Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of service area:	Dublin North
Name of provider:	Tusla - Child and Family Agency
Type of inspection:	Foster Care Thematic
Date of inspection:	24-27 October 2022
Fieldwork ID:	Mon-0037862

About this inspection

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

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

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

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

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

How we inspect

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

The key activities of this inspection involved:

- the analysis of data submitted by the area
- interviews with:
    - the regional chief officer and the regional quality and risk manager
    - the area manager
    - the principal social workers for children in care, fostering and the aftercare service
    - the chair of the foster care committee
- focus groups with:
    - nine social work team leaders
    - 17 frontline staff
    - seven foster carers
    - six external stakeholder representatives
    - three members of the regional assessment fostering team (RAFT)
- observations of:
    - a foster care committee (FCC) meeting
    - a complex case governance meeting
    - a meeting with external support agencies
- the review of:
    - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
    - staff personnel files
    - a sample of 26 children's records and 19 foster carer records.
- separate individual phone conversations with:
    - a sample of five parents/family members, eight children and fourteen foster carers.

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

Profile of the foster care service

The Child and Family Agency

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

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

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

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

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

Service area

The Dublin North service area forms part of Tusla's Dublin North East region. The service area includes the two local authority areas of Fingal County Council and Dublin City Council. It is a highly populated and geographically diverse area with significant pockets of deprivation. The population of Dublin North is estimated at 358,009, including 100,654 children aged 0-17 years (28.11%)[1]. Fingal is the youngest and most ethnically diverse locality in Ireland, with a birth rate that exceeds the national average. The area is under the direction of a regional chief officer and is managed by an area manager.

[1] 2016 National Census data

At the time of this inspection, the service area had a total of 319 children in foster care. This was made up of 215 children in general foster care, 62 of whom were placed with non-statutory (private) foster carers. In addition, 104 children were placed with relative foster carers. A total of 168 children were placed outside of the area.

The service area had a total of 185 foster carer households. This included 96 general and 89 relative foster carer households. Of these, 39 foster carer households received extra help to provide care for 52 children with complex needs or disabilities.

The service area had very limited capacity to accommodate children newly-admitted to care and those who required long-term placements. Eighteen children were awaiting a long-term placement at the time of this inspection. Seven foster carer households had higher numbers of unrelated children placed with them; exceeding the limit of not more than two un-related children placed together, as set out in foster care standards.

Children admitted to care are initially supported by the area's assessment and interventions teams. They are transferred to the children-in-care teams when a decision is made for them to remain in care. Three principal social workers (PSW) and nine social work team leaders manage the workload of the assessment and intervention teams. Two principal social workers and six social work team leaders manage the workload of the children-in-care teams. The principal social workers also each manage a fostering team, and one PSW has oversight of the aftercare team. Front-line team members included social workers, social care workers, social care leaders and family support practitioners.

At the time of the inspection, the service area had six social work and two senior social work practitioner vacancies in its children-in-care teams, and one vacancy in its fostering team. The area also had a fostering team leader and an additional fostering principal social worker post that were in the process of being filled. Staff turnover in the last 12 months was estimated at 13%. Staff absence levels overall was 6%.

Compliance classifications

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

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
24 October 2022	09.00-17.00	Sue Talbot	Inspector
	10.00-17.00	Pauline Orohoe-Clarke	Inspector
		Hazel Hanrahan	Inspector
		Niamh Greevy	Inspector
		Mary Wallace	Inspector
		Lorraine O'Reilly	Remote inspector
25 October 2022	09.00-17.00	Sue Talbot	Inspector
		Pauline Orohoe-Clarke	Inspector
		Hazel Hanrahan	Inspector
		Niamh Greevy	Inspector
		Mary Wallace	Inspector
		Una Coloe	Remote inspector
26 October 2022	09.00-17.00	Sue Talbot	Inspector
		Pauline Orohoe-Clarke	Inspector
		Hazel Hanrahan	Inspector
		Niamh Greevy	Inspector
		Mary Wallace	Inspector
		Una Coloe	Remote inspector
27 October 2022	09.00-15.00	Sue Talbot	Inspector
		Pauline Orohoe-Clarke	Inspector
		Hazel Hanrahan	Inspector
		Niamh Greevy	Inspector
		Mary Wallace	Inspector
		Una Coloe	Remote inspector

Background to this inspection

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

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

Summary of the Findings from Phase 1 and 2

Of the eight standards assessed in Phase 1:

- four standards were judged substantially compliant
- one standard was judged moderate non-compliant
- three standards were judged major non-compliant.

The majority of fosters carers had an allocated link worker and were well supported. However, oversight of foster carers who did not have an allocated social worker required strengthening. There were some gaps in An Garda Síochána (police) vetting arrangements and training in *Children First: National Guidance for the Protection and Welfare of Children* (2017). While assessments of relative and general foster carers were of good quality; there were lengthy delays in the approval of relative foster carers. Foster carer reviews were of good quality, however, there was a significant number of foster carers whose reviews were overdue. The service area took timely and appropriate action to protect children in care, but was not routinely completing reviews following a serious concern or allegation. While the Foster Care Committee (FCC) was well-managed and operated in line with national policy, procedures and guidance; its oversight and monitoring of the outcomes of investigations required improvement. The recruitment of foster carers was becoming more challenging and the area did not have sufficient placements to meet the needs of the service. At the time of that inspection, the service area did not have recruitment or training strategies for its foster carers.

Of the six standards assessed in Phase 2:

- two standards were judged substantially compliant
- four standards were judged moderate non-compliant.

While the majority of children had an allocated social worker at the time of this inspection, there had been significant gaps between statutory visits to some children.

Assessments of children's needs were good quality, timely and comprehensive; with multi-disciplinary input. However, not all children had an up-to-date care plan. Care plans were of variable quality and were not routinely shared with parents, foster carers or relevant others. Child-in-care reviews were not taking place within statutory timeframes for all children. Arrangements for children in voluntary care were not reviewed in line with guidance. Children with disabilities experienced delays and gaps in access to the range of services they needed. Management of complaints, allegations and serious concerns against foster carers was good, however, the safeguarding of children required improvement. The service area had a shortage of foster carers; with a high number of children placed outside the area, and a lengthy waiting list of children awaiting a long-term care placement. Young people in receipt of aftercare services received a good service, but there were delays in referring some young people in line with national policy. Children's records overall were not well-managed, with gaps in the availability and quality of essential documents. Information provided to children on how to make a complaint and the timeliness and recording of complaints required improvement.

Self-Assessment information and what Tusla said about the service

A self-assessment questionnaire (SAQ) was submitted to HIQA by the service area's management team in March 2021. The self-assessment is part of the methodology for this inspection, and it required the management team to assess the performance of the service area against the eight standards relating to governance outlining where improvements were required.

The service area rated its performance as substantially compliant against four standards and moderate non-compliant against four standards. Of the four standards rated as substantially compliant; inspectors found one was moderate non-compliant standard 19 Management and monitoring of foster care services, and one was compliant, standard 25 Representations and complaints. Inspectors agreed with the area's rating of substantially compliant for standard 21 Recruitment and retention of an appropriate range of foster carers and standard 23 The foster care committee. Of the four standards rated moderate non-compliant, inspectors found that all were substantially compliant. This included standard 18 Effective polices, standard 20 Training and qualifications, standard 22 Special foster care and Standard 24 placement of children through non-statutory agencies.

