Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

Inspection of Statutory Foster Care Services 2019-2020

September 2021

Foster Care

Safer Better Care

About the Health Information and Quality Authority (HIQA)

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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About monitoring of statutory foster care services

The Health Information and Quality Authority (HIQA) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 69 of the Child Care Act 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency and to report on its findings to the Minister. HIQA monitors foster care services against the *National Standards for Foster Care*, published by the Department of Health and Children in 2003.

In order to promote quality and improve safety in the provision of foster care services, HIQA carries out inspections to:

- assess if the Child and Family Agency (Tusla), the service provider, has all the elements in place to safeguard children
- seek assurances from service providers that they are safeguarding children by reducing serious risks
- provide service providers with the findings of inspections so that service providers develop action plans to implement safety and quality improvements
- inform the public and promote confidence through the publication of HIQA's findings.

HIQA inspects services to see if the national standards are met. Inspections can be announced or unannounced.

1. Introduction

This overview report focuses on the work undertaken by the Health Information and Quality Authority (HIQA) in the Child and Family Agency's (Tusla's) foster care services during 2019-2020. As part of HIQA's 2019 and 2020 monitoring programme, HIQA commenced a programme of announced inspections across 17 Tusla service areas focusing on the following standards:

- Standard 5 - The child and family social worker
- Standard 6 - Assessment of children and young people
- Standard 7 - Care planning and review
- Standard 8 - Matching carers with children and young people
- Standard 10 - Safeguarding and child protection
- Standard 13 - Preparation for leaving care and adult life.

This report provides a summary of the key findings from 17 inspections, highlights learnings for Tusla and outlines HIQA's plan for further monitoring of these services in 2021.

In 2019, a total of 11 Tusla service areas were inspected, and the remaining six service area inspections were completed in 2020.

This was the second phase of a three phase programme of foster care inspections. The 2017 to 2018 foster care inspection programme, Phase 1, focused on the recruitment, assessment and approval of foster carers, foster care reviews, support, supervision and training of foster carers, including the arrangements in place for safeguarding and child protection.

The 2019 to 2020 inspection programme, Phase 2, focused on the arrangements in place for the assessment of need for children in care, and the care planning and review process, including preparation and planning for leaving care, matching carers with children and safeguarding.

The inspection reports setting out the findings of these Phase 2 inspections are published on www.hiqa.ie. A link to the report on each service area can be found in Appendix 2 at the end of this document.

HIQA would like to thank children, parents, foster parents and staff for their engagement with the inspection process.

2. Methodology

2.1 Focused foster care inspections

As part of the programme of focused inspections, inspectors met with managers and staff involved in delivering services to children in foster care, young people availing of the aftercare service, and with foster carers.

In line with the focus of the inspection programme, HIQA inspectors evaluated:

- the role of the social worker
- how the needs of children in care were assessed
- how children in care and foster carers were matched
- care plans and placement plans for children in foster care
- safeguarding processes
- and the leaving and aftercare service.

The key activities of each of these inspections involved:

- the observation of practices
- the analysis of data submitted by the area
- the analysis of questionnaires completed by children in care and young people in aftercare
- meeting with or speaking to children in care, and young adults availing of the aftercare service
- telephone calls and or meetings with parents of children in care
- home visits to a sample of foster care households
- interviews and meetings with area managers, principal social workers and other managers
- separate focus groups with children in care social workers, fostering social workers, and with foster carers
- the review of the relevant sections of the files of children in care as they relate to the focus of the inspection

- the review of documentation relating to the areas covered by the relevant standards.

The methodology described above was employed in 13 of the service areas inspected. However, due to public health advice and restrictions that were introduced in response to the COVID-19 pandemic from March 2020, adaptations were made to how inspections were completed. Visits to foster care households were replaced by telephone calls to children and foster carers in the remaining four service areas. While some inspectors visited the areas in person to review children's case records and to interview individual managers, other inspectors worked remotely and conducted interviews and focus groups using video technology.

3. Profile of the foster care service

3.1 The Child and Family Agency

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

Tusla has responsibility for a range of services, including:

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

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

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

Tusla reported that, at the end of March 2021, a total of 5,338 children were living in either general foster care or relative foster care. 72% (3,821) of children were in general foster care and 28% (1,517) of children were placed with relatives. 92% (3,520) of children in general foster care had an allocated social worker and 91% (1,335) of children in relative foster care had an allocated social worker.[1]

4. Summary of focused inspection findings 2019 – 2020

4.1 Introduction

Tusla has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in foster care require a high-quality service which is safe and well supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to achieve compliance with standards.

