Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING AND REGULATION OF CHILDREN'S SERVICES IN 2020

July 2021

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority 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.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. 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 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 health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these 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 services, in conjunction with the Department of Health and the HSE.

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A message from the Chief Inspector of Social Services and Director of Regulation

Mary Dunnion, Chief Inspector of Social Services and Director of Regulation

I am pleased to present this report on the inspection, monitoring and regulation of children's services in Ireland in 2020. This report focuses on the work undertaken by the Health Information and Quality Authority (HIQA) in children's services — such as special care, foster care, children's residential care, child protection and welfare and Oberstown Children Detention Campus — during the previous year. It gives an account of what children have described as their lived experiences of these services, and provides an insight into the factors which have influenced their quality and safety.

2020 was an exceptional year due to COVID-19. Children's services were resilient and adapted to meet the unique challenges the pandemic presented. Thankfully, incidences of COVID-19 were low in children's services, and where it occurred, services implemented effective contingency plans.

Our inspections found that governance and management improved in many of the services we inspected. Notwithstanding these improvements, variations remained in the quality of services provided to children, and there are opportunities to improve inconsistencies in the quality of services provided to children. Where risks were identified, these were reported at a local, regional and national level to providers, and appropriate assurances were provided to HIQA.

Significantly, many children in the care of the State faced additional challenges during the year, such as having prolonged periods of time when contact with their families was by video call rather than their usual face-to-face visiting arrangements. Services endeavoured to facilitate children's visits, and visiting arrangements were put in place in line with public health guidance, whenever it was possible.

HIQA is committed to the ongoing quality improvement of children's services, and a range of quality improvement initiatives continued in 2020. For example, we

continued our thematic child protection and welfare inspection programme which found that service areas had made noticeable improvements in the management of child protection and welfare referrals. As always, services that had effective governance and management structures in place were found to have had higher levels of compliance with the national standards than those services that had weaker governance arrangements.

We also completed a focused programme of foster care inspections which evaluated the arrangements that services had in place to effectively assess and manage the needs of children in foster care. In addition, inspectors assessed the arrangements in place to ensure that children were being appropriately assigned to foster carers and assessed the systems in place to adequately prepare children who are leaving care.

Furthermore, inspectors found significant improvements in relation to the governance and oversight of children's residential services. The majority of children in these services received good quality and well-planned care. Similarly, inspectors found that children in Oberstown Children Detention Campus also experienced good quality care that was planned appropriately.

In special care units, inspectors found areas of concern in the quality and safety of some services provided by the Child and Family Agency (Tusla). Through ongoing monitoring of these services and engagement with Tusla and front-line staff, Tusla successfully brought about effective changes which improved the quality and safety of care that was being provided to these children.

Listening to children's voices during inspections is crucial in how we determine service performance. In 2020, we continued to seek the views of children, both during inspections and outside of the inspection process. We consulted with over 1,000 children and young people and also heard the views of parents and foster parents. The majority of children who were consulted with were positive about the service that they received and felt well cared for.

This overview report will provide a summary of the key findings from the six focused foster care inspections conducted in 2020. A separate report will be published later this year with more detailed findings from inspections of foster care services from 2020-2021 in all 17 Tusla service areas. Similarly, the overall findings from seven thematic child protection and welfare inspections are outlined in this report, with a separate more detailed report being published in due course on this particular 2019–2021 programme. These reports will assist Tusla to inform their own quality improvement initiatives in the interests of children and families who need these services.

I want to acknowledge the ongoing support and co-operation of providers, foster carers and staff during our inspections. Many of you work diligently with children and their families to provide safer and better services. Finally and most importantly, I would like to thank the children, their families, friends and advocates for the assistance and time which they give to our inspectors when they visit children in their homes or when temporarily living in special care, or in detention.

Mary Dunnion

Chief Inspector of Social Services and Director of Regulation

Health Information and Quality Authority

1. Introduction to regulation and monitoring

About this overview report

This report sets out the overall findings of the Health Information and Quality Authority's (HIQA's) inspection and regulation of children's services in 2020. It also includes:

- how HIQA inspects and regulates the services within its legal remit
- what children told inspectors during the course of the year
- engagement with stakeholders and informed and interested parties
- a concluding statement in relation to work undertaken in 2020 and focus for future inspections.

Introduction to the work of the Children's Team

The Health Information and Quality Authority (HIQA) and the Chief Inspector of Social Services within HIQA's Regulation Directorate are responsible for regulating and monitoring the quality and safety of a range of adult and children's health and social care services across Ireland. The Regulation Directorate fulfils its statutory obligations set out in the Health Act 2007 (as amended) under the stewardship of:

- the Chief Inspector of Social Services, which oversees the registration and regulation of designated centres for adults and children, such as (in the case of this report) designated special care units for young people
- the Director of Regulation, which is responsible for monitoring or regulating certain healthcare services and medical exposure to ionising radiation services, and monitoring children's social care services (which are featured in this report), as follows:
  - child protection and welfare services
  - foster care services
  - children's residential services
  - special care units
  - Oberstown Children Detention Campus.

This overview report outlines the Director of Regulation and the Chief Inspector's 2020 regulatory programme for services for children in need of care and or protection, including designated special care units and Oberstown Children Detention Campus. It primarily sets out how HIQA met its business plan objectives[(2)] in 2020 in relation to children's services, including to:

- receive and assess all solicited and unsolicited information across children's centres and services and respond to risk in a proportionate and timely manner
- carry out phase 2 of a three phase focused programme of monitoring inspections of statutory foster care services to review the arrangements in place for:
  - the assessment of need for children in care
  - the care planning and review process, including preparation for leaving care, matching and safeguarding
- carry out a programme of inspection of private foster care services
- carry out an inspection of Oberstown Children Detention Campus by the end of 2020 to assess children's rights, planning for the care of young people and staff supervision
- deliver a programme of specific (termed 'thematic') inspections of child protection and welfare services
- carry out a programme of inspection of statutory children's residential centres to assess the leadership, governance and management arrangements in place at regional and local levels
- carry out a programme of inspections of designated special care units
- issue notices of proposal for all designated special care units, as required, in response to these centres making a complete application for a renewal of registration or new registration
- issue notices of proposal for all designated special care units, as required, in response to a complete application from these units for a variation or removal of a condition of registration.

Inspection reports are available on the HIQA website: www.hiqa.ie.

2. How we regulate services

2.1 The statutory framework — monitoring against standards and regulations

HIQA and the Chief Inspector of Social Services within HIQA's Regulation Directorate carry out three different types of inspections:

- inspections to check compliance with legally binding regulations, in the case of registered designated centres
- monitoring inspections which monitor ongoing compliance with specified nationally mandated standards
- thematic inspections which aim to promote quality improvement by focusing on national standards relevant to particular aspects of care and to improve the quality of life of people using services.

Each type of children's service has its own statutory framework that gives authority to HIQA and the Chief Inspector of Social Services to monitor and or regulate the service using standards and regulations which set out what is expected from the service.

Table 1 on the following page shows the statutory framework for each type of children's service monitored by the Director of Regulation or regulated by the Chief Inspector.

Table 1. Statutory basis for inspection and monitoring of children's services by HIQA and the Chief Inspector

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Child protection and welfare services	Inspected under Section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)¥ (1)		*National Standards for the Protection and Welfare of Children* (HIQA, 2012) (3)
Foster care services	Inspected 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 (4)	Child Care (Placement of Children in Foster Care) Regulations, 1995 (5) Child Care Placement of Children with Relatives) Regulations, 1995 (6)	*National Standards for Foster Care* (Department of Health and Children, 2003) (7)

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Special care units for children and young people	Inspected under Section 41 of the Health Act 2007 (as amended)[¥]	Health Act, 2007 (as amended)[¥]	Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 (8) Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 (9) Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations 2018 (10)	*National Standards for Special Care Units: November 2014* (published 2015) (HIQA) (11)

[¥] Number 23 of 2007: Health Act 2007 Revised: Updated to 8 January 2019. Health (Amendment) Act 2016. Dublin: Government Publication Office 2017. Available from: http://www.irishstatutebook.ie/eli/2016/act/6/enacted/en/pdf.

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Children's detention campus	Inspected under Section 185 and Section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006 (12)		*Standards and Criteria for Children Detention Schools* (Department of Justice, Equality and Law Reform, 2008)[1] (13)
Children's residential centres	Inspected 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 Residential Care) Regulations, 1995 (14)	*National Standards for Children's Residential Centres* (HIQA, 2018)[#](15)

[1] From 1 January 2021, annual inspections of Oberstown Children Detention Campus will be against the Oberstown Children's Rights Framework.

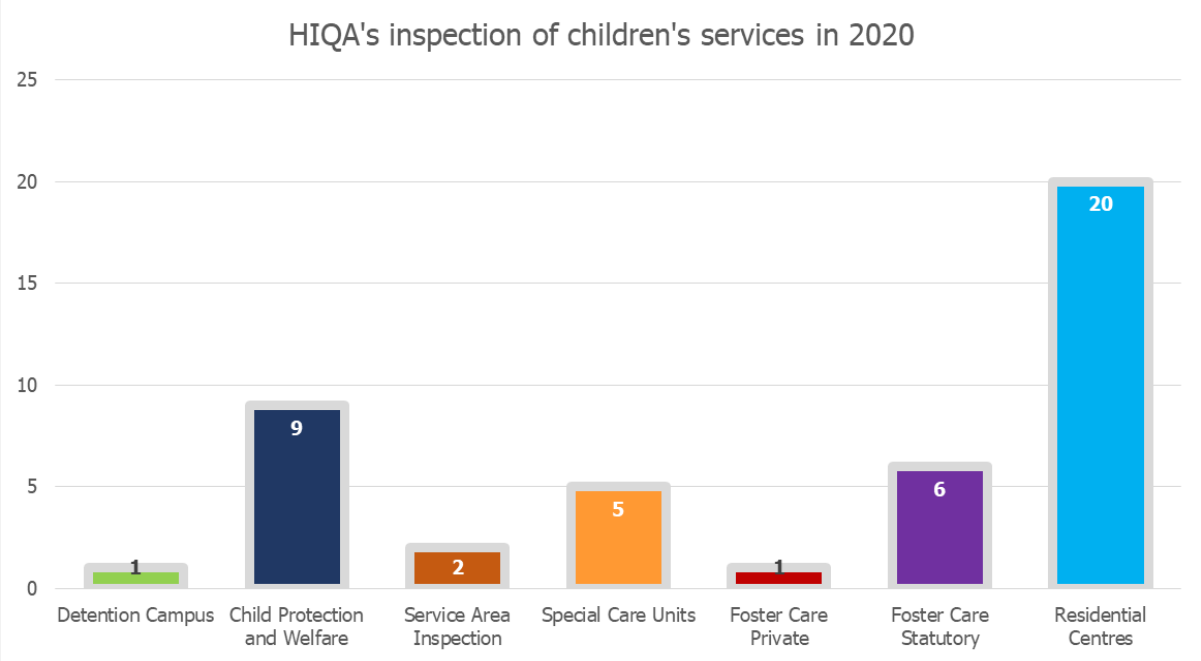
[#] On 7 November 2018, these standards replaced the *National Standards for Children's Residential Centres* that had been published by the Department of Health and Children in 2005.

2.2 Registration and inspection activity 2020

During 2020, HIQA conducted 44 inspections of the various children's services under its remit.

This included inspections of statutory children's residential centres, private and statutory foster care services, child protection and welfare services, and Oberstown Children Detention Campus. Five of the 44 inspections were carried out in order to monitor ongoing regulatory compliance in designated special care units.

Figure 1. Inspection activity 2020 by service and inspection type



* The service area inspection incorporates both child protection and foster care services.