The reasons for the inspection team's judgments are detailed within the report.

Children's experience of the foster care service

Children's views and their experiences were established through speaking with them, their parents, foster carers and external advocates and professionals. Review of case records, complaints, and management and supervision records also provided further information about their experiences.

Inspectors spoke with eight children individually over the phone. All said they were happy overall with their care arrangements. They had no complaints and all were aware of how to complain. In speaking about their social workers, they said:

'She is nice - I see her every couple of months. Sometimes she takes me out on my own and we sit and talk together'.
'My social worker listens to me and tries her best to do what I want'.
'I am able to see my family when I want to'.
'I know what's happening up until I'm 18'.
'She asked me what I liked and what I did not like'.

One child with experience of different foster care placements said:

'Tusla needs to make sure social workers are listening to children and that they are making the right choices about where to place them'.

Children were generally aware of the role of their social worker or social care worker and how they could help them. Children spoken with knew about the child-in-care review process and had completed forms in advance of their meeting; but few said they had attended.

The five parents or family members that inspectors spoke with said they felt involved in children's lives, and that they were listened to and supported at meetings. They said they were aware of how to complain. Comments they made included:

'I have no problems with my social worker. They are really good and make sure my child gets the help they need'.
'Now that they are including me more, things are getting better'.

The 14 fosters carers spoken to individually, together with the seven foster carers who participated in a focus group, were generally positive about their experience of working with Tusla in the Dublin North service area. Most said they valued the support they had received over time from their link social worker.

They said they had regular phone contact, and that support and supervision visits took place when required. Comments they made included:

'Support from the fostering team is brilliant. They always ring me back and call to the house when needed'.
'I can bring up any issues and feel comfortable talking to them'.
'If I need anything, I know they will be there for me at the drop of a hat'.

Foster carers also shared their experiences of support from children's teams. They said:

'We have had the same social worker from day one - she is brilliant'.
'The young person loves the social worker he has now and everything is great'.
'The social worker is a great support with school, assessments and getting appointments'.
'The social care worker is amazing and helps us understand what is going on for the child'.
'The aftercare worker recognises the young person's interests and capabilities and has been helpful with her career choices'.

Less positive comments related to staff turnover and whether they, and the children they cared for, felt listened to.
'It took a while to get to the bottom of the child's needs and for the right support to be put in place.'
'We were not sure what the longer term plan for the child was.'

Foster carers said their experience of the fostering assessment process overall had been positive, although the process was lengthy. They were satisfied with the availability of training and its content. Foster carers said they were well-informed about Tusla policies, including how to make a complaint. However, both children and foster carers said they thought the review forms used for feedback were repetitive. They suggested these could be updated to better reflect the length of time children were in care and the different experiences of foster carers, including relatives.

Most foster carers said they had been given relevant information about children prior to their being placed with them and that social workers regularly saw the children when they first settled into their new home. They also remarked that visiting had reduced over time which did not help maintain good relationships. Social care workers or leaders were seen to provide good support to children who did not have an allocated social worker and foster carers who did not have a link social worker.

Foster carers reported positively on the promotion of enhanced rights for children they had been caring for, for considerable periods of time. However, a few foster carers said they thought the service area could do more to review the appropriateness of voluntary care that had continued over long periods of time.

Foster carers who had been subject to Tusla's procedure for managing allegations or serious concerns said, that although the process had been difficult; overall, they were satisfied with the way issues were dealt with and that everyone had learned from these experiences.

Foster carers told inspectors about the continued shortage of foster carers in the area and that they were increasingly approached to take more children at short notice. They also highlighted ongoing difficulties in obtaining the right services for children, including in some cases needing to take children long distances to access specialist services. They reported long waiting lists for therapists, psychologists and counselling; and that for some children with less high priority needs, the timescales were lengthy.

Foster carers said family contact was encouraged, and that there were generally appropriate arrangements and support for them in managing complex family relationships. However, foster carers also said there was a need to improve local access facilities.

External professionals and agencies generally spoke positively about their relationship with Tusla staff and senior managers. They said they were open to and supportive in working with them to address concerns and in continuously improving services for children.

Overall, case records showed that front-line practitioners had a strong focus on ensuring children in foster care were safe and well-cared for. They gave priority to supporting children with their health and education, including any additional support they required. Almost all of the sample of 26 children's records reviewed by inspectors complied with the time frames set out in child care regulations for statutory visiting, care planning and reviews.

The next section of this report provides an overview of work undertaken to deliver improvements in fostering services following HIQA previous inspections, and assesses the area's current performance. The report outlines where further work is needed to address current gaps in the capacity of foster carers and social work teams to enable a consistently high standard of care and better outcomes for children.

Governance and Management

Overall, the leadership and governance of foster care services in the Dublin North service area was well-structured and provided ongoing monitoring and review of the quality and effectiveness of its services. Managers had clear reporting lines and were accountable for the delivery of safe, child-centred services. Partnership working was strong, and supported good joint working between front-line teams, managers and partner agencies. Senior managers were open to and encouraged new and creative ways of building service capacity. They were responsive to feedback from children and foster carers. However, there was still work to do to ensure all children in foster care had a social worker allocated to work with them and that there was a sufficient number of local foster carers with relevant expertise to meet current levels of need.

Senior managers had a clear strategic direction with service improvement plans to address service gaps, fill staff vacancies and enhance the skills of its workforce and foster carers. Managers sought to ensure the performance standards set out in legislation, regulations and best practice guidance were widely understood and effectively delivered. Regional and area governance meetings ensured regular review of organisational risks and performance trends. Managers closely monitored progress in line with agreed priorities, targets and time frames for action. Service development activity was informed by organisational learning from a number of sources including inspection, complaints and placement breakdowns; as well as feedback from its workforce. The foster care committee (FCC) also played an important role in maintaining high standards and provided feedback about the quality of foster care services and areas for further improvement.

This inspection found the Dublin North service area overall had made steady, and in some cases, good progress against most areas for improvement identified in previous HIQA inspections. However, the number of unallocated children in foster care had increased since the last inspection in 2019. At the time of this inspection, there were 66 children on a waiting list for a social worker whose care was overseen by social care workers and team leaders. Some children had not had a social worker assigned to them for a long period of time. This included a small number of children in non-statutory (private) foster care. Although the service area had an agreed system for monitoring increased risk to children without a designated social worker; inspectors found limited evidence on children's records of use of the assessment tool to record management decisions about their priority for allocation in line with the area's procedures. This included review of any impact for a child, their families and foster carers who did not have a social worker for a lengthy period of time.

During 2022, the service area continued to have a small number of children (and their respective foster carers) who did not have a social worker assigned to them - referred to as 'dual unallocated'. This is unacceptable practice since in these cases no Tusla social worker has oversight of the child or the placement. At the time of the inspection, the service area had three such arrangements. This was a concern to inspectors given the commitment previously made by Tusla's national managers that no child and their foster carers would be without a social worker at the same time. Inspectors raised this issue with the area manager who took immediate action to ensure social workers were allocated in these cases.