This chapter provides a summary of the findings of the programme of focused inspections and the extent to which the processes involved in the child and family social worker, assessment of children and young people, care planning and review, matching carers with children and young people, safeguarding and child protection, and preparation for leaving care and adult life, met the relevant *National Standards for Foster Care*, 2003.[2]

All 17 Tusla service areas were inspected as part of this programme. Major non-compliances and risks identified in two service areas led to one of these areas, Carlow/Kilkenny/South Tipperary, having a further follow-up risk based inspection in October 2020. Where areas had non-compliances, a plan to achieve compliance was submitted to HIQA post inspection. HIQA continues to monitor area's ongoing progress against these plans, and this ongoing monitoring may include further follow-up inspections.

5. What children told us

In order to get the views of children, this inspection programme included issuing questionnaires to all children in care over the age of six years and visiting children in their foster care households to observe or speak with them directly. From March 2020, when the COVID-19 public health restrictions were introduced, inspectors were no longer able to visit children in their foster homes. However, inspectors spoke to children on the phone where appropriate to do so, and spoke to the foster

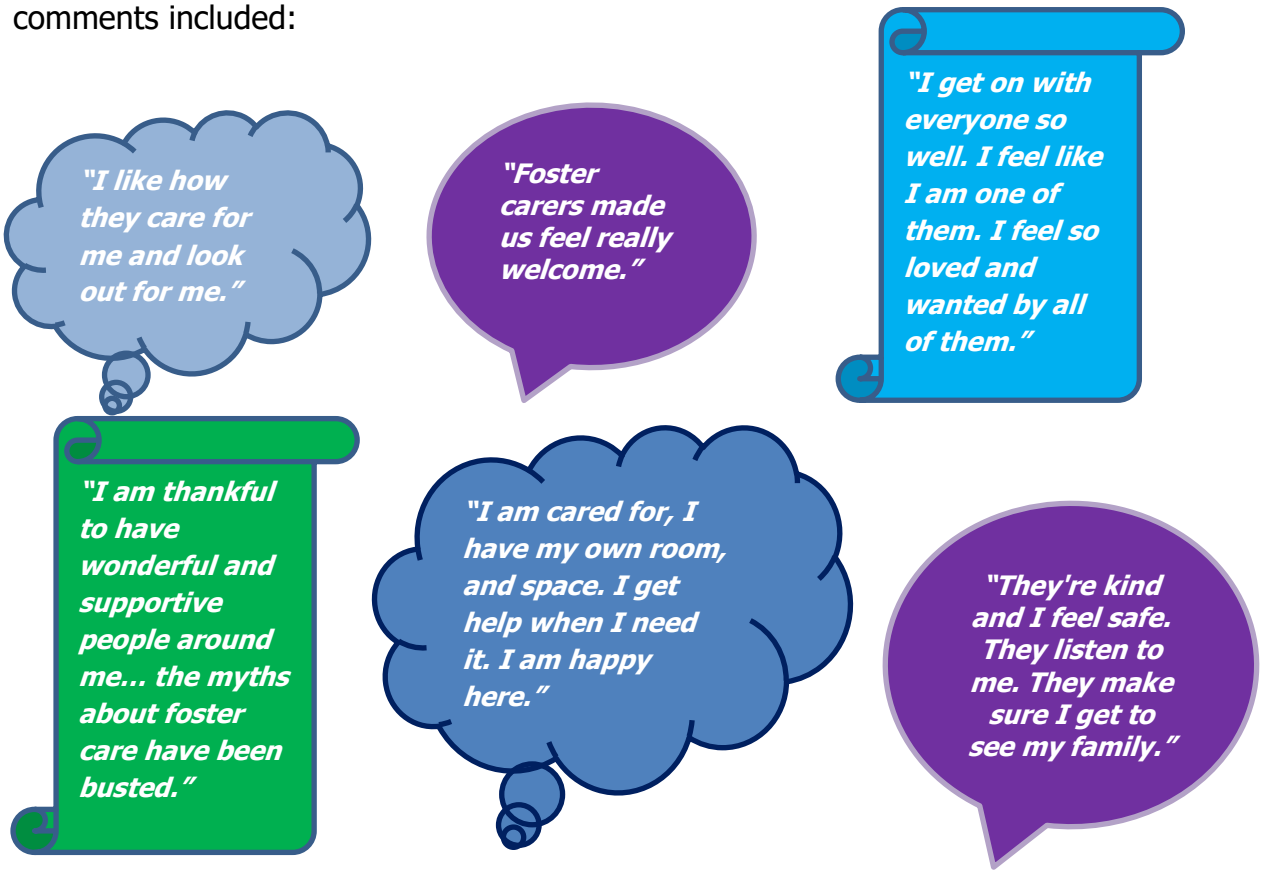
[1] Tusla Quarterly Service Performance and Activity Report Quarter 1 2021.