2.3 Receipt of information

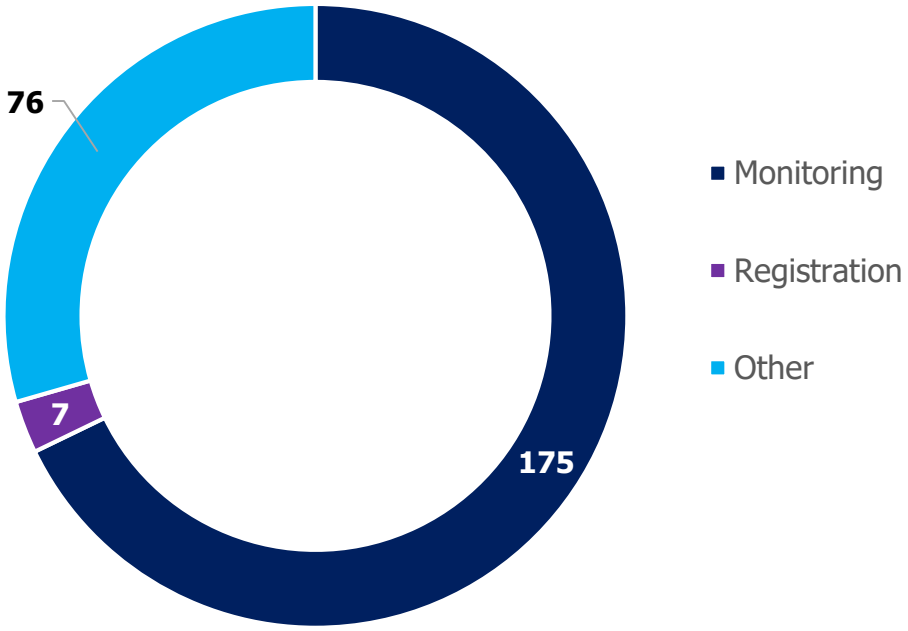
HIQA receives notifications from Tusla relating to designated centres for special care as well as non-regulated children's services. It also receives unsolicited information from people who have a concern about services provided to children.

2.3.1 Regulated children's services (special care units)

During 2020, HIQA received 258 notifications from Tusla relating to designated special care units. These are notifications that special care units are required to submit to the Chief Inspector within specified time frames.

The majority of notifications received in 2020 were those prescribed in the care and welfare regulations for special care units. They primarily related to issues such as absconsions, allegations of abuse and times when children were injured and required medical attention. Figure 2 below provides a breakdown of these notifications.

Figure 2. Number of notifications received from designated special care units by type of notification



2.3.2 Non-regulated children's services

Notifications of serious incidents involving children who are known to Tusla's child protection and welfare services, including the deaths of children in care, are issued to HIQA's by Tusla within 48 hours of the death or serious incident happening.

In 2020, HIQA received 44 notifications of serious incidents, including the deaths of children in care. Local reviews are carried out by Tusla following such incidents. Some of these incidents are also referred to the National Review Panel[2] for further review.

As with all information received in 2020, reports of local provider-led reviews into these incidences and four reports completed by the National Report Panel were risk assessed by HIQA and informed HIQA's regulatory activity in regard to the specific service area concerned.

2.3.4 Unsolicited information

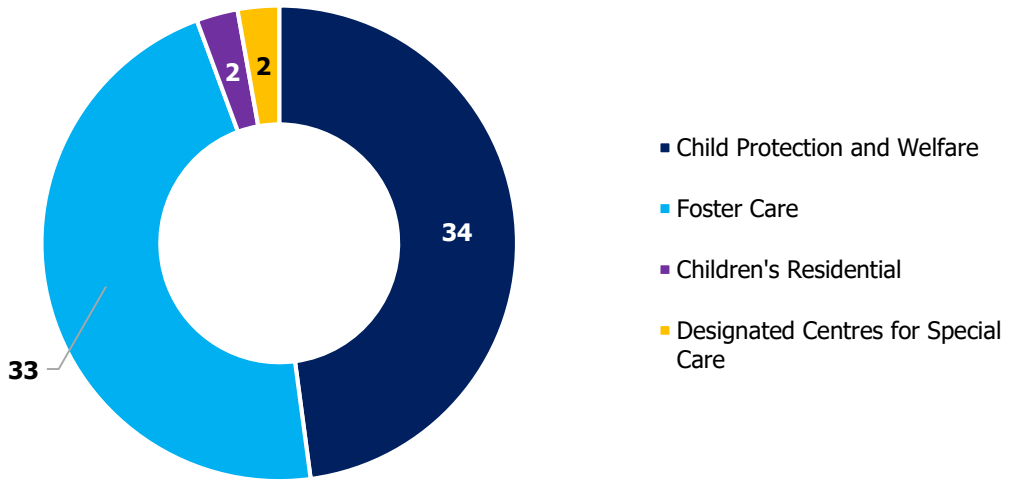
Unsolicited information is information which is not requested by HIQA. During 2020, HIQA received a total of 71 pieces of unsolicited information from members of the public who had a concern about services mainly provided by Tusla.

[2] This is an independent panel established in 2010 to review serious incidents including the deaths of children in care and those known to the child protection system.

Of these, 34 pieces of unsolicited information related to child protection and welfare services, 33 related to foster care (two of which related to private foster care), two related to special care units and two related to children's residential centres.

Figure 3 shows the number of pieces of unsolicited information received about the different functions we monitor, inspect and regulate.

Figure 3. Unsolicited information received by children's services



When HIQA receives unsolicited information of concern in relation to services within its legal remit, it is reviewed by an inspector to monitor whether there are any trends or patterns that suggest something is happening in a service that falls outside of what is expected in the national standards, or what is required under the regulations.

In responding to unsolicited information, HIQA sought the following from service providers in 2020:

- additional information on the issue
- requested a plan from the service provider outlining how the issue would be investigated and addressed
- used the information to inform what areas of practice we would assess on inspection.

Where the information indicates that children's welfare may be at risk, HIQA reported the incident to Tusla, in line with the Children First (2017) guidelines.[16]

HIQA also receives information about services that are not within its remit. Whenever this happens the person may be directed to the organisation best placed

to address the information, the provider of the service, the Office of the Ombudsman or the Ombudsman for Children.

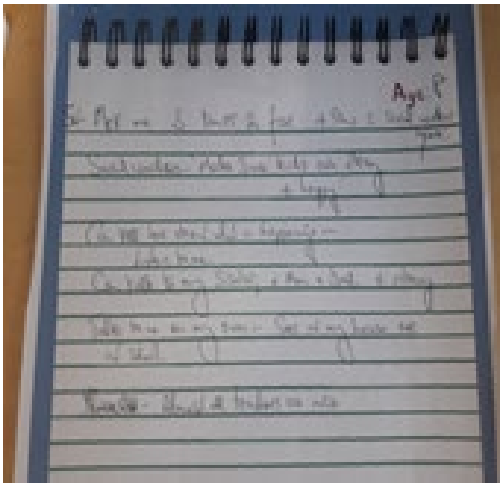
3. Amplifying children's voices

In 2020, HIQA continued to actively promote and reflect the voice of children and young people in its work. It is through this consultation process that we can explore children's lived experience of their care, and understand the impact of the governance and management of these services on the quality of care and support that children receive.

A particular focus of participation of children and young people in our work is to capture how they are involved in decision-making on issues that affect them. Such decision-making is enshrined in the Irish Constitution and in Article 12 of the United Nations Convention on the Rights of the Child (UN, 1989), ratified by Ireland in 1992.

Inspectors consult with children accessing a wide range of services, such as child protection and welfare, foster care, residential and secure care. These children differ in age and ability, and it is for this reason that a variety of tools, incorporating the use of pictures and words, are in place to help children to express their views.

Due to the size of some services we inspect, such as foster care, and the number of children involved, tools such as questionnaires have been developed to promote participation in the inspection process by large numbers of children. This diverse approach has proved to be very successful in capturing children's experiences to date.



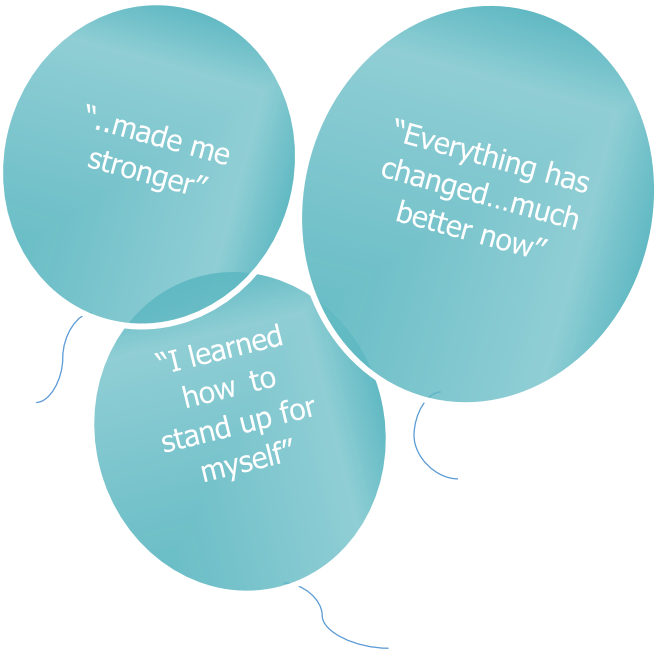
As part of inspections completed in 2020, inspectors engaged with a total of 1,041 children, comprising 914 children in foster care, 60 in statutory children's residential centres, 13 in special care units, 11 in Oberstown Children Detention Campus, and 43 children receiving a Tusla child protection and welfare service. Children participated in inspections by talking directly with an inspector (196), or by completing and returning a questionnaire (845).

3.1 What children said about their experience of services

Children described their experience of the services that they received support from — such as a child protection and welfare service — or were placed in, such as residential, secure or foster care service. Children were largely complimentary about all the services. The majority said that they benefited from being involved with these services and that their lives had changed for the better because of them. Importantly, children understood why they were not living at home and or why social work services were involved with them and their families.

Children talked freely about the positive relationships they had formed with a variety of staff in all the services and with their foster carers. They told us that these relationships had helped them build trust, which allowed them to let people help and support them.

They talked about the fun things they liked to do, activities they were involved in and the interests they had. Children told us how staff encouraged them to pursue these, and many had gained new experiences, such as horse riding, outdoor pursuits and gardening.



Children described mixed experiences of being placed with other children. The majority got on well with their peers in care and considered them friends. However, several children talked about witnessing aggressive and assaulting behaviour by other children in their placement, and they said that they found this distressing. In some of these cases, the children said that they felt less engaged or connected to the staff team as a result.

Many children placed in residential or foster care who participated in inspections said that they felt respected, nurtured and cared for. They enjoyed their placements and were fond of the people who provided their care. They liked the house and area they lived in and they especially liked their bedrooms. Understandably, however, some children did not like their placement as it was not their own home, and although they had good contact with their families, they wished to return to their family home.

Children's experiences of services were impacted somewhat as a result of COVID-19. For example, children in receipt of a child protection and welfare service said that although contact with their social worker continued, it was mostly by phone. This was due to public health guidance, and children were looking forward to their social workers visiting them in the future. Children in foster care told inspectors that there were some delays in convening meetings to plan their care, and that in some cases this meeting was held over the phone.

3.2 Rights

Inspectors asked children if they were aware of their rights and if they thought they could exercise them. The majority of children said that their rights were explained to them by staff members, and that they were given a booklet explaining them further. They also said that they learned a lot from talking to independent advocacy officers they had contact with.

Typically, children were aware of their right to complain and had exercised this right. Common complaints made by children related to house rules which they wanted to see changed, and older children challenged the level of independence afforded to

them. Children also complained about the lack of ready access to their social workers and access to siblings. These kinds of complaints were usually resolved quickly, and children were happy with the result. Other complaints were more complex, and although they were resolved, this took time. They included delayed moves from one placement to another when resources were limited, and the impact of living with other children who displayed challenging behaviour.

Children were also aware of their right to access information about themselves, and although they were encouraged to do so, many did not want to. There were many examples of children stating they had read daily records written by staff members about them. Inspectors saw that when children did not agree with the content, arrangements were in place for the child to add their own commentary to these records.

Contact with family and friends was particularly important to children who did not live at home. These children said that although meeting family and friends was limited as a result of COVID-19 restrictions, they were satisfied that they had good contact through other means when necessary. They were happy that their family was welcomed into their placement to visit and spend time with them, and looked forward to these visits.