In managing these pressures, senior managers had sought to make best use of organisational capacity. The service area had targeted its resources to children in foster care assessed as high priority, while also strengthening compliance with statutory regulations for all children in its care. There was a new duty system to help improve its response to issues for children without an allocated social worker. The new team had helped to significantly improve the area's performance in undertaking statutory visits, care plans and reviews. At the time of this inspection, senior managers reported that the service area was meeting its time frames for all statutory visits, and had significantly reduced the number of reviews that were overdue. Just 17 child-in-care reviews and 16 care plans were over-due. All were less than 10 weeks outside the required time frames. The service area also had 11 unallocated foster carers supported by a social care leader. A duty system was also in place to deal with any issues that required an urgent fostering-related response. It too, was operating satisfactorily in the context of making best use of team resources.

Senior managers recognised and were responsive to the organisational risks and pressures faced by front-line teams. The service area's people management strategies included a clear focus on recruitment and retention; with priority given to staff wellbeing, training and career development. Senior managers were visible and accessible to frontline teams at a number of levels. They were kept well-informed through *'Need to Know'*[2] reports about risks to children or foster carer capacity. Supervision of staff overall was adequately managed, with a working group in place to strengthen practice. However, greater attention needed to be paid to embedding Tusla's performance development and review system to enable all staff and managers to benefit from an annual learning and development plan.

[2] Tusla's governance system for ensuring managers were kept informed about emerging risks to children or to the organisation.

The service area had actively encouraged relevant family and friends to put themselves forward as relative foster carers. Children and their foster carers said these arrangements worked well. However, the service area continued to experience capacity gaps in the availability of local foster carers. This had led to the continuation of children being placed out-of-area and with private providers. The service area had appropriate contract monitoring systems in place to review the performance of private foster care agencies. However, a small number of children in private foster care did not have an allocated social worker and this should be addressed. The service area was working to strengthen its capacity to attract new foster carers and tackle gaps in its emergency and long-term foster care placements though joint arrangements with a neighbouring service area and the regional assessment fostering team (RAFT). Dublin North had also made important strides in expanding the range of training for foster carers, including training for newly approved foster carers and specialist training.

In June 2022, the service area had the highest number of children placed with unassessed and unapproved relative foster carers for more than 12 weeks in the country. This had also been highlighted as a concern by inspectors in the 2017 inspection. Senior managers had implemented a new approach to reducing the number of relative foster carer households awaiting assessment. This involved commissioning private foster care agencies to undertake assessments given the gaps in the capacity of local fostering teams. Inspectors reviewed a sample of these records and found the standard of assessments was good, with improved performance in meeting agreed timescales. At the time of this inspection, work was progressing well to complete the assessments of 22 relative foster carers, and there were four relative carer households still awaiting allocation.

Two private foster agencies had also been commissioned to address the backlog of foster carer reviews and long-term matching of children to foster carers. At the time of this inspection, the backlog of foster carer reviews had been effectively tackled, with plans for completion of the remaining 27 overdue reviews. This was a significant improvement on the 108 foster carer reviews that were outside statutory time frames in 2021.

Previous HIQA inspections had found areas of weak practice in the governance of allegations against foster carers, including how incidents were assessed and managed and how information was shared with An Garda Síochána and the FCC. This inspection found a number of improvements had been made, with evidence of stronger joint working and implementation of safety plans. Overall, support for children and their foster carers had been strengthened, with tighter tracking of outcomes at the conclusion of investigations.

Governance of the foster care committee (FCC) was strong. The work of the FCC was effectively linked to wider service improvement and area governance priorities enabling a shared approach to continuously raising standards. The FCC chair was supervised by the area manager, and provided updates to the area management and children in care governance meetings. The chairperson also met quarterly with principal social workers to share learning about good practice and areas where further improvement was required. This promoted shared understanding and accountability for ensuring statutory requirements were met.

Although the service area did not have any special foster carers, there was evidence of good joint working with other health and education professionals and community agencies, with regular joint review of children awaiting specialist services. The senior management team sought to address the urgent health and education needs of children in the absence of wider agency resources. However, further work was required locally and nationally to ensure timely identification and levels of resource to meet children's emotional, behavioural and mental health needs and disabilities. The service area gave priority to ensuring foster carers had the levels of training and support they needed to continue to look after children with a range of needs and disabilities.

Inspectors found children's records overall were of an adequate quality, but there were some delays in completing or uploading records onto NCCIS Tusla's electronic case management system. Better quality records routinely included the voice of the child alongside observations of their relationships with others and timely progression of care plan actions. Since the last inspection, the service area sought to make better use of chronologies to provide a clear picture of significant events in children's lives which formed a central part of the child's care record. The area's case transfer protocol for example, required practitioners to prepare a chronology as part of the transfer record when children moved between social work teams. Foster carer records overall were adequate; but did not always provide an up-to-date picture of children previously placed in the household. Managers had appointed additional administration staff to help address delays in recording and uploading documents and offered protected time to help practitioners catch up with outstanding work. Manager audit of the quality of case records, however, was under-developed; and was not yet providing good assurance of the quality of practice.

The service area had also effectively strengthened its systems for managing complaints since the last inspection. Learning from complaints and compliments was a key part of the area's governance system. A good standard of complaints management practice was evident in line with Tusla's *Tellus* procedures.

Overall, this inspection found the Dublin North foster care services had strong leadership and an improvement-driven culture. There was a clear programme of work to continually strengthen the quality of local services and the area's compliance with statutory regulations. The culture of the organisation was positive and aspirational. There was a strong sense of working together within and between teams and with partner agencies to meet children's needs and provide improved support to foster carers. Senior managers had clearly recognised gaps in organisational capacity and had appropriate plans in place to strengthen the recruitment of social workers and foster carers, which remained areas of risk for the service area. Nonetheless; a sustainable solution was needed to ensure all children in the care of the State had an assigned social worker. Eliminating the practice of 'dual unallocated' children and foster carers; and ensuring all children in private foster care had their own social worker, remained priorities for improvement.

Standard 18 : Effective Policies

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

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

The Dublin North service area had clear plans, policies and procedures for the delivery of safe and effective foster care services. Inspectors found that staff at all levels were aware of the standards of practice expected of them. Partnership working with children, foster carers and other agencies was strongly promoted and was leading to innovative practice in some areas. However, although the service area had detailed recruitment and retention strategies for social workers and foster carers; the impact of such plans in sustainably addressing service gaps and unmet need had not yet been realised.

Since the last inspection, the service area had strengthened its arrangements for consulting with and learning from the experiences of children. The Young Person's Fora[3] and the Aftercare Forum were making a significant contribution to promoting child-centred practice. Children were being supported to share their personal experiences about what would help them feel safer and cope better when they were placed in care. They were also encouraged to speak about what they wanted for their future.

