed on the CPNS, of which 67 were allocated to a social worker. The remaining three children had been allocated on a short-term basis to a social care leader due to unexpected leave and their cases had been actively worked on. These children were subsequently allocated to a social worker following the matter being raised during fieldwork with the principal social worker. In the Dublin North City service area, seven children on the CPNS were allocated to social care staff, and despite the cases being actively worked, this practice was not in line with the national standard operating procedure and was not accurately reflected in the local and national reported metrics.

HIQA was concerned that the impact of cumulative harm was not routinely considered when children's needs were being screened or assessed. Cumulative harm is the outcome of multiple episodes of abuse or neglect experienced by a child. It refers to the effects of patterns of circumstances and events in a child's life which diminish a child's sense of safety, stability and wellbeing. In order to identify

potential cumulative harm it is important that the social work screening process includes checks to ascertain whether or not there have been previous referrals on the child. The nature and severity of previous referrals and the impact on the child should be considered when determining the actions to be taken in individual cases. Some children were allocated to social care staff who were undertaking work without proper child protection training and without the required skills, knowledge and experience in relation to assessing child protection risks and cumulative harm. Failure to consider cumulative harm and neglect was also evident in cases where the child was allocated to a social worker. Where areas had guidance for staff on recognising and assessing cumulative harm, this was not found to be consistently implemented on the case files sampled. As a result, there was potential for children to be exposed to ongoing harm. Individual cases and systems risks pertaining to cumulative harm were escalated in the Cork, Dublin South Central, Dublin South East Wicklow and Louth Meath service areas to the area managers and regional chief officers. The service area responses from Cork and Dublin South Central to these escalations did not adequately assure HIQA in relation to the immediate actions to address the issue raised, and was therefore escalated to the CEO.

There were significant inconsistencies in practice in relation to screening and preliminary enquiries, which meant that not all children at actual or potential risk were being appropriately assessed and where necessary, protected by Tusla in a timely and effective manner. Similarly, practices in relation to safety planning were inconsistent. While some children were adequately safeguarded, with a safety plan in place, these plans were not always monitored and reviewed to ensure the continued safety and wellbeing of the child. Other children who did not have a safety plan or where the plan was inadequate, continued to be at risk.

Staffing capacity issues and consistently high numbers of referrals in all service areas were the biggest contributing factor to the significant delays from the management of new referrals through to providing statutory services to children in foster care.

Not all children in foster care had an allocated social worker in line with the standard. All six service areas where foster care services were assessed, were challenged or unable to ensure compliance with statutory requirements and standards in relation to the service provided to children in foster care. Common across all of these service areas was an over-stretched child-in-care social work capacity, which resulted in service areas expanding their approach to welfare visiting for children who did not have a designated social worker. However, these arrangements were not in line with national foster care standards and inconsistencies in practice in how services were delivered created a potential risk.

According to Tusla's *Unallocated Children and Young People National Policy and Guidance,* February 2024, where a foster carer and the child in placement with them do not have an allocated social worker, this is known by the term 'dual unallocated'. In line with the standard operating procedure, when children are dual unallocated this should be in exceptional circumstances and for the shortest period of time. If it does occur, the risk needs to be escalated to the area manager. An audit had been completed on these cases in one service area and illustrated that the majority of statutory requirements were being met; however, capacity remained an issue in terms of the possibility of allocating these cases. In the Carlow Kilkenny South Tipperary service area, where there had been dual unallocated cases in 2023, risks were tightly monitored and reported in governance reports. Managers had ensured through bi-monthly meetings with the fostering principal social worker, early identification and prevention of the risk of 'dual unallocated' cases, and there had been no recent reoccurrences.

Of the six service areas where foster care services were assessed, the Dublin South West Kildare West Wicklow, Waterford Wexford and the Mid West service areas demonstrated effective monitoring and took appropriate steps to ensure there were no dual unallocated cases. The Louth Meath and Dublin South Central service areas had a total of 22 dual unallocated cases at the time of inspection and the Carlow Kilkenny South Tipperary service area had a number of dual unallocated cases over a six month period in 2023. This systems risk was escalated to the respective regional chief officers to outline the long-term plan to ensure there are no dual unallocated cases and to outline how their area will come into compliance with the national standards.

Where inspectors identified a specific issue of significant concern or systems risk that presented an immediate and or serious risk to the health or welfare of children, then, these risks were escalated to the relevant local Tusla manager during the inspection fieldwork and following completion of the inspection fieldwork to the regional chief officer and area manager. For example, immediate action was required for five of 10 child protection and welfare cases escalated during the inspection in the Donegal service area, and required social workers to visit the children on the same day.

Child protection and welfare services

As noted earlier in the report, the national policy and guidance on the management of cases awaiting allocation had yet to be fully implemented across the service areas in line with the national service improvement plan. Some areas had local standard operating procedures aligned to the national policy, while others did not. Tusla acknowledged that different areas implemented the policy in different ways, and as such different safeguards were put in place. Inspectors found risks associated with how children's unallocated child protection and welfare cases were overseen with areas implementing their own local policies. The national policy was formally implemented by May 2024. The level of cases awaiting allocation and the lack of capacity to meet demand was well established across all service areas.

While all service areas had waiting lists across the various points of the referral pathway, and were reporting on these figures nationally, cases awaiting allocation were not appropriately accounted for in several areas. For example, in the Dublin North City service area the principal social workers and social work team leaders held cases that were not being actively worked on. This amounted to 176 cases that were inappropriately categorised as allocated to a social worker with the following priority levels:

- 16 were marked as high priority
- 152 were marked as medium priority
- eight were marked as low priority.

A sample of these cases reviewed by inspectors found that the cases were not being actively worked, as the principal social worker and the social work team leaders did not have the capacity. This was in part due to an increase in their role and responsibilities to bridge the gap in service provision from staff vacancies. As a result, these children were not receiving a service and their views were not known.

In Dublin South Central, 300 cases were assigned to the 'low harm, high need' (LHHN) team, which as outlined earlier was not fully operational at the time of the inspection. Upon enquiry, these cases were not allocated, and were still awaiting a service. As mentioned earlier some areas were reporting that all children on the CPNS were allocated to a social worker, despite this not being the case in at least three of the service areas. This meant that the executive management team did not have all the information it needed when reviewing service areas.

Screening and Preliminary Enquiry

An effective good quality screening and preliminary enquiry gives Tusla the appropriate information to decide on what action is required to progress with the

referral and to protect children at immediate risk. A well-governed service will have effective processes in place to detect actual and or potential risk to children and put in place arrangements to mitigate these risks. The objective of screening is to assess Tusla's need to complete preliminary enquiries under their referral process. Some referrals may not require an intake record to be launched on Tusla's case management system. When there are reasonable grounds for concern for a child, or where there is harm to a child and further investigation is required, an intake record must be completed. Relevant information regarding the concern is gathered and considered so as to understand a child's circumstances and their family's strengths and challenges, the immediate safety of the child is established, the primary report type and priority status are established, and where required a notification of suspected abuse of a child is sent to An Garda Síochána. The analysis of the concern and decisions made should be based on evidence of what is likely to bring about the best outcome for the child.

Inspectors found during inspections that Tusla was not consistently adhering to their own standard business processes in relation to screening and preliminary enquiries, which are separate stages of one process that should be completed within a five day period from receipt of a referral, (screening should be completed within 24 hours). Any delays in screening and preliminary enquiry meant that children at potential risk were not being assessed and where necessary, protected, in a timely and effective manner.

Of the eight participating service areas where the child protection and welfare service was assessed, there was varying levels of compliance with the standard business process in relation to screening. For example, in some cases, screening was comprehensive, was completed within 24 hours as per Tusla's standard business processes, was of a high standard and clear actions for follow up were clearly outlined. In other cases, information was incomplete and the categorisation of the referral was not always accurate. Consideration was given to the immediate safety of a child and the necessary protective action to be taken where required. Actions included strategy meetings, parallel planning, meeting the persons subject to an allegation of abuse, home visits and meeting parents. Children who were considered at immediate risk of harm, received an appropriate response and those prioritised as high generally received an appropriate response. However, children who were prioritised as medium or low, and referrals categorised as child welfare generally experienced lengthy delays and did not receive a timely or appropriate response.

Some referrals that were incorrectly categorised or prioritised at screening were being put on a waiting list for allocation and therefore children potentially remained at risk. Inspectors found in some cases that prioritisation of referrals was based on limited information received at screening which in some instances could not provide

a complete picture of harm or the risk posed to a child.

From the sample of cases reviewed by inspectors, delays in adhering to the standard business processes in relation to the screening of referrals were particularly evident in the Cork, Dublin South East Wicklow, Dublin North City and Louth Meath service areas. These delays ranged from two days to 12 months (in the case of one referral). All eight participating service areas could not be assured that risk was appropriately assessed as there were significant delays in the completion of preliminary enquiries as well. Delays in preliminary enquiries ranged from two days to 13 months.

In the 12 months prior to these inspections, most service areas were not adequately resourced to ensure the efficient management of child protection referrals from the receipt of referrals to completion of assessments. Of note, in the Donegal service area, there was a lack of appropriate service delivery planning as well as resources, resulting in screening and the safety of the child not being fully established once a referral was received. Gaps in staffing, including senior management posts existed between July 2023 and March 2024, and another contributing factor included inexperienced new staff. During this time period, inspectors found that many of the referrals were at the screening stage with no further information and checks sought. However, following the filling of a vacant principal social worker post, the temporary assignment of another principal social worker to the duty team in January and April 2024 and the appointment of an interim area manager in January 2024, it was evident from records reviewed that there was a greater focus on service improvement in this area. This included a change in the duty system, the deployment of an additional social work post to actively work on the waiting list and the introduction of a new Prevention, Partnership and Family Support (PPFS) team at the front door for diversion of cases that did not require a social work response.

The Waterford Wexford service area had established an area-wide screening team in November 2023 as part of its change management project for the coordination and delivery of integrated services. The inspection found that although at the initial stages of being embedded, the area wide screening team was operating as an effective team, where different professionals worked together in the interests of children to help keep children safe and protected from harm.

Some area managers could not be assured that risk was appropriately assessed without the timely completion of preliminary enquiries. However, where it takes weeks or months as outlined above to complete, the delay raises concerns for safeguarding where referrals are open to the service but children are not met with for such long periods.