Children knew that they had a right to be involved in decisions made about issues that affected them, and children said that they exercised this right regularly. The majority of children told inspectors that they attended planning meetings and contributed to decisions made about their care. These children said that they felt listened to and that their views and wishes were respected. Many of the children said that they were more likely to participate in meetings when they understood what the meeting was about and when somebody talked through the decisions with them.

Older children talked with inspectors about their right to free movement and they described times when they felt restricted. For example, some described 'not being allowed to leave' or 'go to their friends' when they wanted to. They did, however, understand that these decisions may have been made to keep them safe and said that doors were not locked to prevent their exit. However, in their view, some actions taken to safeguard them impacted on their independence.

Children, particularly those in residential care, felt that they 'had a voice' and were listened to. They described weekly meetings with the staff team and other children living in the centre, during which they could express their views and contribute to life in the centre. They explained that they would, for example, ask that a particular house rule be changed, make suggestions about leisure activities and have a say over meals. They also talked about being part of decorating the centre and there were some good examples of children developing vegetable plots and home gyms with the staff team.

Bedrooms were a favourite topic for most children as they considered these areas to be their private space. Time alone was something children in care valued a lot, and all of the children said that this was respected by staff and other children.

Significantly, children talked with inspectors about their right to be safe, and the overwhelming majority said that they did feel safe. They all said that they had a responsible adult to confide in and they saw their carers and staff members as people who looked out and advocated for them. Some children said that there were times when they did not feel safe, and this was typically linked with aggressive or violent outbursts by other children placed with them.

Some of the children who talked with inspectors were from different cultural and ethnic backgrounds. Inspectors saw, and children recounted, how their cultural heritage was being well looked after. These children told inspectors that their religious preferences and rituals were respected and that their preferred food was available to them. Some of these children were delighted to have cooked traditional meals for their peers. Not all of these children had English as a first language, and they explained that interpreters were in place to assist them to communicate effectively and to participate in decision-making processes.

Their right to an education was explored with children, and the majority had an educational and or training placement. Children told inspectors they enjoyed going to school and continued to engage in an educational programme during COVID-19-related restrictions. Many of these children told inspectors of their future plans, and some said they would like to go to university and felt supported in this and that it was a real possibility for them.

3.3 Transitions

Times of transition out of care or between services can be difficult and sometimes stressful for children and young people. Over the course of our inspections, children and young people told us that their experience of coming into a care placement was well managed. They had time to meet the other children in the placement and their carers.

However, young people on the verge of leaving care had mixed experiences. Some felt well prepared and had plans in place to support this transition into young adulthood. They were part of the planning process and felt they had a strong say in preparing for their future lives. Some children that inspectors met did not share the same experiences, and they told inspectors that they did not have aftercare plans or were not aware of their aftercare plans, and did not have a dedicated aftercare worker to assist them in this critical time of their lives. For these young people, their future seemed uncertain and they said that this caused them to feel anxious.

3.4 Social worker

The majority of children who engaged in our inspection programme in 2020 had an allocated social worker. Those who spoke with us said that they valued their social worker and needed their support. Almost all of the children told us that they liked and got on well with their social worker and they spoke positively about their impact on their lives. For example, some children described them as 'lovely', 'easy to talk to', 'like a friend' and 'made my life better'.

Children understood the role of their social worker and why they were in their lives. They said that social workers ensured they contributed to planning meetings, explained what was going on, took them out on their own for a treat and visited

them regularly. The majority felt able to confide in their social workers and trusted them.

However, similar to other years, some children had experienced multiple changes to their social worker and this was difficult for them. As one child stated: "I told that social worker everything and then she was gone."

On a different note, other children had experienced stability and consistency with their social worker and missed them when they were no longer in receipt of a social work service.

3.5 Areas of improvement

Over the course of our inspections, we asked children to tell us what kind of improvements they would like to see, which would enhance their experiences of the services they were in receipt of. The overwhelming majority said that their experiences were positive and that they could not recommend any changes.

There were, however, trends in the improvements recommended by children, which reflected findings of non-compliance by HIQA in those children's services inspected over the course of 2020. These improvements identified by children and echoed in inspection findings included:

- more frequent contact with an allocated social worker
- stability and consistency in social work allocation
- social workers could take action quicker
- rules for children should be stricter
- always explain to children what is happening
- listen more to children
- keep in contact with children who are no longer part of the service if they want you to
- better planning for children leaving care.

3.6 Secure care

HIQA inspects special care units where children are placed, when it is determined that they need care and protection as their behaviour places them at risk. It also inspects Oberstown Children Detention Campus, where care and education is provided to children who have been committed to custody following conviction for a criminal offence or who have been remanded in custody while awaiting trial or sentencing.

HIQA has found over the years that although many of the experiences of children and young people placed in secure care are similar to those in other types of placements, there are some differences. Generally, there is a higher value placed on contact with the outside world, the importance of good relationships within the placement, keeping busy, and being discharged from the service when expected.

The children and young people in secure care who met with inspectors in 2020 felt well cared for and looked after. They said that their rights were being promoted, and they felt listened to and valued. These children were happy with their level of participation in decisions about their placement and their lives.

They were keen to tell us about the staff teams and how well they got on with them. They all highly valued their keyworker (a staff member assigned to each child), who they experienced as a person they could trust and confide in.

Some children reported being bored and this was difficult for them to manage. However, overall, children and young people said they were kept active through sports, outdoor pursuits, indoor activities and school — which they really liked attending.

Several children and young people placed in special care units were not happy with the length of time they stayed in their placement. They felt that they had done everything required of them to ensure they could move on to an open environment. Commonly, the lack of an appropriate follow-on placement had prevented this from happening. They said that this was upsetting for them and their families.

Some more feedback from children is shown here in these speech balloons.


"There's nothing to do here... I'm bored."
"We get on well here but in our own way."
"If I don't want to go to meetings I'll tell my social worker and she will say it for me."
"...looked after well... you can have your say."
"I have a voice."
"This place has supported me and done a lot for me
"I need help to understand some rules as it's hard to see why a rule is in place."
"I need them to explain why I'm not allowed to walk around the grounds by myself... they can't be on top of me 24/7."
"I like that they are fair and teach me life skills."

3.7 Consulting with children during COVID-19 restrictions

From mid-March until the end of June 2020, in consultation with public health, we decided to limit inspections of children's secure and residential centres to risk-based inspections in order to help limit the potential spread of COVID-19 in these services. Therefore, the opportunity to engage with children as part of the inspection process was reduced.

To combat this, HIQA took a two-phased approach to consulting with children on specific national standards related to:

- family and friends
- their allocated social worker
- independent advocates
- educational supports
- and the promotion of their physical and mental health and wellbeing.

Inspectors also asked children to describe their experience of COVID-19 restrictions in order to gain an understanding of their perceptions of changes to practice in residential settings, how informed they were of the risks of COVID-19 and how they could keep themselves safe.

In Phase 1 of this approach, inspectors made direct contact by telephone with 72[3] children placed across 39 statutory children's residential centres and three special care units, over a two-week period in May 2020. Overall, this consultation process found that children were generally satisfied with efforts being made to ensure they maintained contact with the important people in their lives and their social workers. Children also said that they had ongoing support from staff to stay engaged with their education and to have their health and wellbeing needs met. It was evident that children were fully aware of COVID-19 and the risk it posed to them and the people around them, with some children describing feelings of anxiousness. These findings were consistent with what managers of these services were also reporting to inspectors at this time.

[3] Fifty-eight out of 114 children placed in statutory CRCs, and 14 out of 17 children placed across three special care units at that time.

"We've done loads of things it's been really fun…we started an Olympics where we're all in teams and play games…"

"…food is the same but we have separate sittings for breakfast, lunch and dinner."

"If I need to see a doctor, I can, not a problem"

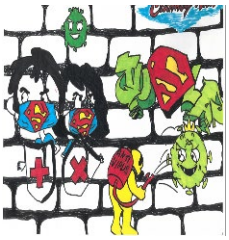
"I'm angry about the cancellation of the Leaving Cert…"

"routine is the same every day, it hasn't changed since Covid"

"Staff make school very enjoyable, as much as you can make school enjoyable, and I'm enjoying school much more than before."

"We're using outside spaces to keep us busy… painting and planting… I'm not going out, sticking with the rules for COVID-19 and getting out for walks and things with staff, it's grand."

During Phase 2 of this approach in May 2020, HIQA organised a competition for children placed in statutory residential and secure care settings inspected and or regulated by us. Children were invited to tell us about how they were being creative or had shown or experienced a kindness during the COVID-19 pandemic.



Entries were received from children placed in statutory children's residential centres across all four Tusla regions, all three special care units and Oberstown Children Detention Campus. The entries received showcased the quality and breadth of these children's talents, including storytelling, poetry, drawings and undertaking complex projects.

Significantly, their entries showed how aware children were of the risks of COVID-19 and how they could keep themselves safe. The Children's Team and the services that these children were placed in were moved by the compassion shown by children towards others during this difficult time, and the lengths they went to express this to the people they cared for and to older people living in their local communities.

4. Child protection and welfare services

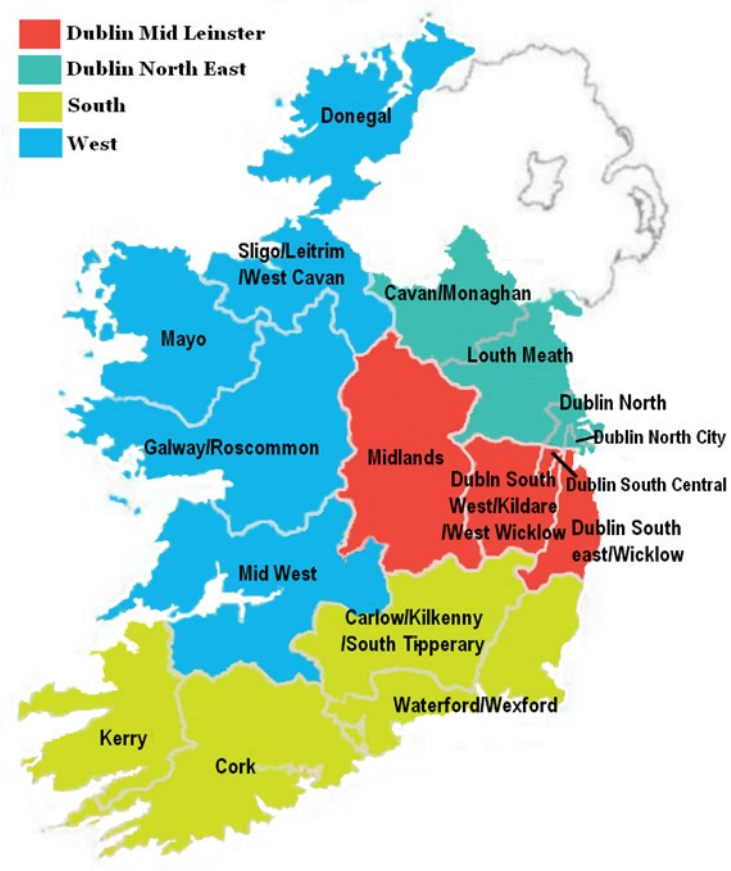
HIQA monitors and inspects child protection and welfare services against the *National Standards for the Protection and Welfare of Children* (2012);[3] the *National Standards for Foster Care* (Department of Health and Children, 2003);[7] the Child Care (Placement of Children in Foster Care) Regulations, 1995 [5] and the Child Care (Placement of Children with Relatives) Regulations, 1995.[6]

4.1 The role of Tusla

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act, 1991[4] and the Child and Family Act 2013.[19]

Child protection and welfare services are provided by Tusla in 17 service areas, located within four regions across the country (see Figure 4).

Figure 4. Tusla's service areas^



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

The Child Protection Notification System (CPNS) is a national electronic record of all children, who are assessed by Tusla, as being at ongoing risk of significant harm. Children placed on the CPNS have a child protection plan which is agreed at a child protection conference.

At the end of 2020, Tusla reported that all children on the CPNS[4] (939 in total) had an allocated social worker.[5] This has been a consistent finding for the last four years, which indicates that Tusla continues to prioritise social worker allocation to children who are most at risk.