[2] Judgments were made against four descriptors: Compliant; Substantially compliant; Non-compliant – major; Non-compliant – moderate.

carers of younger children. Of the 17 inspections completed, foster care household visits were conducted for the first 13, and children were spoken to on the phone for the remaining four.

Over the course of the two year inspection programme, 1,416 questionnaires were received. 1,132 were from children in care aged 6-15 years, 276 from children in care aged between 16-18 years, and a further eight from young adults in receipt of an aftercare service. In addition, inspectors met with, observed or spoke to 186 children in care and 44 young people who had left care.

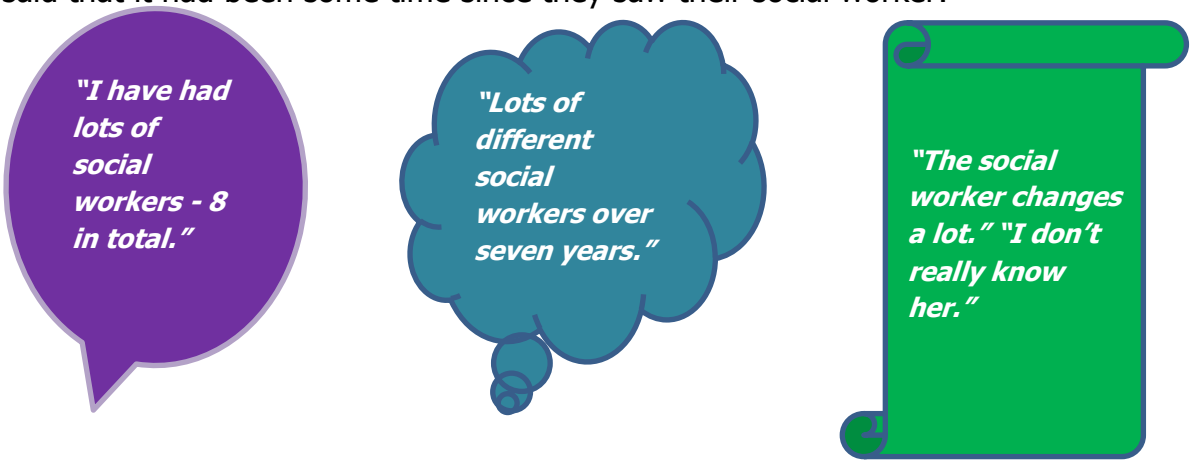
The vast majority of children spoke positively about their experience of being in foster care and the relationships they had made within the families. Children's comments included:

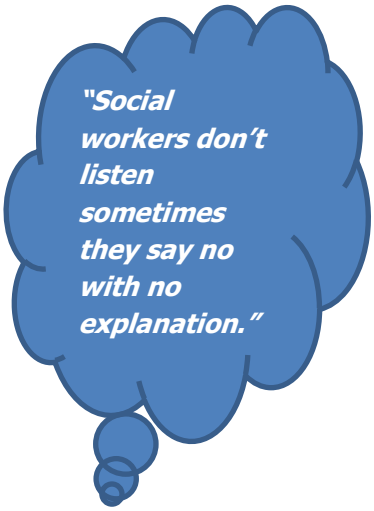


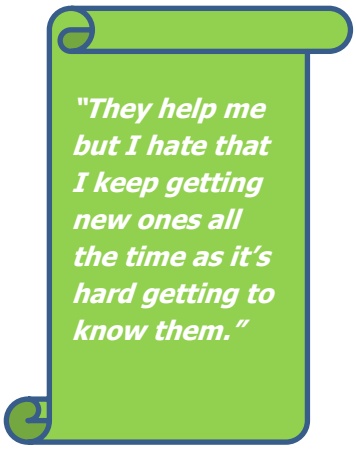
Children spoke about things they liked to do and people and things that were important to them, such as family members, friends, school, pets and hobbies. Children also told inspectors some of the hard things about living in foster care:

Overall, the majority of children were very positive in their comments about their social workers. Children said:

Some children did not have similar views or had experienced several changes of social worker and in some cases had either not met their new social worker yet or said that it had been some time since they saw their social worker:

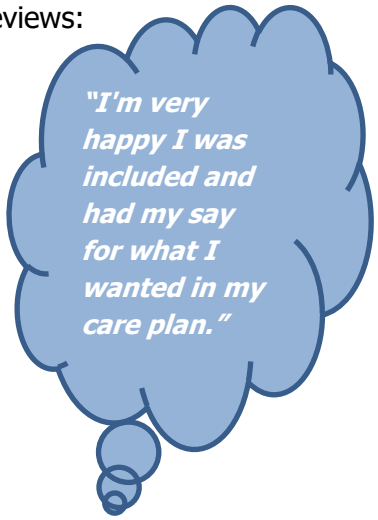


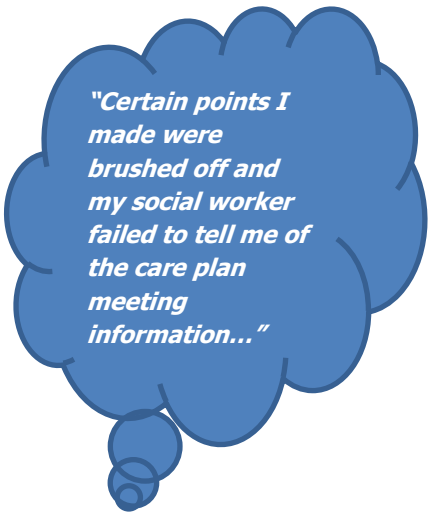


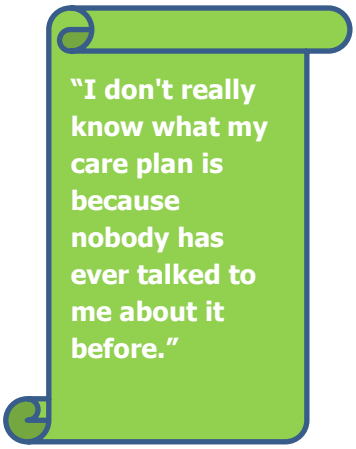


The majority of children said that their social worker did visit them regularly with some stating that they sometimes visited and others saying that they did not visit them regularly. Most children stated that they met their social worker on their own, and felt listened to.

Children, in general, said they had a care plan. While many stated that they were helped to prepare for their care plan review and had been spoken to about it by their social worker, children had mixed views about their care plan and care plan reviews:

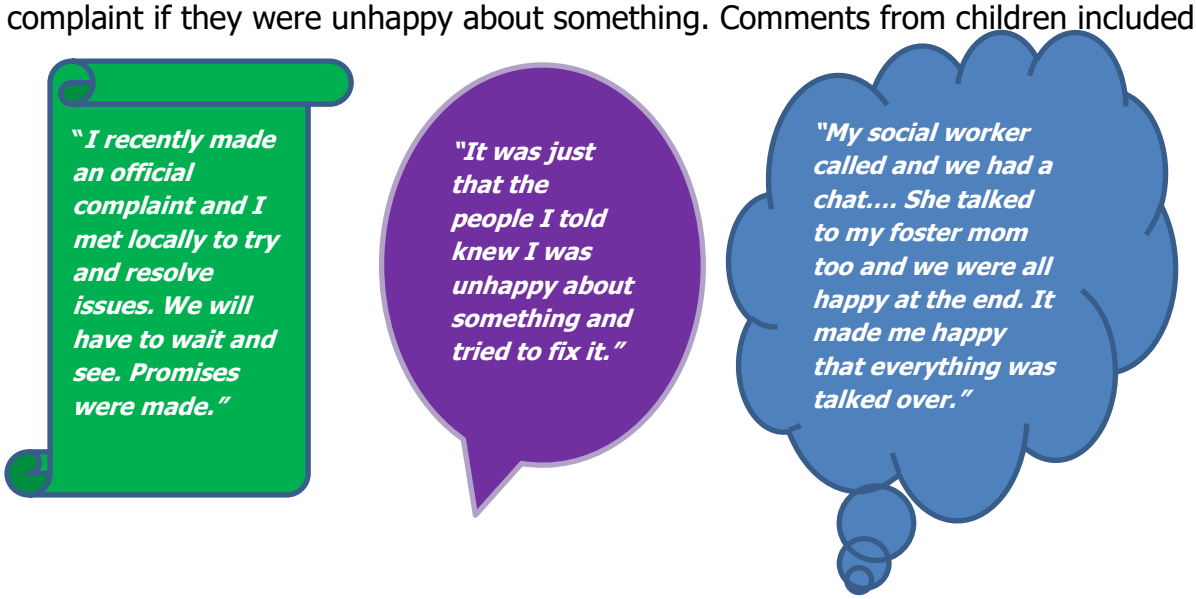






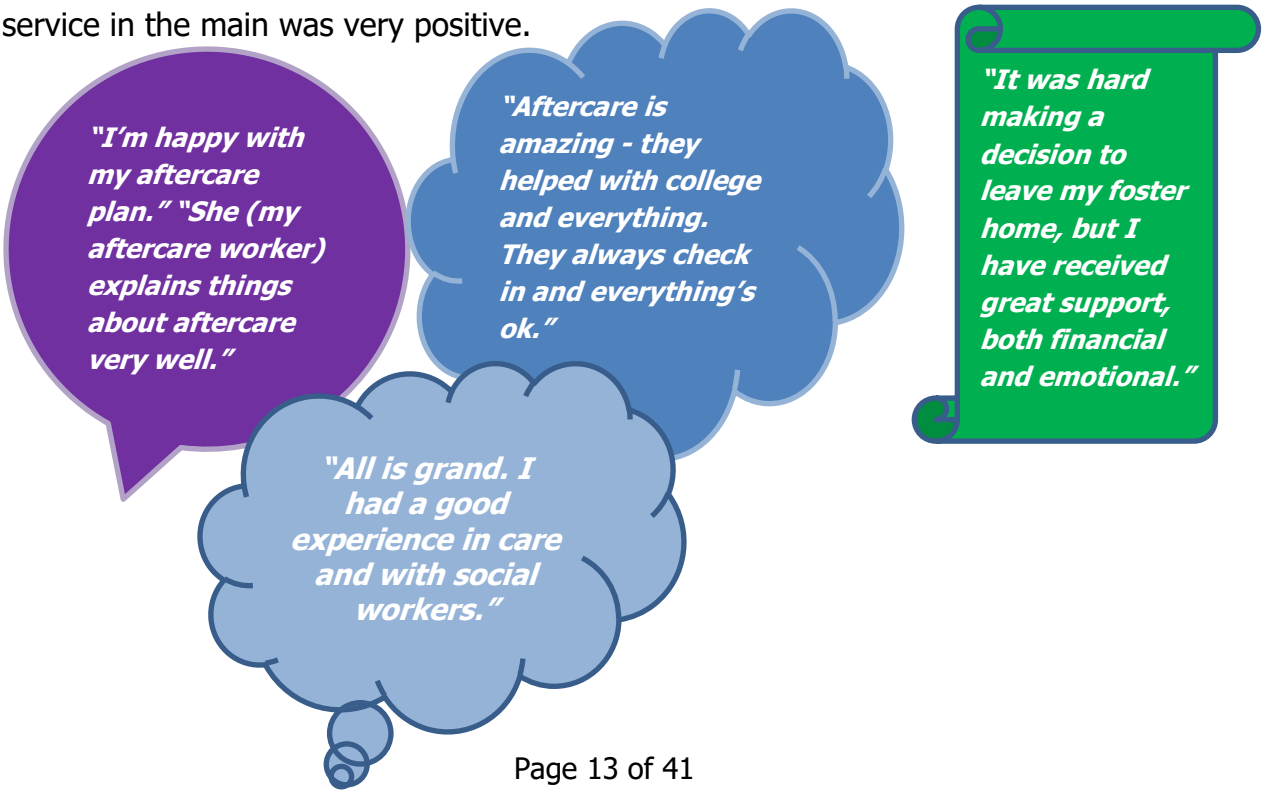
Of those children who responded to inspectors in relation to their rights, most said that the social worker helped them to keep in touch with their family and friends and they were generally happy with the level of contact they had. While a few children commented that they didn't know, some children said they did not see enough of their family and friends. Generally, children felt their background and culture was understood and respected. Some of the comments made by children included:

Children and young people said their social worker had told them how to make a complaint if they were unhappy about something. Comments from children included:



Of the young people aged 16 or over who answered the question about having an aftercare worker, the majority said they had an aftercare worker who listened to them and helped them prepare for the future. A few young people said they did not have an aftercare worker or that they had not met their aftercare worker yet. Many young people indicated that they either had an aftercare plan or one was in the process of being developed and that they had a say in it. Most young people said they had been provided with the necessary skills for independent living and that they had their own bank account. Most young people knew what their financial entitlements were, but a small minority were unsure or did not know what their entitlements were.