Despite delays, the majority of completed intake records contained good quality

analysis of available information. Inspectors found evidence of internal checks, adequate interagency co-operation and consultation with families that informed decision-making at this stage and in the majority of cases, details were clarified with the referrer prior to completion. Clarification or further information on a number of cases was sought from individual social work staff and managers during the inspection fieldwork.

Initial assessment

If concerns for a child remain unresolved following screening and preliminary enquiry, an initial assessment is undertaken by Tusla. The purpose of the assessment is to determine whether there has been harm, if there is potential for future danger to the child or children, and if there are any existing safety measures in place to address this harm. The assessment will determine if sufficient safety is present within the family and their network, or whether the child or children require a social work-led comprehensive safety planning process in order to develop a safety plan. It is also at this stage that the child is seen by a social worker.

Tusla had not consistently adhered to its 40-day completion business rule from date of initial report into Tusla for initial assessment to be completed. Of the sample of children's case records reviewed by inspectors, the findings demonstrated significant delays in either commencing or fully completing an initial assessment in eight service areas where child protection and welfare services were assessed. For some areas these delays were compounded by delays in the completion of screening and preliminary enquiries. As a result, this meant that the 'front door' of the service was crisis-driven which impacted on initial assessments being undertaken in a timely manner to determine the appropriate next steps to safeguard the wellbeing of the child.

Local initiatives to mitigate against some of the immediate risk were evident in the Dublin South Central, Dublin South West Kildare West Wicklow and Dublin North City service areas. These areas had made attempts to mitigate against some of the immediate risk through commissioning an external service to complete initial assessments for those children who were prioritised as medium, however, there were waiting lists in these areas for these cases to transfer due to the external agencies capacity. These cases were prioritised for transfer and once the assessments were assigned to the commissioned services, the assessments were completed in a timely manner. These were local initiatives, which had not been replicated in the other areas that were in this risk-based monitoring programme. This required significant improvement to promote the best interests of the child.

Inspectors reviewed a sample of completed initial assessments across the service areas and found that they were comprehensive and of good quality. These

assessments covered all the relevant areas required by Tusla's national approach to practice including development of a danger statement and identification of complicating factors. Parents and children were consulted, as were other agencies where appropriate. There was also evidence of interagency co-operation where appropriate. Risks were clearly outlined, and the immediate safety for the child was established and support networks were identified. Where ongoing risk of significant harm was identified, children were appropriately referred for a child protection conference. However there were delays in the completion and commencement of the assessments and some cases sampled demonstrated drift in the progressing of the assessment.

With service areas having such a significant number of children awaiting allocation for social work assessments, it was not within their ability to ensure timely assessments for all children. Therefore, a national response is required to promote children's rights and to assess children's needs in line with Tusla's own timelines and the *National Standards for the Protection and Welfare of Children*.

Low Harm High Need Teams

The low harm high need (LHHN) response pathway was initiated in February 2022 to target additional resources to priority regions and further enhance their response to children assigned low and medium priority awaiting a child protection or welfare response. Five pilot service areas – Cork, Waterford Wexford, Louth Meath, Dublin South Central and Dublin South West Kildare West Wicklow were identified by Tusla as having the highest number of unallocated cases at the end of 2021. Three of these service areas had operational LHHN teams at the time of the inspections. As noted earlier, the Dublin South Central service area had received permission to temporarily deviate from the LHHN model prior to the inspection. This meant that while they had a staff team in place, this team diverted cases to commissioned services where children were awaiting initial assessments for a prolonged time frame. At the time of inspection, the other remaining area (Dublin South West Kildare West Wicklow) was not able to establish their LHHN team primarily due to recruitment challenges and service priorities – despite these areas having significantly high numbers of unallocated cases for prolonged lengths of time. Similar challenges were reported at times in the service areas that had the established teams.

There were variations in how local service areas utilised LHHN teams. In the Waterford Wexford service area, the LHHN team were part of an area-wide screening team who were operating in line with their standard operating procedure for the team. Inspectors found that reviews were undertaken of cases awaiting allocation to a social worker, priority levels were discussed, with clear decisions for

the cases to be transferred to the LHHN team in line with the standard operating procedure. However, it was hard to determine the full extent of the team's effectiveness as the cases reviewed were at the initial stages of being worked.

In one service area, the LHHN team only became fully operational in November 2023 as it was not fully staffed. The scope of the LHHN team assessments at the time of the inspection was to complete initial assessments on medium and low priority welfare cases on the waiting list from two social work teams within the area. At the time of the inspection, 68 cases unallocated to a social worker were being worked by the LHHN team. There was a significant concern for inspectors with regard to the capacity of LHHN staff team given their lack of social work qualifications, training and inexperience in child protection and welfare assessment to effectively undertake child protection and welfare initial assessments and safety planning. The concerns regarding capacity of social care staff on the LHHN team, despite significant mentoring of the team by a social work team leader, were acknowledged at interview by the area manager. These concerns had also been identified by PASM and been raised at RORMSIC. Four of 11 cases escalated by HIQA to the area manager were cases that had been diverted to the LHHN team and an appropriate response was received.

In the Louth Meath service area, the pilot of the LHHN team was found to be an effective programme which assisted the area's response to children and families presenting with lower risk welfare issues requiring a social work response and had reduced the number of children placed on waiting lists for a child protection service. Management advised that this team was making a positive impact on cases meeting this criteria, monthly reviews of this team demonstrated its success in meeting the needs of a certain cohort of children requiring a child welfare service. The area manager planned to extend this service by adding a second team in the service area.

Garda Notifications

The threshold for notification to An Garda Síochána is a suspicion that a child has been or is being physically or sexually abused or wilfully neglected. As per Tusla's standard business processes, social workers must notify the Garda Síochána at any point during the preliminary enquiry process if it emerges that there is a suspicion that a child may have been abused. Where a member of the Garda Síochána has reasonable grounds for concern that a child has been, or is at risk of being, the victim of emotional, physical or sexual abuse or neglect, Tusla must be formally notified on a standardised notification form. Where Tusla suspects that a child has been or is being physically or sexually abused or wilfully neglected, the Garda Síochána must be formally notified by Tusla.

While there was generally good practice in the sharing of information with the Garda

Síochána of suspected cases of abuse and in sharing safety plans in order to protect the welfare of the child, improvements were required to strengthen the effective implementation of '*Tusla and An Garda Síochána Children First – Joint Working Protocol for Liaison between both Agencies'* as considerable delays were found in the Dublin South East Wicklow, Louth Meath, Dublin North City and Donegal service areas, as collectively, 32% of referrals where a garda notification was required had not been completed.

Of serious concern, were the cases reviewed in these four service areas where there was an allegation of either physical or sexual abuse and a notification of suspected abuse had not been made to the Garda Síochána in line with protocol and Children First (2017). Inspectors reviewed 44 referrals across the four service areas where a Garda notification was required, and found that despite the referrals being correctly categorised, collectively, a garda notification was not completed for 14 (32%) referrals. During the inspections, individual cases where notification to the Garda Síochána was not completed where there were allegations of suspected abuse were escalated locally and HIQA sought and received assurances from the area managers that these were now completed.

The lack of oversight of notifications to An Garda Síochána reported as a systems risk to the respective regional chief officers included:

- notifications that were not completed in line with *Children First: National Guidance for the Protection and Welfare of Children* 2017
- referrals considered to have met the threshold for requiring a notification to the Garda Síochána that were not made in a timely manner.

Safety Planning

The safety of children is an integral part of the culture of a good child protection and welfare service and should be embedded in the daily work practices of its staff. Staff must consider whether a safety plan is required at every stage of the process from the receipt of the first report, through all stages of the child protection and welfare service, to the completion of social work intervention with children and their families. Where it is deemed that a child is at potential risk of harm or ongoing risk of harm, then safety planning is put in place to ensure that all known risks are addressed so that the child is safe and can remain at home. Staff in a good child protection and welfare service work with children and their families to ensure that the actions taken promote the safety and welfare of the child. An essential part of the safety planning process is to ensure that children, parents and their network understand the reason for Tusla's involvement. The process involves the monitoring and reviewing of the safety plan in order to assess its effectiveness and to determine any changes

required to be made, so as to ensure the ongoing safety for the child.

The participating services implementation of the national approach to practice in relation to safety planning was inconsistent as there were mixed findings across service areas in relation to the oversight and monitoring of safety plans. The inspections found risks due to the lack of implementation and monitoring of safety planning across all stages of the process from the point of referral through to completion of assessment. Some children, including those placed on the CPNS, had appropriate safety plans in place, while others who required a safety plan had none or inadequate safety plans were in place. Safety was not always established before children were placed on waiting lists. There was also inconsistent implementation of safety plans across service areas and a significant lack of oversight of safety planning on unallocated cases, along with gaps in the review of safety plans and convening children's safety network meetings. The safety planning process was impacted by the staffing capacity issues, as a result, Tusla, who had statutory responsibility for safeguarding children had not implemented effective safety planning for all children. Furthermore, the inconsistent implementation of safety plans was evident across all service areas, which meant that while some children were adequately safeguarded, other children were not, as the measures that were necessary to ensure their protection and wellbeing were not set out in a safety plan.

The quality and timeliness of safety planning required improvement. Where safety plans were in place, some were comprehensive and priority was given to keeping a child safe through timely actions taken to ensure the child's safety. Other safety plans lacked detail and had either no evidence of being monitored or were inadequately monitored by Tusla for their effectiveness in ensuring the child's safety. Some children who needed a safety plan did not have one in place. There was a significant lack of oversight of safety planning on unallocated cases, along with gaps in the review of safety plans and convening children's safety network meetings. Tusla, who had statutory responsibility for safeguarding children had not implemented effective safety planning for all children.

Special Emergency Arrangements

Risks impacting on the safety and welfare of children were found pertaining to the placement of children in Special Emergency Arrangement's (SEA's) in some areas. Tusla's definition of a Special Emergency Arrangement (SEA) refers to emergency settings where a child/young person is accommodated in a non-statutory and or unregulated placement, for example, a Hotel, B&B, Holiday centre, Activity centre, Tusla property or privately leased property. The child is supervised by Tusla staff, or staff provided by a private provider, or community and voluntary provider (or combination of those). The overall responsibility for the child remains with the

placing service area and region. Despite having a '*National Standard Operating Procedure – Special Emergency Arrangements'* (November 2023) in place, improvements were required to ensure consistent levels of governance and oversight of these arrangements to accommodate very vulnerable children with complex needs.