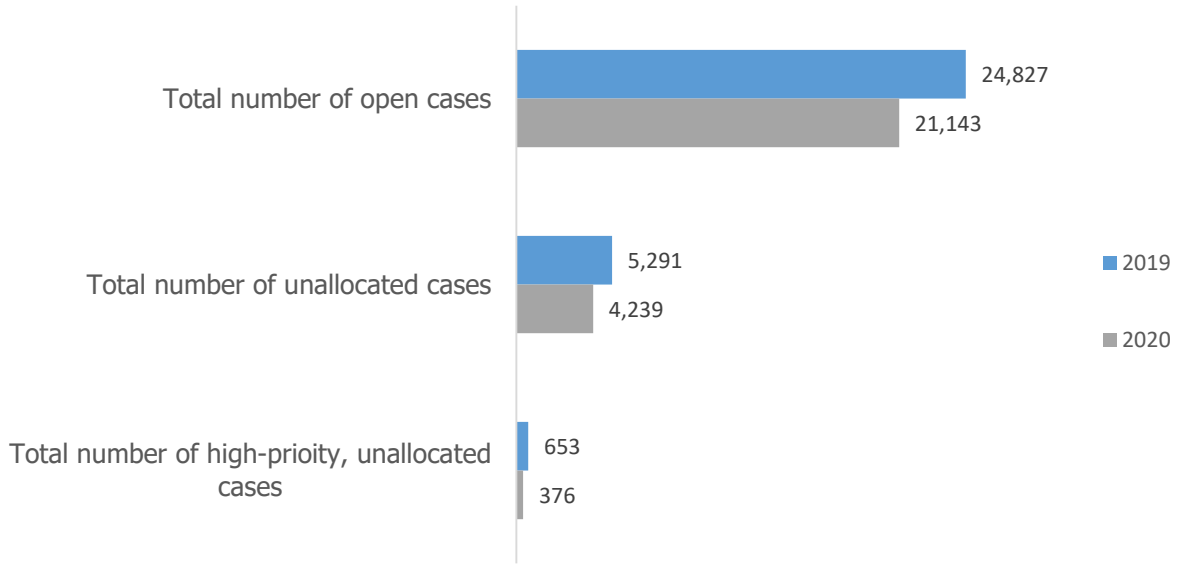
At the end of 2020, the number of cases open to the child protection and welfare service was 21,143 which was a reduction of 3,684 when compared with 2019 (see Figure 5). Open cases are where referrals are either waiting for a service or are being actively worked on by Tusla.

Of the total number of open cases, the number that were not allocated a social worker was 4,239, and 376 of those were high-priority cases. Therefore, there were 1,059 less unallocated cases at the end of 2020 than the year before, and fewer of those were of high priority. Tusla had specific plans in place to reduce unallocated cases in five specific service areas. These plans will be discussed further in the report along with HIQA's monitoring of these.

[4] 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 (Children First, 2017).

[5] End of 2020 data provided by Tusla Quality Assurance Directorate February 2021.

Figure 5. Allocation and activity 2019–2020[67]

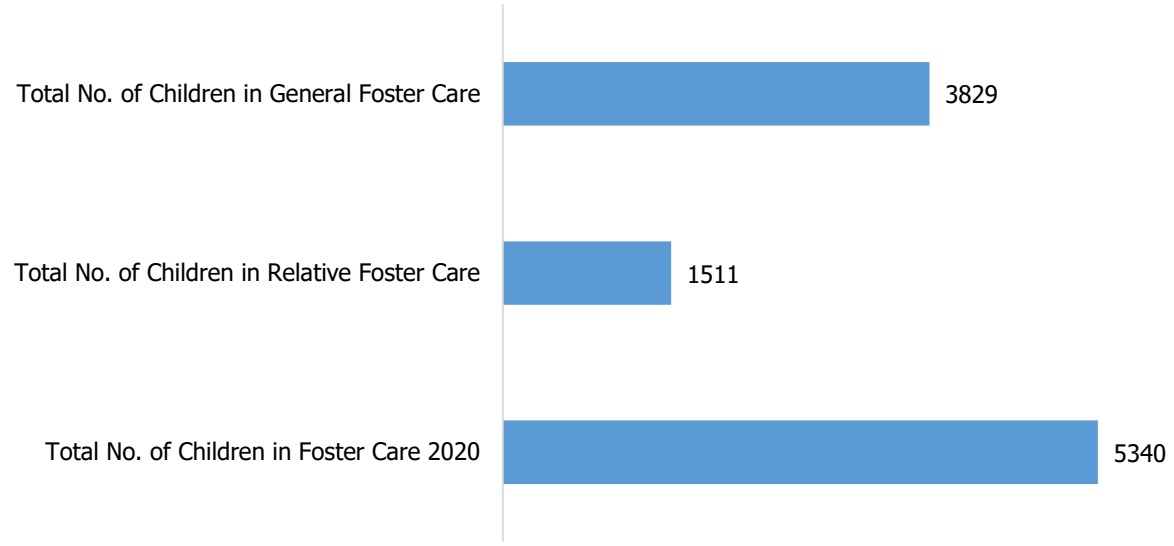


[6] End of 2019 data provided by Tusla Quality Assurance Directorate, February 2020.
[7] End of 2020 data provided by Tusla Quality Assurance Directorate, February 2021.

The highest number of children in alternative care placements were those living in foster care. Alternative care services refers to both residential care services and foster care services provided by Tusla, or the private and voluntary sector for children and young people, who are unable to live within their own families.

The total number of children in foster care at the end of 2020 was 5,340. Of these 5,340 children, 1,511 were living with relatives who were fostering them and 3,829 were living with general foster carers (see Figure 6).

Figure 6. Number of children living in general foster care and living in foster care with a relative at the end of 2020[8]



As can be seen, more than seven out of 10 children (over 71%) in foster care are in general foster care. That is to say, they are living with foster carers who are not members of their extended family. In contrast, nearly three out of 10 children in Ireland (over 28%) who are in foster care live with a family relative who is also their foster carer.

[8] End of 2020 data provided by Tusla's Quality Assurance Directorate in February 2021.

4.2 Child protection and welfare – monitoring and inspection activity

4.2.1 Thematic child protection and welfare programme

HIQA's child protection and welfare thematic inspection programme continued throughout 2020. This programme focused on defined points along a child's pathway in child protection and welfare services from the point of initial contact or reporting of a concern, through to the completion of an initial assessment by Tusla.

The thematic inspection programme began in October 2019, and four of the 17 Tusla service areas were inspected that year. A further seven service areas were inspected in 2020. The remaining two service area inspections will be completed in 2021.

Overall, service areas participating in this inspection programme embraced the concept of quality improvements, and inspections illustrated that services were focused on achieving this through the implementation of their quality improvement plans.

Good governance is essential to delivering a safe and effective service. Inspectors found that four out of seven areas inspected in 2020 were compliant or substantially compliant with standards related to leadership and governance. Good governance in these areas were illustrated through effective:

- service planning
- communication
- quality assurance systems
- risk management
- transfer of learning and implementation of quality improvement initiatives
- effective use of resources
- analysis of data.

Staff vacancies were a challenge across all services — services managed these vacancies through the use of agency staff and expanding the roles of, for example, social care workers. Area mangers were endeavouring to retain staff. Some areas completed staff satisfaction and wellbeing surveys and had plans in place to further improve staff retention. All areas had established supports for new staff, such as early induction, and used measures like a 'buddy' system' to support new staff.

Team days, complex case forums, group supervision and continuing professional development had been enhanced throughout 2020. Staff in all areas had access to a range of training programmes, and regular practice development workshops. Furthermore, two service areas inspected in 2020 had additional learning forums and training events arrangements in place with their local universities.

Overall, staff felt well supported by their managers. However, the consistency of staff supervision needed to be improved, along with improvements to ensure the process was well recorded. For example, including an account of case decisions made within this process.

Despite these initiatives, vacancies in staffing posts remained, with these vacancies adversely impacting on service provision. By way of an example, inspectors found that six out of the seven service areas inspected in 2020 had waitlists in place as a direct result of staffing issues.

In relation to the quality and safety of services provided to children, six of the seven service areas inspected against standard 2.1, which focuses on the consistent implementation of Children First, were found to be partially compliant. This meant that some of the requirements of the standard as outlined below were not met, but the risk to children was low. However, if unaddressed, there was a potential for this risk to increase.

Inspectors found that significant progress had been made across all areas in achieving the timely completion of screening new referrals. Effective screening and preliminary enquiries ensured that children at immediate risk were identified and consistently responded to in a timely and appropriate manner. There were examples of good practice where social workers responded immediately and visited children, and worked jointly with their colleagues in An Garda Síochána (Ireland's National Police Service), to safeguard children.

Inspectors found that the quality of preliminary enquiries was generally good. Preliminary enquiry is the process of collating and analysing all information gathered at the early stage of managing a referral, to inform decision-making. Cases were appropriately classified, prioritised, an analysis of harm and safety was considered, and checks were completed. However, all service areas were failing to consistently complete a preliminary enquiry within five days. Inspectors found a range of reasons for these delays. These included:

- waiting listings in some areas for starting preliminary enquiries
- enquiries completed but the related recording was not, or

- managers had not reviewed and approved paperwork within the required time frames.

Despite these challenges, children were actively listened to and were appropriately involved in their initial assessments. Social workers and social care workers used a variety of methods to include children and their parents or guardians in these assessments, and there were multiple examples of good practice found in this regard. However, Tusla's standard business process states that an initial assessment must be completed within a 40-day timescale from the date of the initial report being received. In six out of the seven areas, children experienced delays in the start and or completion of their initial assessments. The reasons for these delays were not consistently recorded on children's records.

Safety planning was identified as a risk during a statutory investigation by HIQA in 2018, and further improvements were required to ensure a consistent approach to safety planning. In 2020, inspections found that social workers generally were consulting with children and their family members, where appropriate, when developing a child's safety plan. There were, however, variations in how the arrangements for children's safety were recorded. Some children had formal written safety plans, while safeguarding arrangements for others had been recorded in case notes or various correspondence between social workers and parents. Inspectors found some safety plans effectively used the child's family and key professionals involved with them to keep children safe. Overall, improvements were required to ensure safety plans were regularly reviewed and updated so that the measures in place were effective at keeping the child safe. The embedding of Tusla's new standard business process should assist areas in achieving a more consistent approach to safety planning.

Under *Children First: National Guidance for the Protection and Welfare of Children* (2017), if Tusla suspects that a crime has been committed and a child has been wilfully neglected or physically or sexually abused, it will formally notify An Garda Síochána without delay. There was some variation in practice across the seven service areas, as there were often delays in completing these referrals. In addition, four areas had a small number of referrals that had not been referred to An Garda Síochána, and area managers assured HIQA after the inspections that the appropriate referrals were completed.

Children were on waiting lists for a service in the majority of areas inspected (six out of seven) as part of the thematic programme of inspection in 2020. There were variations in how these waitlists were being managed. Three areas had good systems in place, waitlists were being regularly reviewed and decisions in relation to cases were being clearly documented. In the other areas, improvements were

required in ensuring that there was a consistent approach to waitlist management, including recording the decisions of reviews of these cases.

Assurances were sought by inspectors on some individual children's cases, such as what inspectors felt to be a lack of appropriate safety planning for a child, or where there were gaps in the oversight of cases awaiting a service. HIQA received satisfactory assurances from Tusla in relation to these matters. This inspection programme will conclude in autumn 2021, and an overview report will be published outlining the programme's overarching findings.

Service improvement plans

In 2019, Tusla identified five service areas that required service improvement plans in order to reduce high levels of operational risks. On HIQA's request, Tusla provided regular updates on progress by these service areas, which in turn informed the work programme of the Children's Team in 2020.

One service area had significantly improved as a direct result of the implementation of its improvement plan, and had shifted from managing high risk to driving quality improvements in its services. The key improvements it experienced were a significant reduction in cases awaiting allocation and increased staffing resources. By way of an acknowledgment of the progress made in this service area, it was included in the thematic programme of inspection in 2020.