[3] Group for young people to enable them to have their say about the things that matter to them

Managers had listened to and taken action in response to their feedback. For example, initiatives such as 'care bags' had been introduced to support children when they were admitted to care. These contained amongst other items a cuddly toy, blanket and a letter of encouragement from other children about their experience in care. This was highly valued by children, and was recognised by the service area's achievement in receiving Tusla's *'Investing in Children'* award.

Foster carers told inspectors they had been provided with updates to organisational policies and procedures and felt well-informed about their responsibilities for looking after children placed in their care. Attendance at coffee mornings and the annual celebration event hosted by the area manager recognised their important contribution as part of a wider team working together to improve outcomes for children. Foster carers said they valued the support they had received in helping them to understand the issues children were dealing with. The service area had recently set up a support group for the birth children of foster carers, recognising the important role they played in welcoming and sharing their home with other children.

The service area had introduced a local policy and procedure for responding to the needs of unallocated children in care. The service area had 26 children in foster care on its waiting list at the time of this inspection and a further 40 children were assigned to social care workers and team leaders. Those on the waiting list had been assessed as medium or low priority. The policy required that a prioritisation tool be completed and attached to each child's case record. However, inspectors found that only some children's records contained a completed risk assessment with agreed management actions. While the new duty system prioritised children who were due a statutory visit or child-in-care review; there were some children and young people who remained on a waiting list for allocation for long periods of time. Team leaders or another social worker routinely accompanied social care workers undertaking statutory visits. While, this provided assurance that this task was undertaken by suitably qualified staff, and efforts were made to ensure continuity of staff; such practice was not in line with foster care standards for each child to have their own named social worker.

The service area had also a policy and procedure to support its management of unallocated work with foster carers. Monthly reviews were held that kept track of unallocated relative foster carer assessments and delays in foster carer reviews and long-term matching activity. The process enabled shared discussion of alternative methods of service delivery, including commissioning private foster care providers to undertake key pieces of statutory work. The fostering team had a designated person who had oversight of the work contracted out. In addition, a social care leader was deployed in the absence of a link social worker to provide ongoing support to 11 foster carer households who were unallocated. A social worker or the fostering team leader also accompanied the social care leader when undertaking their statutory visits.

The unallocated case procedures also set out the expectation that social care workers or social care leaders would receive monthly supervision of their caseload. Inspectors found that although supervision was mostly regular, it not always in line with the expected frequency or standard set out in Tusla's policy. Where team leaders were case-holders for children, principal social workers provided their case supervision. While such systems ensured essential work was delivered in line with standards; there was growing pressure on the capacity of team leaders to balance case management responsibilities with their wider governance and service development priorities. The need to fill the remaining vacant social work posts remained a critical priority for senior managers in assisting the service area to move to a position where all children and foster carers had the levels of ongoing support they needed.

Children and foster carers told inspectors they understood the different roles of practitioners or agencies supporting them. One experienced foster carer advised that she had not seen any difference in the way her recent foster care review by a private foster care agency was undertaken; saying 'you could not tell the difference, they were both equally good', in comparing this experience with an earlier review undertaken by a Tusla link social worker. External agencies, however, told inspectors they would welcome further clarity about Tusla's longer-term strategies for outsourcing such statutory work.

The service area regularly reviewed and updated its approved panel of foster carers at monthly team managers' meetings and in governance meetings between the FCC chair and principal social workers. The level of demand for foster carers, however, continued to exceed the number of approved foster carers for children newly admitted to care and those who required long-term care. The service area continued to rely on the availability of private foster carers outside the local area. This in turn put additional pressure on the capacity of social workers given the time and travel commitments involved in visiting and promoting children's contact with their family. Managers had introduced a short-term solution to easing such pressures over the summer period through commissioning a trusted local agency to employ student social workers to undertake access visits. Senior managers acknowledged a longer-term solution was still needed to reduce its dependence on private foster care agencies as set out in its recruitment strategy for foster carers.

Dublin North followed the national transfer policy for children it placed outside the area and maintained caseload responsibility for these children. Case records reviewed by inspectors, indicated good joint working with other service areas and providers. The service area did not have any foster carers who transferred into Dublin North in the past 12 months.

Changes to local and national policies and procedures were regularly discussed at management meetings. The service area had implemented Tusla's new child abuse substantiation procedure (CASP, June 2022) to guide its practice in investigating allegations of abuse against foster carers. Initial training had been provided for all staff. Managers were working to embed the new arrangements, including case recording requirements. External agencies highlighted there was a need for greater clarity in Tusla's arrangements for managing serious concerns. They would welcome further guidance about the new CASP approach specific to foster carers.

Dublin North had developed open and effective joint working arrangements with partner agencies. Children's case records showed that schools and specialist services were actively involved in care planning for children. The area manager funded additional therapy and special needs input for children who required urgent and intensive support to help maintain their foster or school placement in circumstances where other public bodies did not have resources to respond.

Senior managers' relationships with the Health Services Executive (HSE) and its clinical leaders was strong, with evidence of a shared approach in working together to improve access to specialist services. Monthly integrated care management meetings and area governance meetings ensured regular review of children who were awaiting specialist assessments and or therapeutic support. Joint support and funding for children with complex needs and disabilities was carefully considered in line with the Joint Protocol between the HSE and Tusla. However, service gaps remained in relation to access to assessments for autism, therapeutic and psychological supports and some children still had to wait years for the help they needed. This impacted particularly on those deemed to have lower priority, with the risk of some young people ageing out of care without the additional help they needed.

Overall, the service area had appropriate policies and procedures that assisted the delivery of high quality foster care services. Senior managers made effective use of partnership working with other agencies to strengthen local capacity. However, further work was required to address ongoing gaps in access to specialist assessments or the availability of therapeutic support.

Judgment: Substantially compliant

Standard 19 : Management and monitoring of foster care services

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

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

Overall, inspectors found the Dublin North service area was well-led and benefited from a stable and experienced senior management team. The culture of the organisation was open, supportive and encouraged child-centred practice. The service area's strategic and service improvement plans were informed by, and updated in line with identification of changing risks and service needs. Senior managers had formed strong partnerships with other agencies which enabled them to make best use of wider expertise. It also assisted them in carrying key tasks the service area itself did not have the capacity to deliver. Senior managers actively promoted organisational learning and review of organisational successes and mistakes, including from inspection and placement disruptions. However, the service area still had work to do to prevent reoccurrence of the 'dual unallocated' children and foster carers. As well as ensuring that all children placed in private foster care had a Tusla allocated social worker to oversee their placements.

Since the previous inspections, the service area had continually strengthened its leadership and governance arrangements; including management accountability and oversight of practice. The service area was led by an area manager and there were two principal social workers responsible for children-in-care, foster care and aftercare services. They supervised the work of fostering and children-in-care team leaders and an aftercare manager. Front-line staff told inspectors that their managers were easy to contact, provided good support and encouraged joint working. The chief officer for the Dublin North East region and their team maintained good oversight of the performance of the service area through quarterly regional governance meetings. This helped to identify shared risk and the need for changes to the allocation of resources in response to organisational challenges. For example, the regional chief officer had recently approved the appointment of a third principal social worker to strengthen the governance of children newly admitted to care.