Special emergency arrangements were operating in the Dublin South West Kildare West Wicklow, Dublin South East Wicklow, Cork, Louth Meath, Dublin North City and Mid West service areas to ensure that children who required an immediate placement that could not be sourced in foster care or a regulated children's residential centre could be accommodated. Insufficient placements for children coming into care resulted in the increased use of SEAs which were resource intensive in terms of cost and staffing. The Dublin South West Kildare West Wicklow and Louth Meath service areas had effective governance and oversight of SEAs, while this varied across the other four service areas.

Children placed in a SEA were allocated to a social worker in line with the standard operating procedure. However, there was poor quality recording of support visits, with limited information documented. In the Dublin North City service area, records pertaining to a child's experience and care planning when placed in a SEA had not been transferred onto Tusla case management system, (TCM). Instead these records were held in a separate system, which the allocated social worker had no access to. Satisfactory information was provided to inspectors on the oversight of this arrangement during fieldwork. However this practice raised concerns about the reliability of the data reviewed at a national level.

The risk-based monitoring programme found risks impacting on the safety and welfare of children in these unregulated arrangements in some areas. Inspectors were concerned about the lack of provision for especially vulnerable children who remained at high risk of harm and continued to reside in unregulated settings, particularly in the Cork service area. The effectiveness of service area and regional based actions to appropriately assess these children's needs and provide an appropriate range of specialist practitioners was of concern. In the Dublin South East Wicklow service area, it was found that a child was residing in a SEA for almost two years. Notwithstanding the length of time, inspectors found that while all available efforts had been made to find suitable alternative accommodation for this child, consideration was given to the child's age, the stability of the current placement and that the child wished to remain in the arrangement. Overall, HIQA had concerns about Tusla's governance of SEAs and its escalation process that had not addressed this issue earlier.

Following the inspections, HIQA sought and received assurances from the area

managers in the Cork service area with respect to two individual cases that included:

- failure to identify cumulative harm and act in a timely manner
- missed opportunities and delays in identifying immediate safety risks
- no evidence of escalation of one case at area or regional level
- current care arrangements not providing the levels of safety and therapeutic care that was required
- urgent need for alternative placement.

The governance and oversight of SEAs was reported as a systems risks to the respective regional chief officers in the Cork, Dublin North City and Mid West service areas, of which, the Cork service area had been previously requested to submit a provider assurance report to HIQA in relation to children placed in SEAs in its region. The subsequent response provided indicated the development of a regional strategy for reducing reliance on and preventing future usage of SEAs in the region. However, HIQA remained very concerned about the lack of provision for especially vulnerable children who remained at high risk of harm and continued to reside in unregulated settings within the Cork service area. This is an area that HIQA will continue to monitor closely.

Closed Cases

A good child protection and welfare service ensures that children and their families benefit from the service for as long as they need it. Cases should remain open and should not be closed until there are appropriate and sustainable arrangements in place to keep children safe. Closed cases should be reviewed by the social work manager before closure to make sure they are not being closed too soon, and signed off by both the social worker and the social work manager. The rationale for closing the case should be recorded on the child's file.

In the eight participating service areas where child protection and welfare services were assessed, inspectors reviewed a sample of cases that were closed[16] to child protection and welfare at different points of the process. For the majority of areas, cases were closed appropriately and where required were appropriately diverted to the PPFS or other commissioned services to provide support and early intervention locally at the earliest point to children and families.

[16] Closed case: is where Tusla has completed all necessary work and or circumstances have changed and the services of Tusla are no longer required. In such cases, the matter has either been brought to a satisfactory conclusion. Before a case can be closed, the social work manager must review the case and agree that it can be closed.

Inefficiencies were found with regard to cases that were on a waiting list for preliminary enquiry and initial assessment. A review of these cases by inspectors found that in some instances, children were on waiting lists for extended time periods and these cases had the potential to be closed and diverted earlier to other services where a child protection and welfare service was not required. At a time when Tusla were struggling with the significant number of cases that were open and unallocated across the eight service areas, the failure to put a system in place to address this inefficiency, and essentially bring about a quick resolution which in turn would bring down the unallocated cases, was an indication of poor governance.

Foster care services

As outlined in the capacity and capability section of this report, staffing resources were a significant challenge and this meant that Tusla were unable to consistently meet the requirements of the national foster care standards, namely that all children in care had an allocated social worker. Common across all service areas was an over stretched child-in-care social work capacity, which resulted in service areas expanding their approach to welfare visiting for children who did not have a designated social worker. Given existing workforce capacity and skill mix, service areas were finding it difficult to maintain or further improve their statutory responsibilities. Therefore, these arrangements were not in line with national foster care standards and there were inconsistencies in practice in how services were delivered.

The Child and Family Social Worker

When children and young people are received into foster care Tusla becomes responsible for the care they receive and allocate a social worker to ensure compliance with statutory requirements and standards. The allocated social worker carries out the statutory duties of the Agency in order to co-ordinate the care of the child. The purpose of their role is to promote the child's safety and welfare and to protect them from abuse and neglect. The child, at a minimum, should be visited in the foster home in line with the Child Care Regulations 1995, but more frequently if required in line with the specific needs of the child. As such, children should have a consistent social worker who they can develop a relationship with while they are in care. Children should be listened to and visited by their social worker regularly and have the opportunity to meet with them in private. Children should be assured that care plans are in place to meet their assessed needs and that actions agreed to meet these needs will be implemented.

At the time of inspection, there were over 800 unallocated children in foster care across the Dublin South Central, Carlow Kilkenny South Tipperary, Dublin South

West Kildare West Wicklow, Waterford Wexford, Louth Meath and Mid West service areas. Furthermore, there was a total of 22 dual unallocated cases in the Louth Meath and Dublin South Central service areas at the time of inspection. This was a systems risk escalated to the respective regional chief officers to outline the long term plan to ensure there are no dual unallocated cases and how their area's will come into compliance with the national standards.

Tusla were also under pressure from the courts in relation to a number of children in foster care who were unallocated to a social worker, and Tusla were not in a position to allocate social workers to these cases. However, some of these children had a secondary[17] worker allocated to them or were managed on the duty system.

Social care practitioners assigned as secondary workers to unallocated children delivered a range of direct work to help children understand why they were in care and to learn more about their history and identity. However, role differences and the accountabilities of social care workers and social care leaders were not clear. Some social care practitioners told inspectors that in assisting with a growing range of statutory tasks, including attending court, they had less time to undertake individual pieces of work with children, including life story work.

Of note, the Mid West service area had made a significant investment in building the skills of its social care workforce with 40 practitioners accessing further training in 2024 (including workers from a partner agency). This initiative was also important in helping children and their foster carers prepare for adoption. Practitioners sought to build children's self-esteem through exploring their interests, their strengths and the things they enjoyed doing.

Practitioners and managers were facing significant challenges in keeping on top of statutory requirements and were finding it difficult to provide the level of continuity of social work support they were previously able to offer, maintain or further improve upon, namely that all children in care had an allocated social worker. This had resulted in service areas expanding their approach to welfare visiting for children who did not have a designated social worker. While service areas made every effort to ensure unallocated children were met by a social care practitioner, there was no guarantee that this was consistent worker.

The oversight of children in foster care awaiting allocation was not effective in every service area. Records of visits to children did not always routinely distinguish between a statutory visit by a social worker and a safeguarding visit by a secondary worker. As such, visits to children completed solely by a social care staff were being

[17] Children who did not have an allocated professionally qualified social worker are assigned a secondary worker which included different grades of social work and social care practitioners.

inappropriately recorded as statutory visits. Some records did not contain evidence of managerial oversight of visits undertaken to children. While audits of unallocated children in foster care were undertaken by principal social workers or social work team leaders, the outcome was ineffective in terms of being able to allocate social workers to these children.

All participating service areas promoted and facilitated contact for children-in-care with their families and siblings. The co-ordination of the majority of children's care was of good quality in the main. Most records sampled evidenced good joint working with other professionals and agencies to help improve outcomes for children. For example, a high standard of practice in supporting a child and their foster carers to move to live in another service area was evident in the Carlow Kilkenny South Tipperary service area, which included joint working with the other service area and follow up statutory visits to see how the child was settling into their new school and community.

It was clear to inspectors that everyone was doing what they could, to try and ensure children were regularly visited and that they were safe and well-cared for. While other arrangements to ensure adherence to statutory requirements in relation to children in foster care were evident across all participating areas, some areas had more effective arrangements in place than others so as to ensure children were visited and had up-to-date care plans. Examples of effective arrangements were found in the Carlow Kilkenny South Tipperary, Waterford Wexford, Dublin South Central and Dublin South West Kildare West Wicklow service areas, of which two areas are in the South East region.

The Waterford Wexford service area had put in place a 'stable cases' team which had been in place for 11 months by the time of the inspection, and was becoming embedded into practice. Inspectors found that the team had provided an effective system for outstanding tasks to be completed such as statutory visits and child-in-care reviews as and when required. Unallocated children were transferred to the stable case team in rotational periods of six months within a 12-month period. This allowed for two rotations to occur yearly, whereby children were allocated to the team for six months, and then placed on the waiting list and in receipt of social care support visits for the alternate six month period. During the six month stable case rotation, the team were tasked with completing a statutory visit in the initial period of allocation, scheduling and attending a child-in-care review, in collaboration with the child-in-care review chairperson, and completing a further statutory visit towards the end of the six-month period. This ensured that children being placed on the waiting list had two statutory visits completed and an updated care plan on file within a 12 month period.

The Dublin South West Kildare West Wicklow service area had developed an effective 'active on duty' (AOD) system to provide services to children in care who were not allocated to a social worker. What this meant was that unallocated children were visited with the regularity required by the regulations and standards and ensured the child was seen where required by a familiar person. Therefore the impact on children of the area's lack of staffing capacity had been minimised by this arrangement in place to provide a service to children in foster care. The active on duty rota had a mix of staff across the children in care and fostering teams that included social worker, senior social worker, social care leader and social care worker. There were monitoring and oversight systems in place to ensure managers had good oversight of the service being provided to children while on the active on duty system. For example, there were times when different people completed tasks or pieces of work with children as demonstrated on the 'active on duty' system that operated in the Dublin South West Kildare West Wicklow service area.