Two out of the five service areas were inspected in 2020 in response to risks identified in previous inspections, and to validate reports from Tusla on its progress in relation to the improvement plan. The findings of these inspections are provided in the next section of this report. Generally, there were improvements in the quality of screening and preliminary enquiries, but risks remained, particularly in relation to managing waiting lists.

The three remaining service areas will be inspected by HIQA in 2021.

4.2.2 Risk-based child protection and welfare inspections

HIQA completed four risk-based inspections of child protection and welfare services in 2020, in three Tusla service areas. Two risk-based inspections were of one area's management of children's cases, where the children had been placed on Tusla's Child Protection and Notification System (CPNS). One of these inspections followed up on progress since the first inspection. Two service areas which were subject to a Tusla service improvement plan were inspected in order to assess their progress since their previous inspections in 2019. Both of these service area inspections encompassed the delivery of child protection and welfare, and foster care services.

4.2.3 Key findings of child protection and welfare risk-based inspections

Children who are assessed as being at ongoing risk of significant harm are placed on Tusla's Child Protection and Notification System (CPNS) following a child protection conference (CPC). The CPC also devises a protection plan to keep these children safe. The social worker's role is to coordinate this plan, and this includes regularly visiting the child.

In 2020, HIQA carried out two inspections of one service area's management of children's cases, where the children had been placed on Tusla's CPNS. This was in response to inadequate assurances received from the service area, following a local review of a serious incident in relation to one such child.

Overall, the first inspection found that the implementation and monitoring of actions and interventions to protect children placed on the CPNS had been inconsistent, and as a result, some children had been less safe than others.

While CPCs were being well facilitated, the implementation, monitoring and subsequent interventions to keep children safe had been poor. Some children had not had regular visits by a social worker, and safety planning meetings had not been held as required. Actions to keep these children safe had not been progressed as a result. This lack of service meant that some children would remain at ongoing risk of significant harm, and on the CPNS for longer than required.

In the opinion of the inspection team, the service area's management team structure had not sufficiently identified these shortcomings through its own monitoring and oversight systems, and as a result HIQA escalated its concerns about the governance structure in the area to Tusla's senior managers. In response, Tusla provided satisfactory assurances to HIQA, along with a comprehensive action plan to begin to address the risks involved.

In a follow-up inspection 10 months later, HIQA found that significant progress had been made. There had been a considerable improvement in how child protection safety plans were being implemented and monitored by social work teams. Improvements to systems of oversight, such as staff supervision, became a driving force in ensuring a better service for children listed on the CPNS. Overall, children placed by the service area on this system were safer as a result.

Service area inspections

Two service area risk-based inspections assessed how Tusla responded to and managed new referrals of concern about a child, and specific aspects of the delivery of foster care services. Both inspections followed the entire referral pathway from the receipt of a concern to the point of completing an initial assessment. In addition, one inspection reviewed the arrangements for the management of the waiting list of retrospective allegations of abuse in that service area (retrospective allegations are made by adults who allege they were abused when they were children).

Screening and preliminary enquiry

Screening is the first step taken by a social worker in the management of a referral. Each referral is assessed at this stage to determine whether it is an appropriate referral to Tulsa's child protection and welfare service and, importantly, to take protective action for those children at immediate risk of harm. Tusla has a 24-hour time frame within which screening should happen.

These inspections found that both service areas had shown significant improvement in their timeliness of screening with the majority of screened referrals meeting Tusla's 24-hour time frame. One area had a thorough and well-implemented screening process in place, but further improvements in the quality of screening were required in the other area. These improvements were primarily in relation to the consistent completion of initial checks of Tusla records to determine if a child is known to the service.

Preliminary enquiry is the process of collating and analysing all information gathered at the early stage of managing a referral, to inform decision-making. This information is recorded on a standardised form known as an intake record. Tusla has a time frame of five working days during which a referral should be screened and a preliminary enquiry completed.

The overall quality of preliminary enquiries in both areas had improved, including their timeliness, but neither of the service areas had fully met Tusla's five-day time frame for completion. This meant that timely responses to all children and families had not always been possible.

Inspectors found that the application of thresholds and classification of abuse types were being appropriately applied, and priority levels assigned to new referrals had been accurate across both service areas. There had been good interagency co-operation at that stage of managing a referral in both areas.

Initial assessment

An initial assessment is completed to identify the level of unmet need and or risk to a child or children. This assessment informs social workers' determination on the steps required to meet the children's needs and to safeguard them. An initial assessment may, for example, identify that a child is at ongoing risk of significant harm, which requires a particular protective response.

Overall, there were some positive findings in relation to initial assessments in both service areas inspected, but delayed assessments continued to be a feature of these services. Children were being met with and observed by social workers as part of these assessments, there had been good analysis of children's needs, and good quality initial assessments were as a direct result of good managerial oversight of the process. One area had made some progress in reducing delays to completing initial assessments, but neither area consistently met Tusla's 40-day time frame for completion of these initial assessments. This had posed a potential risk to children whose needs and level of risk had yet to be identified and managed.

Safety plans

Safety planning refers to the arrangements put in place to enable children at risk of harm or abuse to be safe. Over the course of all risk-based child protection and welfare inspections completed in the three service areas, it was evident that Tusla's amended standard business process (introduced in June 2020) had yet to be fully implemented. This document provides staff with guidance in relation to safety planning and when fully implemented should improve consistency in safety planning.

Safety planning in place for children was of mixed-quality and required greater consistency in both service areas. Good quality safety planning identified the risks to the child and the actions needed to manage these risks. These safety planning arrangements ensured that safety networks were identified for children and families, with safeguarding measures put in place, which were proportionate to the risks involved. Where safety planning was of poor quality, improvements were required in the assessment of safety networks and the monitoring and review of safety planning arrangements by social work teams.

Notifications to An Garda Síochána

Risk-based inspections of two service areas in 2020 found that improvements had been made in relation to the timely notifications to An Garda Síochána of suspected crimes of wilful neglect or physical or sexual abuse against children. This was a direct result of management in both areas effectively monitoring and overseeing this aspect of practice.

Retrospective allegations

Retrospective allegations of abuse are made by adults who allege they had been abused when they were children. The quality and safety of the management of retrospective allegations of abuse in one service area was assessed in 2020. The inspection focused on how the area had managed those retrospective cases that had been awaiting allocation to a social worker for progression. Disappointingly, the overarching finding of this inspection was that the management of waitlisted retrospective allegations of abuse was poor. Tusla provided appropriate assurances to HIQA that an appropriate system was being put in place to manage and review waitlisted retrospective cases.

Waiting lists

Children and families were waiting for a child protection and welfare or foster care service in the two service areas inspected in 2020. Examples of waiting lists included the completion of a preliminary enquiry or initial assessment for those waiting a child protection service. Waiting lists in the foster care service included the allocation of a social worker to children in care, convening of a child-in-care review, assessments of relative carers and aftercare services.

Although there were systems in place to manage various waiting lists, they were not being consistently implemented. Risk to children was not always well managed, in particular for children about whom multiple referrals of concern had been made to child protection and welfare services. There was an inconsistent approach to the management of waiting lists, as there were different procedures in place in the two areas inspected in 2020. Poor management of waitlisted cases did not ensure a responsive service to these children where increases or decreases in risk to a child resulted in changes to their level of prioritisation for a service in both service areas. This meant that cases may have remained open unnecessarily or children needing a more immediate response did not receive one. In addition, reductions in waiting times or in the number of cases awaiting a service had not been not fully achieved in both service area.

In relation to delays in convening child-in-care reviews, there was no clear plan in place in one service area to address this failure, and this waiting list was expected to increase as a result. Care plans were not up to date for all children in this service area. Despite improvements with regard to quality, participation and consideration of all children's needs in the care planning and review processes, there was a lack of capacity within this service to ensure compliance in relation to adherence to the statutory time frame set out for holding child-in-care reviews for all children. There had been a slow rate of progress in this area since it was last inspected.

Leaving care and aftercare

Progress had been made by both service areas in relation to leaving and aftercare, but inadequate resources had impacted on the ability of one area to improve this further. While aftercare services to young people were timely in one area, a lack of resources in the other meant that new referrals to the service could not be allocated. There was a system in place to support young people who did not have an aftercare worker, but records of interventions, support and guidance provided were not always sufficient. There were, however, plans to develop this aftercare service once additional staff were recruited.

Managerial oversight of aftercare services in both service areas had improved. A better quality service was being provided in one service area as a result. Overall, management of the second service had improved, there was a clear vision for the service, and there was a dedicated and committed team in place. The aftercare manager in this service area had identified that stronger oversight of the provision of aftercare services by an external provider was needed, and a plan was in place to ensure this would happen in the coming months.

Child-in-care social worker

In one service area, children continued to experience changes in social workers in the months prior to inspection. Some improvements had been made to ensure children had one consistent professional in their lives, while significant improvement was found in the system of allocating children to a social worker. There had been improved monitoring of the impact of changes in social workers on children and the systems in place had ensured children's needs and experiences were at the centre of such decisions.

While the area was not compliant at the time of the inspection with its statutory responsibility to ensure children in care were being visited regularly by a social worker, improvements had been made. Most children had been visited in the months prior to inspection and there was a plan in place to make sure this continued. Where children were visited the quality of these visits was good.

The joint protocol for interagency collaboration between Tusla and the Health Service Executive (HSE) had been implemented in the area, and social workers coordinated specialist services to ensure that children received specialist services in a timely way.

Relative fostering assessments

In the one service where this was reviewed, there were significant delays in allocating relative assessments to social workers and delays in the completion of these assessments once they had commenced. Reasons for the delays in the completion of these relative assessments were not being recorded by the service area.

There were inadequate arrangements in place to oversee relative assessments, and this meant that actions required to progress these assessments did not always happen.

In some circumstances, relative foster care assessments had been contracted out to external providers. However, the process for tracking the progress of these assessments was inconsistent, and could not fully assure managers on the process being followed.

Governance arrangements

An overarching finding of the four risk-based inspections completed in three service areas in 2020, was that the quality and safety of child protection and welfare services, and foster care services, was significantly influenced by two factors:

- the strength of leadership shown by managers across all levels
- the effectiveness of the governance arrangements and managerial systems that were in place.

Overall, inspectors found that progress had been made in relation to improved compliances across all three areas. Incremental improvements were being made in two service areas in relation to compliance levels in the majority of standards inspected. However, governance arrangements required further strengthening in order for these services to provide consistently good quality services to children and families and to achieve full compliance with national standards. All three services provided action plans to address specific non-compliances identified by inspectors. HIQA will continue to review the progress in these Tusla areas during 2021.

Common areas that required improvements across all three service areas inspected in 2020 included:

- increased learning opportunities and transfer of learning across Tusla services
- consistent implementation of policies and procedures

- adherence to standard business processes and national directives maintaining up to date and sufficiently detailed records
- the safe and effective management of waiting lists
- providing timely access to services and assessments
- systems of monitoring and oversight of practice
- staff supervision
- risk management
- workforce planning and use of resources.

In 2020, Tusla remained committed to building on, and sustaining the progress it had made in 2019. This level of commitment at national and regional levels was particularly evident in the full implementation of its national approach to practice, operating a national electronic information system and implementing staff recruitment initiatives. Notwithstanding risks identified in one service area, the allocation of social workers to children placed on its CPNS remained high.

There were, however, indications in 2020 that Tulsa continued to be challenged in key areas. These included its capacity to significantly reduce waiting lists across all priority levels. While there had been significant improvements in filling vacant social work posts, significant vacancies remained in some Tusla services which was directly impacting on service delivery to children.

5. Alternative care services

Alternative care refers to both residential care and foster care services provided by Tusla or the private and voluntary sector for children and young people who are unable to live within their own families. HIQA monitors and inspects the 37 statutory children's residential centres provided by Tusla, and both statutory and private foster care services.

5.1 Statutory children's residential centres

5.1.1 Inspection and monitoring findings

In 2020, HIQA completed 20 inspections of children's residential centres run by Tusla.[≠] During 2020, none of these inspections were risk based. Centres within each Tusla region were selected where an inspection was either due or there had been non-compliances in the previous year which required further monitoring.