Monthly governance meetings, chaired by the area manager, promoted effective scrutiny and review of operational activity, emerging risks and performance metrics and trends. This included routine reporting of unallocated children in care and foster carers, overdue statutory visits and reviews, voluntary care and the progress of serious concerns and allegations, complaints, and foster carer assessments.

Data analysis also included children with disabilities and or complex needs who were awaiting specialist assessment or support and outstanding medicals for children-in-care. Meeting minutes indicated a steady reduction in waiting times in some areas of performance, with an ongoing programme of work to provide assurance of the quality of its data. Analysis of performance reports also assisted the area in monitoring trends in meeting fostering regulations concerning Garda vetting checks, medicals and the coverage of *Children First* training.

The service area's approach to the identification and management of organisational risks was well-developed. The areas of highest risk related to its capacity to fill vacant social worker posts and expand the provision of local foster care placements. Risks to the sufficiency of staffing had led to a comprehensive review of the workforce in August 2021. The regional chief officer had approved the establishment of additional team leaders and social work posts and the reconfiguration of resources to enable the appointment of non-social work roles within front-line teams. New social work graduates had been attracted to work in the area. The service area had developed a joint approach with its neighbouring Dublin North City service area to encourage better community awareness of fostering.

The foster care committee annual report (2021) provided key information in line with the requirements set out for Tusla's *'Adequacy of the Child Care and Family Support Services'* report. The FCC annual report provided key information about levels of demand and the effectiveness of local foster care services, which helped inform future recruitment and retention and training strategies for foster carers.

Senior managers were kept well-informed about risks to children through supervision and the *'Need to Know'* risk escalation process. This helped managers monitor escalating concerns such as gaps in the availability of suitable long-term placements for children with disabilities. Children's records indicated good support from senior managers in working with partner agencies to address these issues. This included joint working with housing and the HSE to secure building adaptations and specialist equipment to help maintain children's placements.

The Dublin North service area reported 21 adverse events up to the time of the inspection in 2022. Ten of these were COVID-19 related. Case records sampled by inspectors demonstrated appropriate follow-up and management of risks to children's safety. Front-line staff were aware of their responsibilities for children missing from care and ensured appropriate information-sharing with An Garda Síochána. The area reported three missing-from-care episodes in relation to one child in foster care over the past year.

Inspectors found that foster carer allegations or serious concerns had been correctly categorised and reported to the FCC, with relevant actions taken to protect children in line with *Children First*. Strategy meetings ensured regular monitoring and joint discussion of risks of harm to children. All case records sampled by inspectors had safety plans that set out clear actions to protect children; and where appropriate, to work through crises to help maintain their placement when this was in the best interests of the child. Children's views and wishes were clearly recorded within these safeguarding arrangements. However, review of case records also indicated capacity pressures in a couple of cases. This included a three-month gap in available records on one child's case, and an outstanding action in relation to a child's use of social media in another.

The service area reported six placement disruptions in the past 12 months. Multi-disciplinary professionals meetings were routinely held for placements at risk of breakdown and for complex cases. Team leaders were responsible for completing reviews and presenting placement disruption reports to the FCC. Disruption reports reviewed by inspectors identified areas for learning including strengthening the knowledge, skills and availability of support for foster carers looking after children with complex needs. The placement of siblings and matching of children's individual needs with the level of experience of foster carers were also recognised as areas of practice to strengthen. Counselling support was widely offered following placement breakdowns, and any further placements moves were carefully considered.

The senior management team had good arrangements for commissioning and monitoring the performance of community and voluntary sector providers. Inspectors observed a contract monitoring and referrals meeting chaired by the area manager. The focus on agency accountability was strong and ensured effective discussion of the quality of service required. Children with high and complex needs were identified for early allocation. Priority actions and next steps for each new referral were clearly identified and jointly agreed. Participants also reviewed the impact of work undertaken prior to case closure.

Social workers and managers made appropriate use of the service area's complex cases forum to explore the best care options for children where there were ongoing challenges in keeping them safe or finding the most appropriate care placement. Inspectors observed a complex cases forum and found that meeting participants made effective use of visual aids to explore the time span, severity of risk and impact of trauma on a child. Discussions helped to build a shared picture of what practitioners and managers were worried about and what appeared to be working well. The process was child-centred, with good challenge and support from senior managers in helping to map future actions.

At the time of this inspection, the service area had three children and their respective foster carers who did not have an allocated social worker - 'dual unallocated'. A similar number of children had been reported as 'dual unallocated' within governance meeting minutes over the past 12 months. Senior managers routinely monitored this data, but this had not led to these children and their foster carers being allocated up to the point of this inspection.

Inspectors reviewed the records of these three children. Two of the children had not had a social worker allocated to them for over three years, and a further child had remained unallocated to a social worker since they transferred from the assessment and intervention team 12 months earlier. All three children were being supported by social care workers while awaiting a social worker being assigned. For one dual unallocated child, there were growing concerns about their needs and risks to their placement. Although this had not prompted timely re-prioritisation and allocation to a social worker; team leaders from both fostering and children-in-care teams ensured relevant follow-up actions were taken. Inspectors raised these children's circumstances with the area manager who took immediate action to assign social workers.

Inspectors reviewed the service area's unallocated children management tracker and considered the period of time that had elapsed since children were last assigned their own social worker. In all cases, a team leader or social care worker was named as the main contact for the child. However, a total of 22 children were awaiting allocation for three years or more. For one child it had been over five years since they had an assigned social worker. The majority of these children (58) were on voluntary care orders and ranged in age from three to 17 years. The list also included eight children in private foster care, three of these were living some distance outside the service area. The needs of pre-school age children and those placed in private foster carer needed further review in making decisions about children's priority status and urgency of allocation.

While inspectors did not identify that any child was unsafe in the sample of children's records reviewed; there was limited evidence that their unallocated status had been regularly reviewed. Few of the children's records contained the prioritisation tool in line with the area's procedure. While the tool provided a structure for identifying children who were high priority for allocation, other key issues in relation to the distance children were placed from home and the impact for them given the length of time they had been without an assigned social worker was not adequately captured.

As highlighted in an earlier section of the report, while the child-in-care duty system was effective in ensuring statutory visits, care plans and reviews were undertaken by social workers; the levels of visiting meant that some children did not have opportunities to build their relationship with a social worker, and oversight of their needs between statutory interventions was limited. In turn, key milestones in children's development or early changes in their individual needs were at risk of being missed.

Inspectors also reviewed a sample of unallocated foster carers that were open to a social care leader under the direction of a fostering team leader. Inspectors found the quality and frequency of support to foster carers overall was satisfactory. However, inspectors considered that given the level of risks and complexity within one case, the earlier assignment of a link social worker may also have been appropriate.

The service area had implemented a tight management system for overseeing the quality and timeliness of its assessment and approval of relative foster carers. Monthly allocations meetings helped identify whether the team had capacity to complete assessments or whether they needed to be contracted out. In these cases, a nominated member of the fostering team continued to have oversight of the assessment. Once the assessment was completed and approved by the foster care committee (FCC); a fostering link worker was appointed to support the ongoing development of foster carers. Recently approved foster carers told inspectors they were satisfied with the levels of support they had received. However, the process had been a lengthy one for some foster carers, well outside the expected 16 week timeframe set out in Tusla's guidance.