An 'active on duty' system was also in place in the Dublin South Central service area to provide a service for children who remained unallocated over a long period. When possible, children would be visited by a familiar person to provide consistency for children not allocated a social worker. Another measure was the allocation of a number of high priority cases to the fostering team to ensure children most in need received a social work service. Managers were aware that while these arrangements were not ideal, they worked well when the service was stretched beyond capacity and they did not have the social workers to allocate to children.

The Carlow Kilkenny South Tipperary service area had a local standard operating procedure outlining that each child awaiting allocation should receive a quarterly safeguarding visit and at least one statutory visit each year that matched the length of time they were in care. Safeguarding visits could be undertaken by social care practitioners on their own, and statutory visits were led by a social worker and jointly undertaken with the child's social care practitioner.

Front-line practitioners advised inspectors they gave priority to getting to know the child and building their trust. They also acknowledged that time pressures meant that the recording of their visits did not always reflect the level of work they had undertaken. Most records evidenced good joint working with other professionals and agencies to help improve outcomes for children. However, there were occasions when such records were completed retrospectively which carried the risk of some information being missed.

Most children continued to experience turnover of social workers or social care practitioners which impacted on a child's ability to develop a relationship with and trust their worker while they are in care. In the Dublin South Central service area,

some children had not been allocated a social worker for a number of years. Despite a social care practitioner being allocated in the absence of a social worker, this was unsatisfactory and poor practice. For example, a child in foster care had been unallocated for five years and was not prioritised for allocation. In the Carlow Kilkenny South Tipperary service area, one child had three different workers appointed to oversee their care in the previous 12 months to the inspection. Children with disabilities were not consistently allocated a social worker in the Dublin South Central service area. Of the sample of 32 children's care files reviewed, three (9.3%) individual cases were escalated to the area manager in this service area following the inspection.

In the Louth Meath service area, eight unallocated children with complex needs and diagnosed with a disability had periods of being unallocated from six to 30 months and there were gaps in the frequency of statutory visits to these children throughout 2023. While unallocated children in foster care had secondary allocated workers such as social care practitioners, these children remained listed as a child awaiting allocation and were subject to the same mechanisms for oversight. The majority of these children were visited by their secondary worker in between statutory visits. Some secondary workers noted that assigned tasks agreed for completion in child-in-care reviews were not always completed due to workload pressures. Children and families were not routinely or adequately informed when a child became unallocated. Of the sample of 42 children in foster care files reviewed, three (7.1%) individual cases were escalated to the area manager in this service area following the inspection.

In the Mid West service area, 211 (46%) children in foster care did not have an allocated social worker. While all children had a named practitioner they could contact, children had experienced a number of changes in relation to the roles and the stability of workers appointed to oversee their care. Despite this, there was generally an adequate level of contact with children, their families and foster carers. In practice, social work team leaders were often the first response when there were risks or issues with children in foster care and some team leaders continued to carry a small caseload. Principal social workers were also increasingly drawn into responding to day-to-day operations and managing crises, which severely limited the time they had for quality assurance of the service. This included ensuring the priority status of unallocated children was accurate and up-to-date in line with the new national policy for unallocated children.

While the arrangements to provide a service to unallocated children in foster care did not appear to negatively impact on the safety or overall experience of children sampled, there was a regulatory risk associated with the non-adherence to the national foster care standards. Six individual children's cases were escalated to the

area managers in the Dublin South Central and Louth Meath service areas.

Care Planning and Reviews

Each child-in-care has a written care plan which sets out what services and other supports will be provided to them and their family. A child's care plan is informed by the assessment of their needs, and will change as circumstances or their need for support changes. The care plan must be in writing and agreed with everybody involved in the care of the child. The plan must be regularly reviewed by a range of professionals so as to ensure that the child receives a well-co-ordinated, integrated and consistent service. The child-in-care review meeting is the process by which the social worker ensures that the care planning agreed is being followed, that the current placement continues to meet the child's needs, any agreed interventions are taking place for the child and that child continues to require care. Reviews of the care plan take place within legally defined time limits, as outlined in the regulations. Children and their families should be facilitated and supported to participate so that they can be confident that their views will be taken into account.

Despite the challenges in social work capacity, it was evident that the six participating service areas where foster care services were assessed had endeavoured to ensure care planning and review arrangements were largely undertaken in line with regulatory requirements. Some areas maintained their performance better than other areas, and effectively used the care planning and review processes to identify and respond to the needs of children in its care.

The Carlow Kilkenny South Tipperary service area had undertaken a programme of work to strengthen business processes and workforce accountabilities for care planning and review of children's care. Senior managers had taken appropriate action in response to a significant increase in the number of children's reviews that had been cancelled in 2023. An effective recovery plan had been implemented that enabled the service area to reduce the number of child-in-care review cancellations from 44 to nine. This had resulted in the service area being able to sustain good performance in delivery of its care planning and review activity. The Waterford Wexford service area had made substantial improvements since a previous inspection in July 2023, by undertaking work on 139 outstanding child-in-care reviews that had been identified at that time. Inspectors found that this number had reduced significantly to 13 at the time of this inspection.

However, in the Louth Meath service area, 25% of children in foster care did not have an up to date care plan. Not all child-in-care reviews were held in line with regulations over a two-year period, and the care planning process was not sufficiently child-centred given that the majority of reviews continued to be held virtually. There were significant delays both in the updating of care plans following

the child-in-care review and in the signing of care plans by team leaders. In two cases reviewed there was a delay of seven and eight months in signing of children's care plan. There had been issues with a lack of administrative support and also the practice whereby care plans were not updated until after the child-in-care reviews had taken place and the minutes written and approved, which caused further delays. In two cases reviewed there were gaps of 21 and 22 months between children's child in care reviews. In one case a child who was in care for nine months had no child-in-care review since they were placed in care. HIQA requested and received assurances that this child's child-in-care review was prioritised following the inspection.

In the Dublin South Central service area, while care plans were up-to-date and comprehensive for the majority of children and the quality of care plans was good, there were gaps in timely sign off by social work managers. Not all child-in-care reviews were held within statutory timeframes. This meant that children and their families did not receive an approved care plan in a timely manner. This did not prevent actions being taken following child-in-care reviews as tasks were assigned and acted upon. For example, children accessing specialist services, consulting with external agencies and being supported by social care staff and social workers.

Preventing placement breakdowns was an area for improvement. While the quality of the placement breakdowns reviews were of good quality, there was a common feature of the lack of support being provided to children and foster carers prior to the placements breaking down. For example, foster carers not being provided with sufficient information about the child, a high turnover of social work staff, the impact of children not having an allocated social worker and gaps in care plans to meet children's needs.

The Mid West service area had taken forward a number of improvement actions since the July 2023 HIQA inspection. This included work to embed a new review checklist that helped to strengthen the voice and participation of children in their reviews. The use of the checklist was reviewed in January, February and March 2024 and evidenced steady progress was being made to embed the new approach in practice. Care plans also included a reference to whether there had been any instances of restrictive practice which might impact on the privacy of children or any challenges foster carers may be experiencing in setting boundaries or managing episodes of challenging behaviour. Most reviews were held face-to-face, and if they were held virtually, the chair was required to provide a clear rationale for doing so. These examples showed the area's ongoing commitment to promoting the rights of children and to continual improvement of the quality of its services.

At the time of the inspection, the metrics for the Mid West foster care services

indicated that 74.8% of children had an up-to-date care plan. Most of the sample of care plans reviewed by inspectors demonstrated that updated care plans were overdue by a few months which was outside the required timeframes, of which the longest overdue was seven months. There was no evidence that delays had any adverse impact on children. Additional administration support had been secured, however, practitioners and managers felt more input was needed to support further efficiencies in the planning and co-ordination of reviews. Supervision records of front-line practitioners routinely considered when reviews were due, completed or over-due. Similarly, there were some delays in care plans being signed off by team leaders, but most were approved within two months of the review taking place.

There were some good examples of child-centred work with the child's views clearly articulated. There was evidence of multidisciplinary input into the care planning process for children. When children were awaiting allocation, secondary workers were tasked with following up on agreed actions. The voice of the child was recorded and where appropriate, children were met with prior to their reviews to obtain their views. Children exercised their right to choose not to attend their review.

Of note, the Dublin South West Kildare West Wicklow service area had an active on duty system, which ensured that unallocated children in foster care were visited and had good quality care plans in place and their reviews took place as required. Weekly handover and handback meetings took place at which unallocated children in care were discussed. Inspectors observed these meetings and found that they demonstrated good discussion of required tasks, ensuring the child was seen where required by a familiar person, dates were set for upcoming reviews of the child's care plan and statutory visits were completed. As such, unallocated children were getting a service.

Overall, inspectors found that care plans were of good quality and actions from care plans were followed by social workers or social care workers for children that were unallocated. Consideration was given to factors that safeguarded the child and the suitability of the foster care placement in meeting the needs of the child. There were some good examples of child-centred work with the child's views clearly articulated. There was evidence of multidisciplinary input such as GP, school, child and adolescent mental health services (CAMHS) and other therapeutic services into the care planning process for children to gain a more holistic understanding of children's diverse and complex needs. When children were awaiting allocation, secondary workers were tasked with following up on agreed actions. There was evidence of participation by children, families and foster carers in the care planning and review process. There was timely recognition of children who needed to be referred to aftercare services. Reviews routinely checked for the suitability of placements,

including placements that were under pressure. Additional support and respite was provided to children and or their foster carers, until a more appropriate placement could be found. Placement at risk and placement breakdown meetings were held to provide additional learning and review in relation to matching, children's specific needs and the skills and experience of foster carers.

Managers had oversight mechanisms in place such as trackers that monitored levels of activity and waiting lists which provided critical information to help managers identify risks, track any gaps in service provision and reduce delays in the planning and delivery of its statutory work. Despite this, not all child-in-care reviews were held in line with the regulatory timeframes and not all children had an up-to-date care plan. There were also some delays in the writing up of review meeting minutes and of care plans being issued. There were mixed findings in relation to discussions held with children about the outcome of their care plan meeting in accordance with their age, stage of development and individual needs. Participation by children and families was encouraged and facilitated, however, reviews continued to be held virtually in some areas, which did not always promote child-centred practice. While delays in the care planning and review process were evident, children's safety was maintained within these placements.