Generally, inspections focused on key standards related to leadership, governance and management, and the provision of safe, child-centred and well-planned care. Additional standards were included for specific centres, based on the nature of their history of non-compliance.

Overall, these 20 inspections found that the vast majority of children received good quality care in a safe and nurturing environment. Their rights were promoted and their health and educational needs were being met. It was evident that these centres were working collaboratively with social work departments and specialist services, to plan and deliver care to children, which provided them with opportunities to reach their full potential, either as children or as young adults.

Similar to 2019 inspection findings, in a minority of cases, the needs of some children could not be met in their placement. The level of disturbance arising from their behaviours and care needs impacted negatively on other children placed with them and caused them distress. Finding alternative placements for these children proved challenging to Tusla, and resulted in some children feeling unsafe and lacking the attention they needed from staff members for unnecessarily lengthy periods.

Following these inspections, HIQA sought and received assurances from Tusla that all necessary safeguards were in place, and that placement concerns would be resolved. These assurances, however, do not prevent similar occurrences in the

[≠] The number of Tusla-provided children's residential centres fluctuated between 36 and 39 in 2021. It remains at 37 at time of preparing this report.

future, and the lack of appropriate placements for some children with complex needs will be a focus of HIQA inspections in 2021.

The impact of COVID-19 on life in residential care was apparent throughout the year. Our inspections found that residential centres made great efforts to keep children occupied and safe, maintain meaningful contact between them and their families and friends, and to progress the plans in place for them during this time. This was effective for most children living in these centres. While absconding from their care placement is not an unusual behaviour for some children, these occurrences brought particular challenges in relation to infection prevention and control.

Our inspections found that some children continued to abscond during the pandemic and that necessary adjustments were being made to receiving a child back into a centre on their return from an abscond. Staff supervision of children increased during this time, and there was an increase in the use of restrictive practices in some centres. The use of restrictive practices were well monitored and reviewed by centre managers for their effectiveness, necessity and proportionality.

All of the children in the centres inspected had an allocated social worker who coordinated their care, but in a few cases, there were delays in reviewing care plans. In addition, contact with social workers could have been more frequent. Centre managers promptly advocated on behalf of the children in this regard. Importantly, these delays did not impact on the overall care of these children or the purpose of their placement.

Leadership, governance and management of residential centres has continued to improve year on year. Our inspections found greater uniformity across the country in relation to governance and oversight of these services and the systems of monitoring at a local, regional and national level. Risk management systems were in place and were effective, quality assurance mechanisms were established, and a culture of learning and supporting continual improvement was a common finding. There was a noted improvement in the collection and use of information and data.

However, there were some exceptions. In a minority of centres, there was evidence that leadership structures were severely challenged and managerial systems were not being implemented consistently or effectively. This impacted, for example, on the notification of all child protection and welfare concerns to Tusla social work services, the implementation of a national model of care, the identification and management of risk, the quality of staff supervision. In these circumstances, HIQA liaised with external managers of these services and sought written assurances that plans were in place to improve these services. These centres continue to be monitored closely by HIQA.

Statements of purpose and function were examined as part of each inspection and there were some key findings. There was a sustained growth in the delivery of respite residential care which catered for children in and out of State care. However, national policies and procedures and the model of care were not adapted to suit these services. In fact, residential services as a whole had not been provided with an up-to-date suite of policies and procedures since 2010. It was apparent that Tusla had responded to the actual or potential need for emergency placements during the pandemic. Statements of purpose and function for several centres across the country had been amended to ensure children could be placed there in an emergency. There were occasions when centres amended their statement of purpose and function to facilitate the admission of a sibling group.

HIQA inspections of children's residential services found that most centres were well staffed by skilled and experienced staff teams, or with a proportionate mix of new and existing team members. These teams were well established and contributed to a stable environment for the children placed there. There were, however, centres that experienced staffing shortages through vacant posts and or staff restricting their movements as a precaution or self-isolating as a result of contracting COVID-19. Although the use of agency staff was widespread across the country, there were times when this resource was not available. While staffing shortages did not result in the interruption of services, it did bring about a reduction in the number of placements available in a small number of centres.

Similar to previous years, there were a number of centres with managerial posts filled on an interim basis. Interim positions at this level do not provide service stability in the medium to long term. Vacant social care leader posts were also evident and this impacted on the consistent coordination of shifts. In some centres, inspectors found managers working shifts in addition to fulfilling their managerial roles. A rolling recruitment campaign was ongoing by Tusla.

There is a process in place for Tusla to inform HIQA of any new children's residential centre that it opens. In 2020, three such centres were established. These were temporary arrangements. One centre provided emergency placements for children during the COVID-19 pandemic. The others were opened on an unplanned basis by a Tusla service area to provide temporary placements for children for whom a placement in centres provided directly by Tusla or on its behalf by private providers was not available. These two centres were staffed by a mix of social care workers and social workers.

One centre that had been closed by Tusla in 2018, as the building was deemed to be not fit for purpose, was reopened in February 2019 and provided a placement to a child with complex needs. Although there had been a plan to close this centre in mid-2019, this did not happen. Despite the uncertainty around the future of this

centre, more admissions were made in 2020, and inspectors were informed that the centre was needed to provide care to children who could not be placed elsewhere.

As mentioned previously, children who present with complex needs may often be hard to place, but this approach to responding to children in the care of the State demonstrates a lack of strategic planning for the provision of residential services by Tusla to children who require it. Strategic planning for the provision of residential services will be a focus of HIQA going forward.

5.2 Foster care – statutory

5.2.1 Introduction to inspection of statutory foster care services

In Ireland, statutory foster care services are provided directly by Tusla on behalf of the State. In 2017, HIQA commenced a three-phase focused programme of inspection of these services across all 17 Tusla service areas.

Phase 1 was completed during 2017 and 2018 and focused on the recruitment, assessment, approval, supervision and review of foster carers, including the arrangements in place for safeguarding and child protection of children in foster care placements.

Phase 2 of the programme began in 2019, and this phase of the programme assesses practice against the following six national standards for foster care:

- the child and family social worker
- assessments of children and young people
- care planning and review
- matching carers with children and young people
- safeguarding and child protection
- preparation for leaving care and adult life.

In 2020, six Tusla areas were inspected as part of this programme. Over the course of inspections in 2020, inspectors met or spoke with 62 children placed in foster care, and seven young people who were over 18. Inspectors also met with or spoke with over 60 foster carers and 18 parents, and over 800 completed questionnaires were received from children in foster care, in which they shared their views about their experience of the foster care service.

During the first two inspections, inspectors visited 11 foster care homes and met or spoke with 33 children. Due to COVID-19-related restrictions and risks, some changes were made to the methodology employed in the last four of these

inspections. Instead of visits to foster care households, inspectors spoke with children and their foster carers by phone. While some inspectors were on site in service area offices to review children's case records and to interview individual managers, others worked remotely and conducted interviews and focus groups through electronic means.

5.2.2 Phase 2 inspection and monitoring findings

Overall, compliance with national standards varied across the six service areas inspected. The majority of the service areas (four) were either compliant or substantially compliant with all six standards assessed. This may suggest a transfer of learning across these Tusla services from previous inspections in 2019. However, one service area was majorly non-compliant with three standards, while another service area was moderately non-compliant with three standards.

Overall, children's rights were upheld in the foster care services inspected. Children were appropriately facilitated to have contact with their families, and the majority of children were consulted in relation to their care planning. In three service areas, there was evidence that children were informed of decisions made at child-in-care reviews, but improvements were required in the other areas to ensure practice was consistent. Complaints were generally being well managed, albeit not always in a timely manner.

Practice related to the allocation of a social worker to children placed in foster care was generally good, but improvements were needed. On a positive note, there were no dual-unallocated cases in any of the six service areas. That is where the child and their foster carers are not allocated a social worker. All children placed in foster care in the three service areas had an allocated social worker and two other service areas had allocation rates of 99% and 94% respectively. Therefore, almost every child in these service areas had an allocated social worker. This rate of allocation was slightly lower (at 84%) in the remaining service area, but inspectors found that there were good arrangements in place there to ensure that children without an allocated social worker had regular visits and had up-to-date care plans.

Children with an allocated social worker generally received a good quality service, and most children who met with inspectors or completed questionnaires spoke very positively about their social worker.

The majority of children in foster care were visited in line with the regulations, but some improvement was required in all service areas. In one service area, although every child had an allocated social worker, approximately one in five were not visited as frequently as the regulations require. In another service area, there were delays in carrying out statutory visits and the quality of records of these visits was poor.

There was a high level of compliance across all the service areas with the standard on the assessment of children and young people. Assessments were found to be of good quality in five of the six service areas. Children, where appropriate, their parents and families, and professionals involved in their care had been consulted as part of the assessment process.

Child-in-care reviews[9] and the care planning processes were generally well managed in four of the six areas. However, improvements were required in one service area where two different systems were in place, and records were not of good quality. In another area, there was poor practice which resulted in long waiting lists of overdue child-in-care reviews.

Although there were insufficient numbers of foster carers in five of the six service areas, matching processes were in place which attempted to match children to foster carers who had the capacity to meet their assessed needs. One service area did not have a matching process in place, and it was experiencing a significant shortfall in the availability of foster care placements. In this area, some children remained for long periods without the foster care placements they required. Backlogs of long-term matching of children with their foster carers were reported in the majority (five) of the areas inspected. Furthermore, shortages in foster carers impacted on each service area's ability to place children within their own communities and to ensure they were placed with carers with similar cultural or ethnic backgrounds.

Child protection concerns and allegations against foster carers were generally well managed. However, in one service area, allegations were not always assessed in line with *Children First: National Guidance for the Protection and Welfare of Children* (2017) and safety planning was judged to be poor.

Overall, preparation for leaving care was good, and aftercare services were found to be of good quality across the six service areas. Young people were actively involved in their assessments and plans, and they were being well supported. The referral of young people to an aftercare service required improvement in one service area, and while aftercare plans were generally of good quality, the timeliness of these plans was an issue in two service areas. All six service areas had aftercare managers to provide oversight of the services provided. Inspectors found that almost all of the Tusla aftercare policies were being implemented, although one service area did not yet have an aftercare steering committee.

Leadership governance and management had improved across the majority of foster care services inspected in 2020, but there was room for further improvement, and one area required signifcant improvement. It was evident, for example, that there

[9] A meeting that takes place to review the care plan of a child in care. The child usually attends the meeting along with people involved in their care, their family members and professionals.

was a transfer of learning across some service areas and an increased focus on building resources and bringing their foster care services into further compliance with national standards.

Staffing resources and how available resources were managed remained a challenge for most services. Under resourced or — in the opinion of inspectors — poorly managed resources resulted in pockets of inconsistent practice, lack of continuous adherence to processes prescribed by Tusla and an inability to allocate a social worker or hold child-in-care reviews for each child. Although campaigns to recruit foster carers nationally continued over 2020, inadequate numbers of foster carers impacted on each service area's ability to match every child with carers who had the skills and experience to fully meet their needs. In addition, there was a lack of emergency foster care placements nationally, and in one service area, this impacted on decisions to bring some children into care in the first instance.

Monitoring and oversight of foster care services required improvement at local and national levels. For example, these systems did not ensure:

- consistently good quality and well-recorded case management through the staff supervision process
- that statutory visits to children always happened, or
- that investigations into child protection concerns about children placed in foster care were timely.

Furthermore, children's case files were not always updated on Tusla's National Child Care Information System (NCCIS). Although there is a national directive by Tusla to ensure voluntary consents by parents to place their child in the care of the State are up to date for each child, this was found not to be the case for all children. Importantly, reporting systems — which should provide assurance at a senior management level — did not identify poor implementation of processes and administrative arrangements nationally.

Individual foster care inspection reports are routinely published by HIQA on its website. However, a national overview report on foster care services, which sets out key national findings and trends across Tusla service areas and regions identified during the Phase 2 inspection programme, will also be published by HIQA. It is envisaged that this report may inform planning for improvements to the overall governance of Tusla's foster care services, and may support and inform consistency of practice at both local, regional and national levels.