Some staff across fostering and children-in-care teams continued to carry high caseloads, and the impact of this was monitored in supervision. Managers recognised the intensity and complexity of work undertaken; and individual practitioner and team capacity was regularly reviewed. Senior managers were kept informed of the small number of front-line practitioners and managers with unmanageable workloads. Inspectors' review of records indicated staffing pressures in some cases had impacted on the capacity of front-line staff and managers to maintain up-to-date case records or complete key projects within desired time frames.

Since the last inspection, service managers had undertaken a detailed review of organisational demands, workforce resources and gaps in capacity and expertise. They had consulted with front-line staff and managers about their support needs, priorities and best ways to manage pressures. The area had secured additional funding for administration staff to ensure data held on NCCIS was accurate.

Additional administration staff had helped to deal with the backlog of case records awaiting uploading to children's case records. However, frontline staff advised inspectors there was a need for greater stability and flexibility in the use of administrators, including the two-week notice period for minuting meetings.

Front-line managers were tasked with ensuring the children-in-care register was accurate and kept up-to-date. The service area had recently developed a new approach that provided a clear picture of the status of each child's statutory review, care plan and statutory visit. Tracking compliance with regulatory time frames was also routinely monitored in supervision.

Inspectors found that in the sample of 26 children's records reviewed, the frequency of statutory visits, care plans and reviews was mostly in line with statutory requirements, with evidence of steady improvements in practice in the last 12 months. In a minority of cases, however, the quality of recording practice was weak. For example, there was insufficient evidence of children's views, a lack of exploration of their cultural or ethnic backgrounds, or delays in actions following statutory visits or implementation of care plan actions. Most of the 19 foster carer records sampled by inspectors were adequate. They contained relevant information about foster carer's assessments, the quality of matching and effectiveness of the placement, including the twice yearly statutory support and supervision visits. There was limited evidence, however, of management audits of children's and foster carers' records. Wider assurance of the quality of practice would enhance the area's governance and strengthen the continuous professional development of its workforce.

Overall, the service area was well-led, with good management scrutiny of its performance. The impact of its service improvement activity since previous inspections was evident in a number of areas; however further work was required to ensure all children and foster carers had an allocated social worker, and that the local area had a sufficient number of foster carers to meet children's needs. Achieving a consistently high standard of performance required tighter review of the risk assessment process for children who did not have an assigned social worker. Increased use of case audits would also provide further management assurance of the quality of work with children, including the maintenance of their case records.

Judgment: Moderate non-compliant

Standard 20 : Training and qualification

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

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

Overall, senior managers gave priority to ensuring frontline-staff and managers were professionally qualified, appropriately trained and supported in line with their roles and levels of accountability. While the recruitment of staff remained an area for further improvement, the service area had a number of initiatives to help fill its vacancies. However, systems to support the professional development of its workforce needed to be embedded.

The service area had appropriate systems for appointing staff, including for An Garda Síochána (police) vetting and checks of social workers' registration with their professional body (CORU). The process for annual renewal of registration was well-managed by the area manager's office. However, there were some inconsistencies between locally and nationally-held records.

Inspectors reviewed 10 employment records held centrally in the national personnel records office in Dublin. Garda vetting was in place and up to date for all records. However, three employee records did not have evidence that their CORU registration was up to date. One record did not contain any professional qualifications and three records did not contain references relevant to their current roles. The inspector provided feedback to the service area about the missing employment records, and was assured in writing that these gaps would be addressed. Staff supervision records held locally contained relevant records of CORU registration and coverage of mandatory training. File audits undertaken by the area manager's office provided assurance that the required documents were in place.

Since the last inspection, the service area had implemented a comprehensive staff wellbeing and retention strategy. This had a strong focus on ensuring staff were equipped with the required knowledge and expertise, and that they felt well-supported and fulfilled in their roles. The service area had a good induction programme for newly appointed staff, with ongoing support provided through mentoring and learning groups. In addition, joint working with other professionals and partner agencies helped strengthen practitioner's knowledge and understanding of children's complex needs.

The wellbeing and retention strategy also sought to promote a career structure for staff. Additional senior practitioner posts had been created, and there were opportunities for social care practitioners to undertake social work training. The service area also actively encouraged social work placements, and this had proved to be an effective means of recruiting new staff.

The provision of regular supervision and team meetings also aimed to promote a jointly accountable and supportive work environment. Some teams had adapted the scoring model used within child safeguarding work within supervision, to enable shared discussion about what was working well and what required strengthening. A new working group had been established that was working to promote a consistent approach to supervision that was also reflective of different roles, professional accountability and seniority.

Inspectors reviewed the supervision records of 10 managers and six frontline practitioners. Supervision records of managers had a strong focus on governance and oversight of risks, with checks for the effectiveness of service delivery. Records routinely included discussion of staffing capacity, compliance with regulations, complex cases, '*Need to Knows'* and compliments and complaints. In addition, unallocated cases, allocated to team leaders, were also discussed in supervision with their principal social workers. Managers' records indicated they had attended training appropriate to their leadership roles and wider service improvement priorities.

The frequency of supervision was not always in line with the time frames set out in individual contracts; but the reason for delay was generally documented. Supervision contracts were generally available on most records, however, not all had not been reviewed on an annual basis. Supervision records of front-line practitioners mostly contained review of issues for children or foster carers. Priority actions for the manager or case-holder were clearly recorded where gaps in practice were identified. However, inspectors found that some supervision records contained repetitive information that had not been updated, that required further management review.

The service area had undertaken a training needs analysis and had a training plan for its workforce that was reviewed on an annual basis. Managers were aware of and responsive to gaps in the quality of social work practice. For example, a learning programme had been developed to help build practitioner skills and confidence in writing children's care plans. Team and senior management meetings also helped to routinely map gaps and emerging learning and development priorities. Joint training, involving social workers and foster carers learning together, had been strengthened. Six joint events had been held in the past 12 months.

Joint training covered areas of shared interest such as aftercare, positive behaviour management approaches, trauma training and 'making moments meaningful' through engaging and building relationships with children. However, some front-line staff reported workforce pressures had on occasion impacted on their availability to participate to the extent they would have wished.

Managers acknowledged the need to give more time to the promotion and review of personal development plans, recognising that this activity sometimes 'comes last' in the face of other workload pressures. Inspectors found that six out of the 10 management records did not have an up-to-date annual performance development review and plan, and only two of the six front-line practitioner's files contained the relevant up-to-date documentation.

Overall, the service area had clear systems for the recruitment, retention and ongoing support to practitioners and managers. Supervision was of an adequate standard; but the quality of a few records required development. While the learning and development skills of staff was widely promoted, the service area had not yet fully embedded Tusla's staff development and review process.