Cases of children in foster care were also reviewed by inspectors to determine the appropriateness of Tusla ending their involvement with a child and their family. Some of these children had returned home, while others had reached their eighteenth birthday and were appropriately closed to social work due to their age.

Safeguarding and Child Protection

Findings in relation to this standard varied across the participating service areas inspected due to variations in practice. The foster care services in the Waterford Wexford and Dublin South Central service areas were found to be compliant with the standard in relation to safeguarding and child protection. The Carlow Kilkenny South Tipperary, Dublin South West Kildare West Wicklow and Mid West service areas were substantially compliant and the Louth Meath service area was not compliant with the standard.

For children in foster care, some areas were working to strengthen their focus on safeguarding children and enhance their practice in their use of safety plans. There were some examples of effective safety planning, however, in the Mid West service area, delays in concluding some investigations under Tusla's child abuse substantiation procedure[18] (CASP) impacted the development of safety plans.

[18] Tusla (2022) Child Abuse Substantiation Procedure (CASP) Version 1.2, June 2022.

Social workers were aware of the particular vulnerability of children in foster care to abuse and there were procedures in place to identify, record and address any concerns raised within a placement across the service areas. Concerns relating to children in foster care included disclosures of abuse or harm that took place prior to them coming into care and also allegations against foster carers. Reported concerns by children were responded to promptly with effective safety planning in relation to allegations and serious concerns.

Allegations of abuse against foster carers were responded to in a timely manner, in line with Children First (2017) and Tusla's Child Abuse Substantiation Procedure (2022) with evidence of appropriate follow-up, including checks of the continued suitability of their placement. There were effective safeguarding measures for the management of significant events for children in care. Appropriate actions were taken to safeguard children. In some cases, where the allegation related to their foster carers, children were removed from the placement, in other cases safeguarding plans were put in place following strategy meetings with relevant people. There was good practice of children being seen and spoken with as part of the process of investigating the concerns raised depending on the child's age and development.

Significant events and serious concerns were managed with appropriate reporting to and follow up by managers. There was clear recognition of risks children were exposed to and records outlined future actions to help strengthen support for children and foster carers and promote their resilience. Episodes of children missing from foster care placements were reported to the Garda Síochána in a timely manner in line with the joint protocol, with evidence of appropriate follow-up, including checks of the continued suitability of their placement. However, in the Louth Meath service area, management advised that the procedure for managing allegations made by children in foster care was not embedded in practice and that further training was required to ensure correct referral pathways were implemented. HIQA sought and received satisfactory assurances with respect to two children's files reviewed which contained child protection and welfare notifications which were not processed at the time of the inspection. The area manager provided satisfactory assurances that the screening and the necessary notification to An Garda Síochána was completed following the inspection.

Positively, in the Louth Meath service area work in collaboration with youth justice organisations for children with complex needs who were at increased risk of harming themselves or others were at the planning stages. The Mid West service area was in the early stages of planning a collaborative project in relation to a 'no wrong front door approach' to young people with complex needs who become involved with the criminal justice system. This service area was also working to strengthen its

preventative safeguarding practice and sought to learn from the experiences of children recorded on its bullying and racial harassment tracker. There was growing recognition of the emotional and mental health impact for children who were targeted in this way.

From a review of a sample of children in foster care files across the service areas, appropriate actions were taken to protect and safeguard children. Strategy meetings were held and reviews of joint actions with An Garda Síochána ensured oversight of risk. In some cases, children were removed from the placement, while in other cases safety plans were put in place following strategy meetings with relevant people. Comprehensive assessments were completed in line with Tusla's national approach to practice and the CASP (2022) procedure, and notifications of suspected abuse were appropriately made to An Garda Síochána. However, delays in concluding some investigations under CASP impacted the development of safety plans.

Improvements were required in the Louth Meath service area where children who disclosed allegations of abuse external to their foster care placement did not receive a timely service and these concerns were not managed in line with Children First (2017), national guidance and policies. Three child protection and welfare concerns reviewed by inspectors demonstrated significant delays in the screening of the concerns. One referral was delayed by seven months and the remaining two were yet to be screened at the time of the inspection which meant there were delays of eight and 12 months in the screening of these referrals. In one case, an allegation was not screened or notified to An Garda Síochána at the time of the referral. Knowledge of the referral was not known to the social worker allocated at the time of the inspection when the inspector sought further information, however, assurances were provided that there was no immediate risk to the child. In another case, where a child made an allegation, staff advised that while the allegation was responded to, it was not processed in line with standard business process. HIQA sought and received satisfactory assurances with respect to the two child protection and welfare concerns which were not processed at the time of the inspection. The area manager provided satisfactory assurances that the screening and the necessary notification to the Gardaí was completed following the inspection.

6. Conclusion

Tusla is under significant pressure to deliver an effective and equitable child protection and welfare and foster care service to all children and their families. Through this risk-based monitoring programme, HIQA found that increased demand for services and resourcing challenges is significantly contributing to Tusla's ability to provide a timely and safe service in participating areas.

While Tusla is particularly challenged in relation to the delivery of child protection and welfare services, it has been more effective in the management of unallocated children in foster care. In addition, inconsistencies in the implementation of national policies is creating risks and inconsistent practice. The full impact of the national service improvement plan was not evident due to the different degrees of implementation of actions across the services at the time of the inspections.

It is acknowledged that at all levels of the organisation, the executive, managers and staff were committed to improving the experience of children and families. Despite exhaustive attempts to source available staff and to increase retention rates, continued resourcing challenges severely impacted the delivery of a timely, safe and effective child protection and welfare service. Tusla will not be able to address this alone and will require the continued cross-departmental supports and short to long-term strategies to address their resourcing issues.

Ultimately, the challenges faced by Tusla had a direct impact on some children receiving the right service at the right time, and this will continue in the future unless the systemic risks are effectively responded to.

While Tusla has put an emphasis on the management of children who are at immediate and serious risk of harm and high priority, it has a statutory responsibility to safeguard all children. This risk-based monitoring programme found that significant improvements were required to ensure that Tusla consistently implement its national policies and business processes in all participating services. The system for the management of unallocated children in foster care differed and these arrangements were ensuring that children were visited, albeit not consistently ensuring that children's care reviews or care plans were updated when they were required.

Governance and oversight at all levels requires strengthening. Tusla needs to be able to rely on reported data to respond to areas of high risk. Tusla was not achieving its key performance indicators in relation to the management of child protection and welfare referrals, in the participating areas included in this monitoring programme and of concern to HIQA is that screening and preliminary enquiries are

not being completed within Tusla's stated time frames. There was evidence of areas of good practice throughout this monitoring programme but the learnings from these initiatives were not being shared or adopted by other areas.

In summary, significant improvement is required in the process for managing unallocated cases in both child protection and welfare and foster care services. HIQA will continue to monitor these services and engage with Tusla on its findings.

7. Compliance Plan for The Child and Family Agency (Tusla) Child Protection and Welfare Service

Compliance Plan for The Child and Family Agency (Tusla) Child Protection and Welfare Service OSV – 0004425

Take Action: 0019849

Date of inspection: February – May 2024

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for the Protection and Welfare of Children 2012 for Tusla Children and Family Services.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which Standard(s) the provider must take action on to comply. In this section the provider must consider the overall standard when responding and not just the individual non compliances as listed in section 2.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector have identified the date by

which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard 2.1 Children are protected and their welfare is promoted through the consistent implementation of *Children First*.	**Judgment:** Not compliant
Outline how you are going to come into compliance with Standard 2.1: **2.1.1:** All areas that were subject to the HIQA inspection process have a local service improvement plan. All other areas that require a local service improvement plan will have develop that plan by the end of quarter 1 2025 setting out how they are addressing children awaiting allocation and compliance with timely screening and assessment of children's referrals as per Children's First: National Guidance for the Protection and Welfare of Children. These local service improvement plans will be tracked and monitored throughout 2025 by the Director of Services and Integration, who will oversee appropriate and effective escalation, response and management of issues that cannot be managed locally. <u>This will be achieved by:</u> • All Regional Chief Officers (RCOs) confirming that all areas that require a local service improvement plan (SIP) have specific local service improvement plans to achieve compliance by the 31st of March 2025. • The Director of Services and Integration (DOSI) will confirm with RCOs in existing one to one meetings that all plans are in place by the end of March 2025.	

- The effectiveness of these plans will be a standing agenda item on on-going DOSI and RCO one-to-one meetings. Any area that reaches the 25% threshold will come into consideration at the National Governance and Oversight meeting as outlined in action 3.2.6 below.

Specific deliverables, owners and timelines:

- Local SIPs in place for all areas that require a local service improvement plan. DOSI. 31/03/25.
- DOSI RCO one to one meetings confirming local plans in place and consider the effectiveness of current plans. DOSI. Ongoing from 31/01/25
- Establishment of National Governance and Oversight meeting. DOSI. 31/01/25.

2.1.2: A standardised An Garda Síochána (AGS) notification report will be developed and implemented by the end of April 2025. The report will allow for the effective oversight and management of An Garda Síochána (AGS) notifications at area level. This report will identify referrals that require AGS notifications and identify whether a notification has been done or not. RCO's will assure themselves through regional governance structures that where children have not been notified to the AGS, they are satisfied that this is done in line national practice instruction and with good professional judgement.

This will be achieved by:

- The Chief Information Officer (CIO) will develop the AGS notification report by the end of January 2025. The reporting functionality will be tested in some local areas in February 2025 and will be implemented by the end of March 2025.
- Area Managers will oversee a validation exercise of AGS notifications (notifications not made are in line with professional judgement).
- RCO's will oversee reports on AGS notifications on a quarterly basis at existing regional governance meetings from April 2025 for Q1 2025.
- RCO's will provide assurances on AGS reports to the Director of Services and Integration in one-to-one meetings every 6-8 weeks from April 2025.

Specific deliverables, owners and timelines:

- AGS notification report developed. CIO. 28/01/25.
- AGS notification report tested. Area Managers. 31/02/25.
- AGS notification implementation. All Area Managers and RCO's. 30/03/25.
- RCO oversight of AGS report quarterly. RCO's. 30/04/25 for Q1.
- DOSI assurance from RCO in one-to-one meetings. DOSI. 30/04/25.