Phase 3 of the thematic programme will commence in 2021, and will focus on the efficacy of governance arrangements in place across Tusla foster care services, and the impact of these arrangements on children placed in foster care.

5.3 Foster care – non-statutory

Children's foster care services are also provided by private non-statutory foster care agencies under agreements with Tusla. However, Tusla retains its statutory responsibilities to children placed with these services. Tusla also approves the foster carers recruited by these agencies, through its foster care committees[10]. Non-statutory foster care agencies are required to adhere to the relevant national standards and regulations when providing a service on behalf of Tusla.

HIQA carried out one inspection of an non-statutory foster care service in 2020 against seven standards. These included the standards on safeguarding, assessment and approval, supervision and support, training, reviews, recruitment and retention of foster carers and the leadership, governance and management of the service.

The inspected service was adequately resourced and well managed, with good governance systems in place. Assessments of prospective foster carers were comprehensive and timely, and there was good oversight of the service by managers.

Practice was found to be good in relation to the support provided to foster carers. Each foster care household had an allocated fostering link social worker, who visited them frequently, was in regular communication with them and provided good supervision and support. Many of the foster carers in the service were attending training on a weekly basis. Foster carers were being reviewed regularly in line with the standards and reviews were thorough. Child protection and welfare concerns were being appropriately reported by foster carers and the service to Tusla child protection and welfare services.

[10] A group of people that meet to make recommendations regarding foster care applications and to approve long-term placements.

6. Regulation of special care units

6.1 Monitoring and inspection findings

There are three special care units in Ireland. These units are secure (locked) residential centres for children aged 11 to 17 years. Children are placed in special care by a court when it has been determined that they require care and protection, as their behaviour places them at risk. Children placed in special care receive therapeutic and educational supports in each unit.

All three special care units were registered by the Chief Inspector within the Regulation Directorate of HIQA in November 2018 and their registration is due for renewal in 2021. Within the three-year registration cycle, special care units are monitored^ by the Chief Inspector to ensure ongoing compliance with the regulations and standards.

Five inspections of the three special care units took place during 2020. Three were announced routine monitoring inspections, one of which was to follow up on risks identified in two previous inspections of one centre. All five inspections focused on regulations related to each centre's governance, including staffing resources, policy and procedure and risk management. They also assessed compliance in relation to the children's programme of care, safeguarding, and positive behavioural support. Two additional inspections of one special care unit were carried out in response to specific risks, one of which was unannounced.

Overall, inspections found that the quality and safety of these units varied and that this was associated with the skill-mix and experience of the management team and the effectiveness of the management and oversight systems in place in each centre. Two special care units were generally well-run services, where children experienced safe care within a secure and well-managed environment, but this was not always the case for the third centre. The quality and safety of this centre fluctuated, and several serious incidents had occurred. These incidents had highlighted the need for better managerial systems and stronger leadership, particularly in response to safeguarding concerns, managing risk and addressing the training needs of a small number of people working in the service.

Resourcing special care units with suitably qualified and skilled staff and retaining these staff has been an ongoing challenge for Tusla. On a positive note, however, this had improved. Two of the centres inspected in 2020 were resourced to meet the number of children they admitted, and staff retention levels were good. This led to a

^ Where the Chief Inspector refers to 'monitoring' in this section of this overview report, it includes inspection, review of information submitted by the special care unit, information held about the unit and ongoing review of information. This is all taken into account when the Chief Inspector is assessing compliance with regulations and standards.

stable environment for children and a cohesion amongst these staff teams in the delivery of day-to-day care to vulnerable children. In the third centre, the skill-mix and experience of the team was insufficient to meet the challenges at hand, and this impacted negatively on the quality of care and decision-making, and on responses to risk in this centre. In the opinion of inspectors, available staffing resources were not always well organised, and as a result, experienced and skilled staff, including managers, were not used to their full effect.

All staff recruited into special care should be appropriately qualified, and a key finding in 2020 was that this did not always happen. While Tusla was exploring ways to address recruitment challenges, several staff members in two centres did not hold a relevant qualification at the time of inspection. This was rectified promptly following inspection.

Children who are placed in special care units typically present with complex needs, and it was evident that the care they received was planned and delivered in each centre through collaborative working with the child, their family and external professionals involved in their care. While children benefited from this approach and the majority engaged with the programme put in place for them, it did not always result in a timely transition out of special care.

It is the role of Tusla's placing social work department to find placements for children leaving special care, but this proved difficult in some cases. The lack of appropriate and or timely placements for all children ready to leave special care meant that although risk to these children had reduced and they no longer required a secure care (locked) placement, they remained in special care. In some instances, they remained there as young adults. Short-term and time-bound extensions to two placements in different special care units, in what were exceptional circumstances, were approved by the Chief Inspector in 2020. These decisions were based on assurances by Tusla that all necessary safeguards and measures were in place. However, the challenges that these types of placements pose to the availability of a special care placement to a child who requires it, and to the units themselves, cannot be underestimated. They include for example:

- consistently operating within conditions of registration
- safeguarding children when placed with an adult who has complex needs
- providing care to children and adults in premises not designed for this purpose
- ensuring staffing levels and skill-mix are sufficient at all times
- promoting the rights of a young adult in a child-focused service.

The Chief Inspector must be notified of any occasion when a child absconds from special care, and when any allegation of misconduct is made against a staff member. Within a 16-week period between February and June 2020, HIQA carried out two inspections of one special care unit in response to the volume and nature of notifications of absconsions, and in response to the level of allegations against staff members. Common to both inspections was what inspectors believed to be the ineffectiveness of the governance arrangements and managerial systems in place to identify and respond effectively and safely to potential and or actual harm to children, and to provide consistently safe care within a secure environment.

In relation to absconsions, the systems in place to ensure outings from the centre were safe, purposeful and resourced adequately were not strong enough. Similarly, decision-making processes to respond to absconsions, particularly established patterns of absconding behaviour by individual children, needed to improve significantly.

Allegations of misconduct against some staff members were not always well managed. The quality and safety of care provided within the centre varied to such an extent that the welfare and safety of children placed there at that time could not be guaranteed. Overall, inspectors formed the opinion that elements of a potentially unsafe culture were developing in the centre and that stronger leadership was required to ensure the service could pre-empt and potentially prevent the type of serious incidents which had occurred. In response to these inspections, comprehensive plans which included immediate actions were put in place by Tusla to strengthen the systems in place. HIQA sought and received adequate assurances from Tusla, as the provider of this service, that children were safe in the centre and that oversight structures at a senior managerial level would improve.

In October 2020, a monitoring inspection was completed to ensure all actions related to this centre had been carried out. At that time, it was evident that the responsiveness of Tusla to the concerns raised had brought about effective changes in the level of compliance with the regulations and national standards, which in turn had improved the quality and safety of care being provided to children. The number of absconsions had reduced as a result of better risk assessment processes and staffing resources. The number of allegations against staff members had also reduced, and there were improved and stronger systems in place to oversee procedures to effectively address concerns about the experience and training needs of people working in the centre.

The Chief Inspector must be notified of any outbreak of an infectious disease in a special care unit. In 2020, one special care unit experienced an outbreak of COVID-19. The unit responded well to this outbreak and this ensured there were no interruptions to service delivery, and the spread of the virus was curailed. Having

learnded from this event, contingency plans in relation to staffing resources were reviewed and strengthened by Tusla.

7. Oberstown Children Detention Campus

Oberstown Children Detention Campus is a national service that provides a safe and secure environment for young people remanded in custody or sentenced by the courts for a period of detention. These young people have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence. The principal objective of the campus is to provide appropriate care, education, training and other programmes to young people between 12 and 18 years, with a view to reintegrating them successfully back into their communities and society.

Oberstown is funded by Department of Children, Equality, Disability, Integration and Youth. Oberstown operates under a single board of management, which is appointed by the Minister for Children, Equality, Disability, Integration and Youth.

HIQA inspects Oberstown Children Detention Campus annually, and 2020 was the last year that this service was inspected against the *Standards and Criteria for Children Detention Schools* (2008). From September 2021, the Campus will be inspected against the *Oberstown Children's Rights Framework,* which was approved by the Minister for Children in mid-2020.

An announced inspection of the Campus was carried out in 2020. The focus of this inspection was on planning for young people, the promotion of their rights, and staff supervision. Two of the three standards assessed were substantially compliant and the remaining standard was compliant.

This inspection found that children and young people were well cared for and their individual needs determined the plans and interventions put in place for them. Their rights were promoted through several mechanisms which ensured their voice was being heard and that a rights-based approach to practice was in place. However, the quality of record keeping had not improved at the pace or standard required since the previous inspection in 2019.

Planning for young people remained a priority for Oberstown and a placement plan was in place for each young person placed there at the time of the inspection. There was a multidisciplinary approach to planning, and levels of consultation and involvement of children, their parents or guardians, and professionals involved in the care was good. This was particularly important for children or young people who were in State care prior to their admission to the Campus, and they benefited from the approach taken by the service to planning. Furthermore, the planning process encouraged children and young people to take responsibility for aspects of their own lives.

The rights of young people as set out in the standards were assessed, and the young people who met with inspectors were generally satisfied that their rights were being promoted. While life in a secure (locked) environment has its limitations and complexities, this inspection found that the campus had made considerable efforts to give young people a voice, not only in relation to their care, but in the operations of the service. There were good systems in place to advocate for young people, and external independent advocates were welcomed to the campus to engage directly with young people, and hear their stories.

Although visits to children were curtailed from time to time and in line with public health advice, the Campus had ensured children maintained contact with their family and advocates through phone calls and other technology.

Overall, this inspection found that staff supervision had significantly improved. The supervision process was valued by staff and managers as a supportive mechanism, and as an opportunity to provide accountability for everyday practice.

Despite these positive findings, the quality of records in Oberstown required significant improvement, and this has been a consistent finding of previous inspections. Although there were some improvements, more was needed to ensure records fully reflected day-to-day practice, the implementation of policy and procedure, and how people were directly held to account for their areas of responsibility.

In summary, the 2020 inspection found that Oberstown actively promoted the rights of young people and valued their input on an ongoing basis. Care of young people was well planned and young people were encouraged to participate in forums where decisions were made about their care. Staff supervision had also improved.

However, and significantly, record keeping by the service continued to fall below the required standard. This has been a consistent finding of inspections of this service, and significant measures must be taken to ensure they improve. This aspect of practice will be one focus of inspection in 2021.

8. Monitoring children's services in response to COVID-19

In response to the initial risks and restrictions related to COVID-19 in March 2020, inspections of children's residential centres, child protection and welfare, and foster care services were confined to risk-based inspections. The regulation of special care units and inspection of Oberstown Children Detention Campus were not interrupted during this time.

From the outset of the pandemic, HIQA put a system in place to support and closely monitor children's services in order to assess how prepared they were for an outbreak of COVID-19, and to ensure they had adequate contingencies in place to manage its potential impact on service delivery. This involved regular phone calls to managers of these services. During these calls, inspectors followed lines of enquiry based on specific national standards and regulations relevant to each service. Over the course of the year, 320 calls were made to children's residential services, 34 calls to 17 Tusla service areas and nine calls to Oberstown Children Detention Campus. Calls to special care units ceased in June 2020, as they are designated centres regulated by the Chief Inspector of Social Services, with established notification systems in place.

From the outset of the pandemic, HIQA maintained contact with Tusla's National Service Director for Children's Residential Services. By way of assurance, in April 2020, Tusla provided HIQA with an overview risk assessment for children's residential services related to COVID-19 matters. It also provided a scenario plan document on best, worst and most likely case scenarios for these services, from the perspective of a service, staff and a child. The National Director also informed HIQA of the reporting system in place between Tusla and the Department for Children, Equality, Disability, Integration and Youth during the COVID-19 crisis.

Inspectors remotely monitored ongoing compliance by children's residential centres with selected national standards related to infection prevention and control, safeguarding and child protection, care planning, family and social work contact, leadership governance and management, staffing and resources and health and education of children.