Judgment: Substantially compliant

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

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

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

The service area had clear plans and strong local and regional partnerships to help continuously build its capacity to recruit and retain an appropriate range of foster carers. While the service area had continued to expand its recruitment of relative foster carers; there remained gaps in its provision for children newly admitted to care and those who required long-term placements. This had led to the continued use of out-of-area placements and private foster care agencies.

Children were placed with relative foster carers and in their local communities when this was appropriate to the child's needs and family circumstances. The Dublin North service area had continued to strengthen its recognition and support for relative foster carers. Inspectors found that their emergency approvals had been completed in a timely manner, with in-depth initial assessment reports on all relative foster carer records sampled. However, given workforce capacity challenges in the fostering team, some assessments had continued over lengthy periods of time; with further requests to senior managers to extend the initial approval period pending full assessment. The longest assessment had been in progress for over three-and-a-half years. There was a clear rationale for this; with a good system now in place to prevent such lengthy assessments. Tight management scrutiny ensured ongoing assessments were now being completed within agreed time frames.

The service area continued to promote and refine its fostering recruitment activity jointly with the Dublin North City area and the regional assessment fostering team (RAFT). Over the past seven months, seven recruitment campaigns had been held. Out of 27 enquiries made to the service area, just three had progressed to the application stage. All enquiries were followed up within one to three working days - well within Tusla's target five-day time frame. In addition, the RAFT team had received 32 enquiries from prospective foster carers living in the Dublin North area in the past year. Six of these applicants had been approved, and a further four general foster carers were in the process of assessment.

Local fostering teams reported positively on the role and support they had received from the RAFT team. Monthly joint recruitment and retention meetings helped ensure a continued strong focus on foster carer recruitment and the qualities and skills required of foster carers. The service area had plans to expand representation from other ethnic or cultural backgrounds including from Traveller and Roma communities.

Two senior practitioners shared responsibility for recruitment and ensured a strong fostering presence at local community events, with targeted 'word of mouth' activities. Foster carers were encouraged to participate in recruitment activity.
The service area had effective systems for tracking the timeliness and progress of Garda vetting and medicals. The RAFT fostering team ran a support group for newly approved foster carers. This approach helped to promote friendships and support between foster carers. It also provided early feedback of their experiences and any emerging issues as they build their confidence and relationships with children.

Since the last inspection the service area had implemented a detailed foster care training strategy which had been informed by feedback from foster carers. The fostering team had a lead training officer responsible for developing and implementing a range of training events for the year.

Foster carers spoke highly of such training, although there were occasions when events had not taken place as planned, due to low take-up. A minority of foster carers had not yet accessed all required training, and a few foster carers living out of area highlighted issues for them in accessing training. These gaps were clearly identified within support and supervision visits and FCC approval recommendations.

Front-line staff and managers recognised that on occasion, the scarcity of placements had impacted on the quality of the matching process. At the time of the inspection the service area had a total of seven foster carer households that were over the numbers of unrelated children they had been approved to care for. Inspectors sampled these records and found that link social workers regularly monitored the capacity of foster carers and the experiences of children. In some cases, additional respite support was offered.

The service area had strengthened its focus on ways to retain foster carers. The area was striving to ensure foster carers felt respected and part of a wider team caring for children. A foster care newsletter and coffee mornings helped to promote awareness of new developments and celebrate foster carers' and children's achievements. The area offered a good range of additional training tailored to the specific needs of children and interests of foster carers. The contribution of foster carers was sought and acknowledged at their reviews and through support and supervision visits.

Over the past 12 months, four foster carers voluntarily left the panel. All had exit interviews which helped to identify ongoing learning about what worked well for them and areas of practice to strengthen. Their feedback was being used to shape future recruitment, training and retention activities. They highlighted the importance of training and access to specialist support, but also the need to ensure contact and support from social workers was maintained over time. The service area did not have any foster carers that had been formally removed from the panel following investigation of an allegation or serious concern.

Overall, the service area had some success in building its foster carer resource, with clear systems and strong partnerships in place to expand its approaches to the recruitment, development and retention of foster carers. However, gaps remained in the adequacy of local placements to reduce reliance on out-of-area placements.

Judgment: Substantially compliant

Standard 22: Special Foster Care

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

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

Tusla nationally did not have a policy or procedure for the provision of special foster care as set out in the *National Standards for Foster Care* (2003). Although the Dublin North service area did not have any special foster carers, it had identified 52 children who required specific additional support. The area manager had approved enhanced payments for 10 foster carer households and 23 households were in receipt of other additional support. In addition, six private foster carers received additional funding in recognition of the complexity of needs of the children they were caring for. The service area's children-in-care register provided a clear picture of the numbers and needs of children with a disability or other complex needs who required a high level of specialist support and supervision.

The service area had a strong ethos of multi-disciplinary working which enabled effective monitoring and support for children's individual and changing needs. Foster carers were an integral part of these arrangements. They had received further training and support in implementing strategies to keep children safe and promote their health and development. Case records showed there was a high level of joint working between Tusla's front-line teams and specialist agencies.

Senior managers were working to expand their service offer to children with a range of complex needs impacted by their earlier childhood experiences. The service area directly employed a clinical psychologist and two art therapists. The psychologist provided consultation to social workers and to foster carers in the management of children's behaviours, and also undertook direct work with some children in relation to attachment and trauma. Their role in transition planning for children whose placement was at risk of breakdown was highly valued.

Inspectors reviewed a sample of records of children with disabilities or complex health needs and overall, found the standard of oversight and support to be good. Foster carers spoken with reported that they valued the additional support they received. One foster carer also commented on the importance of having respite breaks built into the child's care plan as a back-up support. The service area was working to strengthen the availability of respite for children in foster care, having recognised its benefits for some children and foster carers.

Overall, there was good joint working and recognition of the need for additional support for foster carers caring for children with high and complex needs. These arrangements had not been formalised as 'special foster care' given Tusla did not yet have an agreed strategy, policy and guidance for this. Nonetheless, the service area had provided additional resources and training for some foster carers, and was working to expand its respite care provision.

Judgment: Substantially compliant

Standard 23: The Foster Care Committee

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

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

The Dublin North Foster Care Committee (FCC) was well-led by a suitably qualified, independent and experienced chairperson. Its operations were guided by Tusla's *Policy, Procedure and Best Practice* guidance. Its members had diverse and relevant knowledge and expertise about the needs of children in care and the aptitudes of foster carers. Members recognised their accountability for ensuring the 'best interests' of children were kept at the heart of all decision-making and that the contribution of foster carers was clearly recognised. External agencies gave positive feedback to inspectors saying that meetings were well-managed and structured by the chairperson. They considered that the FCC had good oversight of its panel of foster carers, and that it made clear well-balanced decisions about the approval of new foster carers.

Inspectors reviewed 10 of the 18 committee members' personnel records for assurances about their suitability for the role. Their records indicated they were appropriately qualified and experienced, and all had up-to-date Garda clearances. The committee had wide representation and regular attendance from other agencies, with good engagement of two care-experienced adults and a foster carer. The chairperson met with all new members and outlined their responsibilities in line with FCC policies, procedures and guidance. However, there had not been any recent induction or annual training for members. This was an area of work to build on.