2.1.3: All areas subject to HIQA inspection are implementing individual compliance plans in relation to gaps identified in safety planning and compliance with Children First. This has included extensive roll out of safety in action workshops in 2024 and these workshops will continue in 2025.
To ensure further compliance with Children First, the Director of Services and Integration will also develop and undertake an internal validation exercise of the implementation of National Approach to Child Protection and Welfare practice which will inform actions required to support improved implementation through existing learning plans.

<u>This will be achieved by:</u>

- All area learning plans in 2025 will include consideration of safety planning workshop (Safety in Action) where required.
- An internal validation exercise methodology for the review of the implementation of the National Approach to Child Protection & Welfare (CPW) Practice will be complete by the end of February 2025. This validation exercise will include examination to interim and long-term safety planning of children/cases including where children/cases are allocated. The internal validation exercise of the implementation of the National approach to Practice will conclude by the end of June 2025 and will identify additional actions for each area to improve the implementation of the national approach to practice.
- Areas will add relevant additional actions to their area learning plans by the end of August 2025. Each area will be given specific timeframes for actions relevant to their area.
- The action relevant to responses for cumulative harm as set out in 5.2.1 will also support compliance with the assessment and response to children where cumulative harm has been identified.
- The Director of Services and Integration will receive a progress update from each RCO in one-to-one meetings on a bi-annual basis from Q4 2025.
- In the interim implementation of all existing actions in Regional SIPs will be tracked via the Governance and Oversight Group and 1:1 meetings between DOSI and RCOs.

<u>Specific deliverables, owners and timelines:</u>

- Validation exercise methodology. National Lead for Practice Reform. 28/02/25.
- Validation exercise complete. National Lead for Practice Reform. 30/06/25.

- Confirmation from RCO's that all areas have included relevant additional actions to their area learning plans. RCO's. 31/08/25.
- Bi-annual progress update from each RCO to DOSI on area learning plans in one-to-one meetings. RCO's. 31/12/25.

2.1.4: Existing measures will continue to reduce the number of Special Emergency Arrangements (SEA's) There is a dedicated project that is supporting and monitoring the increase in residential beds in 2025.

This is achieved by:

- The continuation of the dedicated project sub-group focused on bed delivery which meets every two weeks.
- The purpose of this group is to set targets, support the increase in the number of residential beds available to Tusla and manage the risks associated with bed capacity. The project is governed by the residential strategy programme which sits under the overall organisational reform programme. Reporting takes place on a monthly basis.
- Local service improvement plans mitigate against the lack of available placements and consider alternative local arrangements or solutions for example creative community alternatives.
- Significant risks in relation to availability of placements can be escalated by RCO's where necessary via Regional Operations Risk Management and Service Improvement Committee (RORMSIC) to via National Operations Risk Management and Service Improvement Committee (NORMSIC).

Dependencies:

Increasing residential beds in 2025 is dependent on relatively stable rate of admission to care, budget availability and the availability and recruitment of staff for residential centres.

Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 3.1:

3.1.1: Present to HIQA in a stakeholder engagement the implementation plan for the Local Integrated Service Delivery (LISD) Programme in February 2025.

This will be achieved by:

- Providing HIQA with the key deliverables, milestones, governance and timelines for the implementation of the Local Integrated Service Delivery Programme.
- Following the engagement, bi-monthly progress updates on milestones will be provided to HIQA throughout 2025.

Specific deliverables, owners and timelines:

- Presentation of the implementation plan to HIQA. LISD Programme Delivery Lead. 28/02/25.

Dependencies:

Board approval of the implementation plan for the Local Integrated Service Delivery Programme prior to HIQA engagement.

3.1.2: The Director of Services and Integration will conduct a review of local standard operating procedures related to unallocated children/cases to confirm they are aligned to the national unallocated cases policy by the end of March 2025.

This will be achieved by:

- Each Regional Chief Officer (RCO) confirming with each Area Manager (AM) that the local standard operating procedures related to unallocated children/cases has been aligned to the national unallocated cases policy.
- The Director of Services and Integration (DOSI) will complete an assurance check with each RCO through individual one to one meetings in February and March 2025.
- Implementation of all existing actions in Regional SIPs to be monitored by the National Governance and Oversight Group. (3.2.6 below)

Specific deliverables, owner and timelines:

- One-to-one meeting minutes between DOSI and RCO that confirms all areas have aligned local SOPs to national unallocated children/cases policy. DOSI. 30/03/25.

3.1.3: All regions will continue to implement the agreed governance structures for the effective oversight and management of Special Emergency Arrangements (SEA's)

- SEA Assurance Integration group continues to meet regularly and oversees status of SEA's in each region, addresses issues including compliance with regulations, data protection etc.
- A crisis management team (CMT) was established under the Agency's Interim National Director of Services and Integration and began work in September 2023. This CMT identified key priority areas and all target areas were met within identified time frames to date.
- All regions will continue to implement SEA standard operating procedures – National Standard Operating Procedure- Special Emergency Arrangements (SEAs) V 0.2.3 (July, 2024) and the Tusla's Summary Requirements on The Care To Be Provided to Children and Young People in Special Emergency Arrangements (July, 2023).
- Where a special emergency arrangement is in operation for more than 30 days, this will be notified by the relevant RCOs office to Tusla's Alternative Care Inspection and Monitoring Service (ACIMS) who will engage with the provider to start the process of application for registration as a children's residential centre. Escalation process to Tusla's National Registration Enforcement Panel for reasons of non-engagement occur when necessary.
- A new cross directorate assurance and oversight group established to increase communication across directorates and regions and up to Tusla's Executive Management Team on the operations and quality of care being provided in SEAs. This group meets weekly and has resulted in better information integration and increased management and mitigation measures for emerging risks
- Practice Assurance Review and Monitoring (PASM) Team will implement the 2025 Practice Assurance Review and Monitoring Plan which will see the PASM team continue to carry out visits to SEAs in line with theses operating procedures. PASM will also review the implementation of the SOP in 2025.

- Actions to date continue to reduce reliance on SEA's – Note in October 2022 SEA were reported as 72, when compared with 24/11/2024 (40), there has been a 44% (32) reduction.

3.1.4: Revise the terms of reference for National Operational Risk Management and Service Improvement Committee (NORMSIC) to strengthen its role in the identification of mitigating actions in relation to unallocated children/cases and to strengthen its role in monitoring actions to ensure they are effective.

This will be achieved by/ specific deliverables, owners and timelines:

- Terms of reference revised incorporating all relevant learning from recent risk reviews. DOSI and Director of Quality and Regulation by 31/01/25

Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 3.2:

3.2.1: The Director of Services and Integration (DOSI), in conjunction with the Director of Quality and Regulation (Director of Q&R), will streamline and standardise local, regional and national governance structures to ensure they capture all systemic risks highlighted by HIQA inspection on a consistent basis by September 2025.

This will be achieved by/ specific deliverables, owners and timelines:

- Effective issue management is attended to 3.2.6 below where any area that reaches the 25% threshold will come into consideration at the National Governance and Oversight meeting.
- Commence review of governance structures. DOSI, Director of Q&R and RCO's. 31/01/25
- Revised standardised governance structures agreed. EMT, DOSI and RCO's . 30/07/25
- Implementation of standardised governance structures. DOSI. 30/09/25.
- In the interim, Areas will continue to manage risks within their area, where risks cannot be managed locally Area Managers will escalate risks to Regional Operational Risk Management and Service Improvement Committee (RORMSIC).

- RCOs to implement recommendations from audit of the risk system at their RORMSIC.

3.2.2: The existing performance template issued by the Director of Services and Integration to Regional Chief Officers (RCOs) will be updated to include key metrics in relation to unallocated children/children/cases and this will be implemented by the end of January 2025. This will allow Regional Chief Officers and Area Managers to assure the Director of Services and Integration and Director of Quality & Regulation that there is regular management, oversight and monitoring of unallocated children/cases locally. These performance templates are reviewed in DOSI and RCO one-to-one meetings every 6-8 weeks.

This will be achieved by:

- Inclusion of relevant additional metrics to the existing performance template. Metrics that will be considered include:
  - Children on CPNS (Allocated a Social Worker)
  - AGS notifications
- In addition, the one to one meetings will include the following items on the agenda as relevant in relation to unallocated children/children/cases:
  - Status overview of local unallocated SIPs
  - Unallocated children/cases policy implementation
  - Interim transfer policy implementation
  - Case allocation framework implementation

Specific deliverables, owner and timelines:

- Report template updated. DOSI. 31/01/25

3.2.3: Unallocated children/cases will continue to be a standing item on the performance meetings between the executive and each RCO as aligned to the quality assurance framework.

This will be achieved by:

- Performance meetings will continue on a quarterly basis in 2025.

3.2.4: As a risk mitigation action, the Director of Services and Integration will implement the Case Allocation Framework as it pertains to children requiring a child protection and welfare response effectively and consistently by the end of March 2025. This framework will assist relevant areas in guiding the allocation of children/cases where a social worker cannot be allocated.

This will be achieved by / specific deliverables, owner and timelines:

- Complete consultation with HIQA and DCEDIY. DOSI. 31/12/24.
- Approve the Case Allocation Framework document. Tusla National Policy Oversight Committee. 28/02/25.
- Implementation plan developed. DOSI. 28/02/25.
- Case allocation document issued. DOSI. 28/02/25.
- Impact analysis for all current allocated children/cases to non-social work staff and any significant issues arising indicating a likely increase in unallocated children/cases will be considered at the National Governance and Oversight meeting as set out in 3.2.6 above.
- This action needs to be read in conjunction with the resources section below where actions in relation to recruiting social workers are set out.

Dependencies:
Timely engagement with key stakeholders in relation to the case allocation framework.

3.2.5: The Chief Information Officer / Director of Quality & Regulation will develop and implement updated performance reports in relation to role allocations by the end of March 2025. The updated performance reports will distinguish between children/cases that are allocated to a social worker and children/cases that are allocated to another professional worker.

We will achieve this by / specific deliverables, owner and timelines:

- Develop updated performance reports including role allocations. CIO. 31/01/25.
- Communications plan in relation to this change in reporting will be developed in January 2025.
- Implement the role allocation report. 20/02/25.
- The report for January data will form part of the published performance reports in March 2025.
- Monitoring of the role allocation report will take place in DOSI RCO one-to-one meetings. DOSI. 31/04/25.