Through this monitoring system, HIQA found that outbreaks of COVID-19 were low in children's centres, and contingency plans were in place. COVID-19 cases were generally confined to staff members who had contracted the virus outside of centres and had not been in contact with children in the centres or other centre staff. Children responded well to restricted movements when needed.

This process provided assurances to inspectors that centres continued to operate well with some revisions to policy as needed. For example, there were times over

the year when visits from families were suspended or curtailed, but alternative means of communication were put in place. Children continued to have their healthcare needs met and professionals visited in line with public health advice. One centre reduced its number of placements to compensate for staffing shortages, but this did not impact on the children already placed there.

HIQA continued calling centre managers for the duration of 2020. While this provided the team with the opportunity to respond promptly to risk if necessary, no risk-based inspections of statutory residential centres were required in 2020 (during the year, 20 other types of inspection of children residential centres were carried out by HIQA).

A similar system of monitoring was put in place for Tusla service areas, which provide child protection and welfare services, and foster care services. While home-working by Tusla staff was facilitated where possible, Tusla ensured its ability to receive referrals about children was not interrupted. However, the number of referrals fluctuated, and area managers said that this was partly due to school closures, as teachers account for a significant percentage of referrers to Tusla's child protection duty intake teams.

Area managers assured HIQA through this process that arrangements were in place to:

- respond to immediate risks to children
- monitor high-priority cases
- and importantly, monitor children identified as being at ongoing significant risk of harm and listed on Tusla's child protection notification system.

Assurances were also provided that contact with children would be maintained, and visits to children would be carried out on a prioritised basis. There was a commitment made by service areas that child protection conferences would continue, and some areas reported that parental attendance at these conferences improved when they were carried out remotely. Child-in-care reviews also continued, and there was a good use of technology to ensure this happened.

Some risks did emerge in 2020, such as increases in unallocated cases in one service area and an increase in delayed child-in-care reviews in another. HIQA sought assurances from managers of these services that appropriate steps were being taken to manage these risks.

Monitoring of special care units was not affected by COVID-19 restrictions. However, a strengthened monitoring system was put in place for a three-month period between March and June 2020. Two-weekly phone calls (33 in total) to the persons

in charge of these units allowed HIQA to assess their preparedness for a COVID-19 outbreak, and to monitor ongoing compliance with specific regulations.

Overall, there were no interruptions to the provision of special care services as a direct result of COVID-19. However, contingencies in place for staffing resources were reviewed and strengthened following an outbreak of COVID-19 in one SCU.

Monthly calls were made to the Director of Oberstown Children Detention Campus, and it was evident that the steps this centre had taken to prevent an outbreak were effective during 2020. Contingencies were in place in the event of an outbreak of COVID-19, and to monitor whether there were any risks to service provision during that period. Overall, this was well managed by the Campus, and every effort was made to occupy the young people placed there and to maintain contact with families whenever visits were restricted.

9. Stakeholder engagement

Engaging with people who use social care services, the general public and the staff who work in or manage such services is very important to HIQA and the Chief Inspector. Their views and feedback is essential in helping to inform our work and provide for more sustainable and informed decision-making.

We usually gather their feedback through a number of face-to-face means. These have included focus groups, forming advisory groups and as part of our inspection process meeting or consulting with children, parents, foster carers and people with experience of social care and child protection services. However, from March 2020, our contact with all interested parties and stakeholders has been by telephone, video call or questionnaire.

Throughout 2020, HIQA continued to engage with various stakeholders and interested parties. Examples of these engagements are described in this section.

9.1 Children and their families

Over the course of 2020, inspectors engaged with 1,041 children and young people in a variety of settings, comprising mainstream residential care (60), child protection and welfare (43), special care (13), foster care (914) and detention (11). In addition, inspectors talked with over 100 parents of these children to hear their views on the quality of care their children received, and to tell us how they themselves experienced these services. The views of children and their parents were reflected in inspection reports to provide service managers with every opportunity to improve the quality of their service and, ultimately, the lived experiences of children using them. In addition, inspectors also met with or spoke to foster carers to establish their views on the service provided, and the quality of support they and the children in their care were receiving.

9.2 Department of Children, Equality, Disability, Integration and Youth

HIQA continued to engage with the Department of Children, Equality, Disability, Integration and Youth (the Department) during 2020, to inform our regulatory and monitoring remit.

HIQA's Director of Regulation and the Chief Inspector and Children's Head of Programme met with the Assistant Secretary, Child Policy and Tusla Governance Division of the Department during 2020. These meetings were held to exchange relevant updates and information on actual or potential risk across the sector, and to discuss progress on regulatory developments.

HIQA participated in the Department's consultation on the review of the Child Care Act 1991. A representative from HIQAwas part of a working group chaired by the Department in relation to the single allocation of social workers in foster care.

9.3 The Child and Family Agency (Tusla)

During 2020, we met with senior members of Tusla's management team, to share information about annual business objectives, discuss practice issues requiring improvement, including areas of risk, to provide general feedback on inspection findings and to keep Tusla up to date on proposed changes to regulatory methodologies. Tusla in turn shared ongoing developments within its service.

The CEO of HIQA and the CEO of Tusla, and managers within both organisations met to develop a terms of reference for engagement at this level, and this will be finalised in the coming year.

HIQA was also represented on Tusla's Research Advisory Group.

9.4 Oberstown Children Detention Campus

HIQA attended Oberstown's annual stakeholder event at which the Campus Director and Chairperson of the Board updated key interested parties and stakeholders on progress made by the Campus over the course of the year.

HIQA met with the Director of Oberstown Children Detention Campus and the Chairperson of Oberstown's Board to share relevant information and to learn of ongoing organisational developments. A terms of reference, to formalise the arrangements for these meetings, will be drafted and finalised in early 2021.

In mid-2020, the Oberstown Children's Rights Framework was approved by the Minister for Children and they replace the *Standards and Criteria for Children Detention Schools* (Department of Justice, Equality and Law Reform, 2008).

Inspections of Oberstown Children Detention Campus will be against this new Framework from 1 September 2021.

9.5 Department of Education

HIQA and the Department of Education established a Memorandum of Understanding in early 2019. In line with the Memorandum of Understanding, contact is ongoing with the Department in regard to those inspection findings of special care units and Oberstown Children Detention Campus that relate to the education provided in these services.

10. Concluding statement

Each year, HIQA and the Chief Inspector design a programme of work that fulfils their legal requirements, while also optimising the opportunity that this work presents to improve compliance with regulations and national standards, and, therefore, improved services for children.

Our work programme ultimately aims to promote continual improvements in children's services, which in turn increases the probability of better outcomes for vulnerable children accessing these services. In 2020, this regulatory approach is highlighted by:

- the critical role that strong leadership and effective governance arrangements play in the delivery of good quality and safe services to children
- how children's experiences of the services they receive are central to informing service improvements
- the many opportunities for services to learn and develop, but they do not always take full advantage of these opportunities
- the fact that risk typically emerges in poorly governed services, particularly when:
  - there is ineffective monitoring and oversight of practice
  - inconsistent implementation of organisational policies, procedures and processes
  - quality assurance mechanisms do not provide assurance on the management of risk
  - available resources are not used effectively and efficiently.

We heard from many children who experienced feeling safe, valued, respected and consulted. They felt that they had a voice and that they had benefited from the services they received. We also heard from a small number of children who had less positive experiences. They told us of the negative impact that changes to their social worker had on them, of being exposed to complex behaviours by other children and of the lack of suitable follow-on care placements for them.

We saw that, in the main, children accessing child protection and welfare services who were deemed to be at immediate or high risk were provided with timely services to safeguard them. However, the plans to keep some of these children safe were not well monitored or implemented.

We observed children being provided with the services and supports they needed despite the challenges COVID-19 presented, but we also saw that things did change for many of them, particularly in relation to their independence and face-to-face contact with their families and friends.

10.1 Improvements

Inspection reports published in 2020 in relation to the wide range of services inspected by HIQA have highlighted incremental improvements in children's services. They demonstrate the ongoing commitment at national, regional and local levels to delivering good quality and safe services to children. This is welcomed as it is the children and families who need these services who will ultimately benefit from any improvements made.

The strive towards consistency of practice and equity in service provision has not gone unnoticed by HIQA over the last two years, and in addition, the shift towards a rights-based approach to care provision. Tusla has had continued success in embedding its national approach to practice and to fully implementing a national model of care in its residential centres. The operation of the NCCIS across its social work and care functions has continued to be progressed by Tusla. While more work is needed, the benefits of a centralised recording system have been experienced across Tusla services and it has increased its capacity to gather and analyse dependable information and data. There has also been the continued successful operation of a National Child Protection and Notification System. Together, these two electronic systems improved Tusla's ability to access and share critical information for the purpose of protecting children.

There has been a noted reduction in the number of high-priority cases awaiting allocation, numbers of medium and low priority waitlisted cases remain at a significant level. However, a significant challenge for Tusla has been implementing its strategy to reduce cases waiting for allocation and or assessment.

Oberstown Children Detention Campus has continued to develop its programme of care for young people and is preparing for operating within the newly approved Oberstown Children's Rights Framework, which is being implemented from September 2021.

10.2 Challenges

Risk remains in children's services to varying degrees, and this presents itself in ways such as an inability to consistently provide the right service at the right time to each child, or to ensure that the desired outcome of interventions put in place are being achieved. Inevitably, the safety and wellbeing of children can be compromised as a result of poorly managed risk. It has been a long-standing finding of our

regulatory activity that high levels of risk are more prevalent in poorly governed and managed services.

While some services have begun to benefit from the initiatives taken by Tusla to increase its workforce, vacancies remain and these vacancies limit a service's capacity to meet demand. The same can be said for other deficiencies, for example, foster care services without sufficient numbers of carers who can care for children with a wide range of cultural and individual needs.

Despite incremental improvements in governance and management arrangements, the systems of oversight, monitoring and quality assurance are not as effective in some children's services as they should be across all services.

The direct impact of the accumulation of these challenges on some children and their families is considerable. It has affected whether they have received the service they needed when they needed it, and whether, as a result, each child referred for a service is safe and well. For these reasons, leadership, governance and management in children's services will continue to influence our work programme in 2021 and beyond.

For the most part, HIQA received appropriate responses to poor inspection findings and to risks identified through its wider monitoring system. While this shows how capable services are at addressing deficiencies found in their services, HIQA is not and should not be the first line of defence in ensuring the delivery of consistently safe, good quality services to children and their families.

HIQA's regulatory and monitoring functions support rather than hinder the responsibility of the service provider to ensure that it has in place strong, effective oversight of its services and responses to any challenges it may face. It is through meaningful engagement with HIQA that a defined pathway to compliance and indeed improvement, can be achieved.

10.3 Moving forward

HIQA will continue to promote ongoing improvements in children's services by sustaining its focus on the regulations and standards around leadership, governance and management of services. In 2021, it has continued to build on its preparatory work completed in 2020, and has started its programme of thematic inspections of statutory foster care services. These are inspections against the national standards related to leadership, governance and management.

Its programme of inspection of statutory children's residential services will continue to assess how well these services are governed and managed, and how learning from the previous year's programme of inspection has been transferred across Tusla's children's residential services.

In relation to promoting quality improvement, HIQA will conclude its thematic programme of inspection of child protection and welfare services in early 2021, commence a programme of inspection of the management of cases placed on Tusla's child protection notification system, and will continue to respond to risk in these services as required.

The proposed expansion of the remit of the Chief Inspector of Social Services to the regulation of all children's residential centres, statutory and non-statutory, will provide further assurances as to the quality and safety of services being provided to children living in all residential services

HIQA and the Chief Inspector of Social Services will work with the Department of Children, Equality, Disability, Integration and Youth to plan for the transfer of the registration and inspection functions for non-statutory children's residential centres from Tusla to the Chief Inspector, when this process begins. HIQA wishes to acknowledge the support and ongoing co-operation of providers, foster carers and staff during our inspections. Finally, as a team, we will continue to seek the views of parents, children and young people accessing the services we inspect to improve how we do this. Their experiences are invaluable in understanding these services, their quality, and their impact on the everyday lives of some of the most vulnerable children in our society.

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