Foster carers were encouraged to attend and give feedback to the committee; but levels of engagement had been relatively limited. Service managers recognised this was an area of practice to strengthen in reviewing the quality and impact of the committee's work. Social workers were encouraged to attend in person so that all queries could be heard and responded to in a timely manner.

An inspector observed a foster care committee meeting as part of the inspection fieldwork. They found the meeting was effectively run, with detailed discussion and analysis of foster carers' suitability, parental qualities and experience. There was thoughtful discussion of the capacity of foster carers to look after children within particular age groups or specific additional needs.

FCC members used a competency-based tool to help them make decisions about the suitability and additional support needs of prospective foster carers. They provided appropriate challenge of the quality of social work records and gave feedback on areas of practice to strengthen. This included ensuring records were child-centred and made good use of words and pictures to promote the wishes and feelings of children.

Members also gave good consideration to the sustainability of children's placements over time and the ongoing suitability of foster carers within their first and subsequent three yearly reviews. Approval decisions and recommendations provided clear direction about foster carers' ongoing support needs. Where there were restrictions to approval or refusal, the rationale for this was openly discussed and documented.

Arrangements for notifying the FCC of serious concerns and allegations, and the outcomes of follow-up investigations were timely and appropriately tracked. The FCC was strong in its challenge of requests for the placement of children in households that were above the numbers of children foster carers had been approved to care for. Decisions were appropriately taken to delay the re-approval of foster carers where key documents such as up-to-date Garda vetting was missing. Recommendations set clear time frames for completion of mandatory training.

The FCC had strong links with front-line teams and private foster care agencies. There were clear processes for the co-ordination of documentation to ensure all relevant reports were available to inform the decisions of the FCC. Meeting agendas gave priority to new foster carer assessments. Additional meetings had been held to address the backlog of outstanding foster carer reviews, with dates scheduled for the remainder. This had led to a reduction in delays or the need for re-submission of foster carer reviews or long-term matching approvals due to children's care plans being out-of-date.

The FCC annual report (2021) provided all relevant information about its performance and activities in line with national standards. Over the past 12 months, FCC members considered seven new foster carer assessments, 14 allegations or serious concerns, six placement disruption reports, 47 foster carer reviews, nine long-term matches and seven foster carer households with children placed above the numbers approved for.

Overall, the foster care committee (FCC) was well-run and played an effective role in the approval and review of foster carers. It provided good challenge in shared work alongside the area's senior managers in raising standards of practice. However, the induction and ongoing training of its members and improving the levels of the attendance and feedback from foster carers were areas to strengthen.

Judgment: Substantially compliant

Standard 24: Placement of children through non-statutory agencies

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

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

The service area had appropriate systems for providing assurance of the quality of care provided by private foster care agencies. Contract monitoring meetings were well-established and helped to identify and move forward individual and joint agency priorities for improvement. At the time of this inspection, however, not all children in private foster care had an assigned social worker which impacted on the frequency that children were seen.

Although statutory visits and reviews of children in private foster care were generally in line with the required time frames; there were some delays in foster carers receiving children's up-to-date care plans. Communication with private foster care agencies overall was adequate, with case records providing examples of good engagement of Tusla staff alongside private agencies in addressing risks to placements or reviewing support for children with complex needs.

The service area had a total of 62 children placed with five different foster care agencies. The number of children placed, although higher than previous inspections, had remained relatively stable over the previous 12 months. However, given the lack of sufficient local placements, demand remained high and all providers faced challenges in meeting placement requests. For example, one provider noted that they had received 100 referrals from the North Dublin service area over the past 12 months, but had only been able to place six children.

A principal social worker was responsible for holding twice yearly contract monitoring meetings with private providers. Tusla staff were encouraged to provide feedback about children's experience of private foster care and of their experience of working with the partner agency's link worker. The service area also provided feedback on the performance of private providers to Tusla's national lead manager for commissioning who was responsible for overseeing service level agreements with private foster care agencies.

Private foster care providers told inspectors that managers were approachable and open to professional challenge. They said there had been occasions when Tusla's staff had not provided information in a timely manner. However, these issues had been promptly resolved once they had been brought to the attention of local managers. One provider said they would welcome further discussion about the levels of additional support they could expect from Tusla in caring for a child with complex needs.

Tusla staff and non-statutory foster care agencies reported an open, shared approach to meeting children's needs. Ten children had moved from Tusla's general foster carers to private foster carers over the previous 12 months. Inspectors found that transitions between agencies were well-managed, with good joint working to secure a suitable long-term placement for a child. Strategy meetings were held for children whose placements were at risk of breakdown to jointly review risk and plan next steps in the best interests of children.

Overall, the service area had appropriate contract monitoring systems in place that provided assurance of the quality of care provided by private foster care agencies. Joint working was adequate overall, but required strengthening to ensure all children in private foster care had an assigned social worker and that delays in key information being shared were minimised.

Judgment: Substantially compliant

Standard 25: Representation and complaints

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

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

The Dublin North service area had good systems for promoting learning from complaints and compliments. Service managers clearly recognised the importance of hearing and learning from the experiences of children, parents and foster carers. They received quarterly updates and annual reports on trends or themes emerging from complaints, and ensured all staff attended complaints management training. Complaints examined by inspectors indicated good compliance with Tusla's '*Tellus*' complaints management process.

Senior managers ensured staff across the organisation had a good understanding of their accountability for ensuring children were able to speak about any problems, concerns or complaints they had. They actively promoted children's and foster carers' right to complain if they were not happy about the quality of the service or support they received. There had been no appeals of foster care complaints in the last 12 months.

A training event had been held early in 2022 to share learning from complaints that had been investigated the previous year. Managers promoted the role of advocacy organisations ensuring that children and young people were provided with Tusla's '*Tellus*' leaflets and information about local advocacy organisations who could offer any additional support they needed while their complaint was being investigated.

Social workers ensured children were aware of their right to complain at each of their statutory visits and reviews. The area manager's office conducted audits to make sure the complaints process was effectively embedded in practice. Taken together, these approaches helped ensure most complaints were resolved in a timely manner and at stage 1, the local level.

The service area had received a total of 10 complaints and 25 compliments about its foster care services over the previous 12 months. Just one complaint was received from a child, the rest were from parents, foster carers and others.

Nine complaints were locally resolved and all were investigated in a timely manner. Issues of concern raised within these complaints were promptly followed up; and in one case record sampled, as a consequence of the issues found, alternative care was provided.

Staff took care when planning and conducting children's and foster carer's reviews that they included checks for complaints. Records of statutory visits showed that children were advised they could complain about anything they were not happy about. This included also making sure that children had a trusted adult they could talk to. Foster carers told inspectors they were aware of relevant advocacy organisations that were available to support them or the children they cared for.

Overall, staff and managers gave high priority to ensuring children, their families and foster carers were aware of their right to complain. Complaints were relatively few, they were promptly investigated, and almost all were resolved at a local level in line with Tusla's policies and procedures. Learning from complaints was an integral part of the area's governance arrangements and informed senior managers' understanding of the quality of services and satisfaction rates.

Judgment: Compliant

Appendix 1: National Standards for Foster Care (2003)

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

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