3.2.6 The Director of Services and Integration will revise the terms of reference for the current HIQA National oversight Group to establish a National Governance and Oversight Group in January 2025. The group will act as an on-going issue management mechanism for areas where regional controls have been less effective in addressing unallocated children/cases.

We will achieve this by:

- The subgroup will include the DOSI and RCO's and representatives from HR, Finance, ICT, Q&R and People and Change.
- The group will meet bi-monthly
- The specific initial focus of the group in January will be on the areas of significant concern identified in the HIQA inspection process
- Any area that reaches the 25% threshold of children/cases awaiting allocation will be included on the agenda for the meeting with consideration of additional special measures, rapid responses required for Executive Management Team consideration and approval.

Specific deliverables, owners and timelines:

- National Governance and Oversight Group terms of reference. DOSI. 31/01/25.
- National Governance and Oversight Group first meeting. DOSI. 31/01/25.

Standard 4.1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 4.1:

4.1.1: In 2025, the executive management team will allocate additional resources. These resources are inclusive of responses to both children awaiting allocation in child protection and foster care and allocation will be made to areas in greater need.

This will include:

- The Executive Management Team will allocate an additional 50 WTE in line with Resource Allocation Analysis & Planning Framework in Q1 2025 to increase capacity in areas where resources are most required to address unallocated children/cases. (€1.25m ½ year funded in 2025)
- The Executive Management Team will allocate an additional 500k for commissioned services in line with Resource Allocation Analysis & Planning Framework in Q1 2025 to increase capacity in areas where resources are most required
- The Executive Management Team have approved 70 Social Work Apprentices for 2025 (50% increase on 2024) and these will be targeted in in line with Resource Allocation Analysis & Planning Framework to areas where resources are most required.

- The Executive Management Team have approved the rollout of a Social Care Apprenticeship Scheme in Q3 2025 and applicants will be prioritised to increase capacity in Tusla residential services.
- The Executive Management Team have approved funding for the provision of additional supports to Tusla Fostering Services (Foster Care Recruitment, Foster Care Travel and Subsistence and Peer Support Workers) for 2025.

4.1.2: As part of the organisational reform programme, complete a resource profiling and gap analysis for community services across the new 30 Networks. This will be presented to HIQA as part of stakeholder engagement by the end of March 2025.

This will be achieved by/ specific deliverables, owner and timelines:

- Completion a resource profiling and gap analysis for community services across the new 30 Networks. LISD Programme Delivery Lead. 28/02/25.
- Presentation to HIQA. LISD Programme Delivery Lead. 31/03/25.

4.1.3: Following on from action 4.1.1 above, submit an estimates bid for 2026 outlining additional resources required to be compliant with National Standards and Children First (2017)

This will be achieved by/ specific deliverables, owner and timelines:

- Develop a draft estimates bid. DOSI. 30/05/25
- Approval of estimates bid by EMT. EMT 30/06/25
- Submission of estimates bid. DOSI. 30/09/25

4.1.4: Implement the actions in people and change strategy that focus on recruitment and retention for child protection and welfare in 2025.

- The People and Change Strategy 2025-2026 is currently being finalised by 31/3/25. The strategy will be accompanied by an implementation plan. Once approved internally, the relevant actions to support recruitment and retention will be shared with HIQA.
- In the interim, all current actions in the current People and Change strategy will continue.

4.1.5: Continued development and review of Regional Workforce Plans

This will be achieved by/ specific deliverables, owner and timelines

- Workforce plans are in place for West, Midwest, Southeast, Dublin Mid Leinster (DML), and Children Residential Services (CRS). Draft plans are in place for Dublin North East (DNE) and Southwest which are work in progress and these will be finalised by 31/3/2025
- In 2025 the workforce plans for each region will employ an increased integrated approach to Workforce Planning to align our people strategy with our business strategy. Scale up on an integrated approach to workforce planning to enable the Agency to be more agile and prepared for the future. The focus will be to further develop regional and service Workforce Plans in collaboration with Human Resources (HR), Operations, Finance, Workforce Learning & Development (WFLD) and the Project Management Office (PMO).
- The plans are implemented through a Workforce Implementation Plan, planned and delivered in collaboration with regional HR, finance, and operations including Social Care and Social Work Management. The WFP/Recruitment Officer tracks and monitors the plans and provides updates on progress to Regional Management Team throughout 2025.
- Impact to be monitored in 1:1 meetings between DOSI and RCOS, Executive Management Team (EMT) Performance meetings and National metric reporting.

Standard 5.2 Staff have the required skills and experience to manage and deliver effective services to children.	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 5.2:

5.2.1: Develop and implement a national workshop for the management of cumulative harm building on existing good practice in areas by the end of March 2025.

This will be achieved by/ specific deliverables, owner and timelines:

- Workshop and process has been developed by Workforce Learning & Development and Practice leads.
- Roll out of workshop will be prioritised for areas subject to recent HIQA inspection in 2025 as part of area learning plans- Ongoing in 2025 by

Area Managers evidenced though area learning plans. These workshops cover definitions of cumulative harm, developing case chronologies using the Tusla Case Management System, using the harm analysis tools and recording the rationale for the assessment decision and professional judgment on safety.

- Examination of cumulative harm will also be a standing item in all PASM reviews going forward.
- In the interim, every area that has been inspected to date where cumulative harm has been identified have actions in their local SIP to address cumulative harm. This will be monitored in the Governance and Oversight meeting as per 3.2.6 above.

5.2.2: In support of the implementation of the case allocation framework, conduct a pilot training needs analysis of social care staff undertaking CPW work in one area to inform immediate training needs of staff to support case allocation framework and devise a training programme to support relevant staff.

This will be achieved by/ specific deliverables, owner and timelines:

- Pilot TNA complete in one area. Workforce Learning and Development. 28/02/25.
- The outcome of the pilot will inform the training programme for relevant staff.
- Training programme devised and plan developed for roll complete by 30/04/25. Workforce Learning and Development.
- Roll out to commence in May 2025. Workforce Learning and Development.
- In the interim practice leads will provide direct support to Social Care Workers and their teams in implementing the National Approach to Child Protection and Welfare practice.

5.2.3: Continue to roll out supervision, mentoring and training programmes for staff in 2025

- Continue to roll out the following training programmes in 2025 which will be encompassed in the People and Change Strategy 2025-2026
  - Leadership programmes available to all levels of staff in 2025
  - Coaching and mentoring available to all levels of staff in 2025
  - Supervision training available to all levels of staff in 2025
  - There is also a range of practice related trainings available to all staff

5.2.4: All managers will discuss training needs with staff members in one-to-one meetings in Q1 2025 and this will be reviewed bi-annually.

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The provider has failed to comply with the following standards(s).

Standard	Judgment	Risk rating	Date to be complied with
Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Not compliant	Red	31/12/2025
Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.	Not compliant	Orange	30/06/2025
Standard 4.1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.	Not compliant	Red	31/12/2025
Standard 5.2 Staff have the required skills and experience to manage and deliver effective services to children.	Not compliant	Orange	31/12/2025
Standard 2.1 Children are protected and their welfare is promoted through the consistent implementation of *Children First*.	Not compliant	Red	31/12/2025

8. Compliance Plan for The Child and Family Agency (Tusla) Foster Care Service OSV – 0004427

Compliance Plan for The Child and Family Agency (Tusla) Foster Care Service OSV – 0004427

Take Action: 0019849

Date of inspection: **February – May 2024**

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for Foster Care, 2003.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which standards the provider must take action on to comply. In this section the provider must consider the overall standard when responding and not just the individual non compliances as listed in section 2.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector has identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk

rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the standard in order to bring the service back into compliance. The plan should be **SMART** in nature. **S**pecific to that standard, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each standard set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard 5: The child and family social worker There is a designated social worker for each child and young person in foster care.	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 5:

The actions set out below are aimed at increasing compliance with Standard 5 within the timeframe specified, i.e. September 2025. These actions also seek to mitigate the risk associated with not being able to achieve full compliance within this specified timeframe.

5.1: In 2025, the executive management team will allocate additional resources to increase compliance with Standard 5. These resources are inclusive of responses to both children awaiting allocation in child protection and foster care and allocation will be made to areas in greater need.

This will include:

- The Executive Management Team (EMT) will allocate an additional 50 WTE in line with Resource Allocation Analysis & Planning Framework in Q1 2025 to increase capacity in areas where resources are most required to address unallocated cases. (€1.25m ½ year funded in 2025)
- The Executive Management Team will allocate an additional 500k for commissioned services in line with Resource Allocation Analysis & Planning Framework in Q1 2025 to increase capacity in areas where resources are most required
- The Executive Management Team have approved 70 Social Work Apprentices for 2025 (50% increase on 2024) and these will be targeted in in line with

Resource Allocation Analysis & Planning Framework to areas where resources are most required.
- The Executive Management Team have approved the rollout of a Social Care Apprenticeship Scheme in Q3 2025 and applicants will be prioritised to increase capacity in Tusla residential services.
- The Executive Management Team have approved funding for the provision of additional supports to Tusla Fostering Services (Foster Care Recruitment, Foster Care Travel and Subsistence and Peer Support Workers) for 2025.

5.2: To address further resourcing gaps that impact on achieving full compliance the Agency, under its organisational reform programme, will complete a resource profiling and gap analysis for community services across the new 30 Networks. This will be presented to HIQA as part of stakeholder engagement by the end of March 2025.

This will be achieved by/ specific deliverables, owner and timelines:
- Completion a resource profiling and gap analysis for community services across the new 30 Networks. Local Integrated Service Delivery (LISD) Programme Lead. 28/02/25.
- Presentation to HIQA. Local Integrated Service Delivery (LISD) Programme Lead. 31/03/25.

5.3: Following on from action 5.2 above, and submit an estimates bid for 2026 outlining additional and required resources required to be compliant with the standards.

This will be achieved by:
- Develop a draft estimates bid. Director of Service and Integration (DOSI). 30/05/25
- Approval of estimates bid by EMT. EMT 30/06/25
- Submission of estimates bid. Director of Service and Integration (DOSI) 30/09/25

5.4: As a further risk mitigation action, implement the Case Allocation Framework as it pertains to children in care effectively and consistently by the end of March 2025. This framework will assist relevant areas in guiding the allocation of children/cases where a social worker cannot be allocated.

This will be achieved by / specific deliverables, owner and timelines:

- Complete consultation with HIQA and DCEDIY. Chief Social Worker (CSW) . 31/12/24.
- Approve the Case Allocation Framework document. Tusla National Policy Oversight Committee (NPOC). 28/02/25.
- Implementation plan developed. DOSI. 28/02/25.
- Case allocation document issued. DOSI. 28/02/25.
- Impact analysis for all current allocated children/cases to non-social work staff and any significant issues arising indicating a likely increase in unallocated children/cases will be considered at the National Governance and Oversight meeting as set out in 3.2.6 above.
- This action needs to be read in conjunction with the resources section below where actions in relation to recruiting social workers are set out.

Dependencies:
Timely engagement with key stakeholders in relation to the case allocation framework.

5.5: Implement the actions in the people and change strategy that focus on recruitment and retention for foster care in 2025.

- The People and Change Strategy 2025-2026 is currently being finalised by 31/3/25. The strategy will be accompanied by an implementation plan. Once approved internally, the relevant actions to support recruitment and retention will be shared with HIQA.
- In the interim, all current actions in the current People and Change strategy will continue.

5.6: Continued development and review of Regional Workforce Plans

This will be achieved by/ specific deliverables, owner and timelines

- Workforce plans are in place for West, Midwest, Southeast, Dublin Mid Leinster (DML) , and Children Residential Services (CRS). Draft plans are in place for Dublin North East (DNE) and Southwest which are work in progress and these will be finalised by 31/3/2025
- In 2025 the workforce plans for each region will employ an increased integrated approach to Workforce Planning to align our people strategy with our business strategy. Scale up on an integrated approach to workforce planning to enable the Agency to be more agile and prepared for the future. The focus will be to further develop regional and service Workforce Plans in

collaboration with HR, Operations, Finance, Information and Communications Technology (ICT), Workforce Learning and Development (WFLD) and Project Management Office (PMO).
- The plans are implemented through a Workforce Implementation Plan, planned and delivered in collaboration with regional HR, finance, and operations including Social Care and Social Work Management. The Workforce Force Planning & Recruitment Officer tracks and monitors the plans and provides updates on progress to Regional Management Team throughout 2025.
- Impact to be monitored in 1:1 meetings between DOSI and Regional Chief Officers (RCO's), EMT Performance meetings and National metric reporting.
-

Standard 7: Care planning and review Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.	**Judgment:** Substantially compliant

Outline how you are going to come into compliance with Standard 7:

7.1: Hold a learning event workshop to examine the areas that are substantially compliant (Waterford/Wexford, Carlow Kilkenny, South Tipperary and the Mid West) to consider the feasibility and suitability of replicating the approach in other areas to support improved compliance with care planning standards.

We will achieve this by / specific deliverables, owner and timelines:
- Plan learning event workshops. DOSI. 31/01/25
- Consider the feasibility and suitability for relevant areas. DOSI. 31/03/25.
- Seek resources via business case to DCEDIY to be developed. DOSI. 30/04/25
- Submit business case to DCEDIY. DOSI. 30/05/25.
- Pending the outcome of the business case, develop an implementation plan for this system to be replicated across relevant areas. DOSI. 30/06/25.

Dependencies:
Funding to support implementation plan for this system to be replicated across relevant areas.

7.2 Consider the additional needs of children in foster care

We will achieve this by / specific deliverables, owner and timelines:

1. Conduct a gap analysis of service provision to children in care with disabilities to and recommendations arising from same to be incorporated as actions into Regional SIPS. – DOSI and RCOs 30th March 2025
2. National Oversight Group to monitor existing actions in Regional Service Improvement Plans. DOSI 28th Feb 2025

Standard 10: Safeguarding and child protection Children and young people in foster care are protected from abuse and neglect.	**Judgment:** Substantially compliant

Outline how you are going to come into compliance with Standard 10:

10.1: Ensure the revised Child Abuse Substantiation Procedure (CASP) version 2 as it pertains to children in foster care is implemented effectively and consistently and monitor CASP metric reports in the context of delay.

- CASP document and supporting resources published on the Tusla Hub on the 24th of October 2024.
- Regional trainings and briefings have taken place in July, August and September and will continue until the end of the year 2024.
- CASP project has closed as of November 27th, 2024.
- CASP leads will continue to meet quarterly, issues/risks will be escalated via RCO's as per existing operational governance structures.

10.2: Implement the revised guidance for responding to concerns of children in care (foster care) effectively and consistently by the end of February 2025.

We will achieve this by / specific deliverables, owner and timelines:

- Finalise and publish guidance. DOSI. 31/12/24
- Conduct briefings in regions. DOSI. 28/02/25
- Areas will continue to track and monitor allegations against children in care as per existing structures and will escalate issues of concern via the RCO for agreement on actions required.
- Review existing tracking and reporting structures and implement recommendation DOSI and RCOs -31st March 2025

Standard 18: Effective policies Health boards have up-to-date effective policies and plans to promote the provision of high quality foster care for children and young people who require it.	**Judgment:** Substantially compliant

Outline how you are going to come into compliance with Standard 18:

18.1: Practice Assurance Service Monitoring (PASM) team to conduct priority reviews of the implementation of relevant policies as they pertain to children in care throughout 2025.

The PASM team will conduct the following reviews in 2025 relating to children in care in 2025:

- The Management of Serious Concerns and Allegations against Foster Carers (Louth/Meath and Midwest);
- National Review of the Management and Oversight of Dual Unallocated Children/cases.

18.2: Assurance about the management of unallocated children/cases of children in foster care to be provided by RCOs and AMs to the DOSI in standing DOSI RCO one-to-one meetings throughout 2025.

<u>We will achieve this by / specific deliverables, owner and timelines:</u>

- Assurances about the management of unallocated children/cases of children in foster care will be included as an agenda item in the standing one-to-one meetings between the DOSI and RCO's. DOSI. 31/01/25.
- Inclusion of the following metrics to the RCO performance template
    - Dual unallocated children/cases
    - Statutory visits to children in care
- National Governance and Oversight Group to track and monitor implementation of existing actions in Regional Service Improvement plans (SIPs). – Ongoing from 28/2/25

<u>Specific deliverables, owner and timelines:</u>

- Performance report template updated. DOSI. 31/01/25

18.3: Children with additional needs (disability/mental health) will continue to be dealt with under the existing Tusla HSE Joint Protocol and existing structures. This protocol will be revised in 2025 to enhance the collaboration and co-ordination between Tusla and the HSE. Tusla HSE joint working protocol.

There is steering group in place for the revision of the HSE Tusla joint protocol.

- A revised protocol will be agreed in March 2025.
- In the interim, we will continue to operate under the Tusla HSE joint protocol arrangements including the ongoing oversight and governance in relation to children with additional needs.

18.4: Implement the transfer policy in foster care by the end of June 2025.

We will achieve this by:

- Implementation plan developed November 2024.
- Leads for implementation to be assigned in January 2025.
- Implementation to begin in January 2025.

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.	**Judgment:** Not compliant

Outline how you are going to come into compliance with Standard 19:

19.1 The Director of Services and Integration (DOSI) will streamline and standardise local, regional and national governance structures to ensure they capture all systemic risks highlighted by HIQA inspection on a consistent basis by September 2025.

This will be achieved by/ specific deliverables, owners and timelines:

- Effective issue management is attended to 19.2 below where any area that reaches the 25% threshold will come into consideration at the National Governance and Oversight meeting
- Commence review of governance structures. DOSI and RCO's. 31/01/25
- Revised standardised governance structures agreed. EMT, DOSI and RCO's . 30/07/25
- Implementation of standardised governance structures. DOSI. 30/09/25.
- In the interim, Areas will continue to manage risks within their area, where risks cannot be managed locally Area Managers will escalate risks to

Regional Operational Risk Management and Service Improvement Committee (RORMSIC).
- RCOs to implement recommendations from audit of the risk system at their RORMSIC.

19.2 The Director of Services and Integration will revise the terms of reference for the current HIQA National oversight Group to establish a National Governance and Oversight Group in January 2025. The group will act as an on-going issue management mechanism for areas where regional controls have been less effective in addressing unallocated cases.

We will achieve this by:
- The subgroup will include the DOSI and RCO's and representatives from Finance, ICT, Quality & Regulation and People and Change.
- The group will meet bi-monthly
- The specific initial focus of the group in January will be on the areas of significant concern identified in the HIQA inspection process
- Any area that reaches the 25% threshold of cases awaiting allocation will be included on the agenda for the meeting with consideration of additional special measures, rapid responses required for Executive Management Team consideration and approval.

Specific deliverables, owners and timelines:
- National Governance and Oversight Group terms of reference. DOSI. 31/01/25.
- National Governance and Oversight Group first meeting. DOSI. 31/01/25.

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider has failed to comply with the following regulation(s).

Standard	Judgment	Risk rating	Date to be complied with
Standard 5 There is a designated social worker for each child and young person in foster care.	Not compliant	Orange	30/09/2025
Standard 7 Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.	Substantially compliant	Yellow	30/06/2025
Standard 10 Children and young people in foster care are protected from abuse and neglect.	Substantially compliant	Yellow	31/01/2025
Standard 18 Health boards have up-to-date effective policies and plans to promote the provision of high quality foster care for children and young people who require it.	Substantially compliant	Yellow	31/12/2025

Standard 19 Health boards have effective structures in place for the management and monitoring of foster care services.	Not compliant	Orange	31/12/2025

Appendix 1 Tusla performance and activity data

Tusla publishes reports on the performance and activity of Tusla services on a monthly and quarterly basis. The monthly performance and activity dashboard and the quarterly service performance and activity reports are structured around key performance and activity measures included in Tusla's Annual Business Plan.

With regard to child protection and welfare services, Tusla's performance and activity reports include referrals data, social work activity data and data from the Child Protection Notification System. These include:

- the number of referrals to child protection and welfare services
- the number of cases:
    - open to the service
    - allocated and or awaiting allocation to a social worker
    - awaiting allocation by priority level
    - awaiting allocation by time waiting
    - children listed as 'active' on the Child Protection Notification System.

With regard to foster care services, Tusla's performance and activity reports include:

- the number of children in care
- the number of cases:
    - allocated and or awaiting allocation to a social worker
    - awaiting allocation by priority level
    - awaiting allocation by time waiting
    - children placed with unapproved carers.

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