The overall feedback from young people about their experience of the aftercare service in the main was very positive.



6. Summary of inspection findings 2019-2020

6.1. Standard 5: The child and family social worker

Standard 5: The child and family social worker

There is a designated social worker for each child and young person in foster care.

Judgment	No of Areas	Service Areas
Compliant	1	**Mayo**
Substantially Compliant	5	**Kerry, Donegal, Louth/Meath, Dublin South Central, Galway/ Roscommon**
Non-compliant Moderate	8	**Sligo/Leitrim/West Cavan, Cavan/Monaghan, Mid West, Midlands, North Dublin, Dublin North City, Dublin South West/Kildare/West Wicklow, Waterford/Wexford**
Non-compliant Major	3	**Dublin South East/Wicklow, Carlow/Kilkenny/South Tipperary, Cork**

Tusla has a duty to allocate a social worker to a child as soon as the need for an admission to care is identified and for as long as they remain in care. The child's social worker is a key person in the child's life as they have responsibility for developing a relationship with the child, visiting the child, managing and coordinating the child's care, and ensuring that the child has an up-to-date care plan and that their care plan is regularly reviewed and implemented.

Of the 17 service areas inspected, six areas (Sligo/Leitrim/West Cavan, Cavan/ Monaghan, Donegal, Mayo, Cork, and Galway/Roscommon) had ensured that each child in foster care had an allocated social worker. In the remaining 11 service areas, the percentage of children in care with an allocated social worker varied from 99% down to 78%. In four service areas, over 17% of children in care were unallocated a social worker — Carlow/Kilkenny/South Tipperary (22%), Dublin South West/Kildare/West Wicklow (19%), Mid West (18%) and Midlands (17%). This meant that approximately one in five children in foster care in these service areas

did not have an allocated social worker. In service areas where the numbers of unallocated children in foster care was high and the negative impact of the oversight of the care of the children was of concern, inspectors escalated the issue to the area managers. Appropriate assurances were received by HIQA. Prior to the first inspection in Carlow/Kilkenny/South Tipperary, HIQA had previously escalated the high numbers of unallocated children in care in the area to Tusla's national office.

According to the standards, approved foster carers are supervised by a professionally qualified social worker, known as the link social worker. When children in foster care do not have an allocated social worker, one of the safeguards that is usually in place is the allocation of a link social worker to the foster carers. This means that at least one allocated social worker is visiting the foster care home on a regular basis.

When there is neither an allocated social worker for the child nor a link social worker for the foster carers, the child's case is often referred to as dual unallocated. This is poor safeguarding practice as it means that neither the child nor the foster parents have a consistent social worker to visit them and work with them. It also means that Tusla oversight of the placement is diminished.

In the Mid West service area there were six dual unallocated cases, while in Dublin South West/Kildare/West Wicklow, there were seven. In Dublin South West/Kildare/West Wicklow, while there was no evidence of outstanding issues or risks that needed to be addressed in these cases, the practice of having both children and foster carers in the same household unallocated did not ensure that adequate safeguarding arrangements were in place, and this was not in line with the standards. In the Mid West, a review of three (50%) of the six dual unallocated cases with a high priority status found that statutory requirements were not fulfilled in relation to care planning, reviews and visits to children. Each of these cases were escalated to the area manager following the inspection to provide assurances that all appropriate safeguarding measures had been put in place and statutory requirements had been fulfilled. An appropriate response was received which included a direction being given by the area manager that, as and from May 2019, no children in care were to be dual unallocated.

While it is acknowledged that it is not good practice for children in care to be unallocated, at times this was as a result of staffing vacancies or extended leave of staff in the service areas identified and, therefore, full allocation of all children in care was not possible. In these instances, the oversight of these unallocated children in care is vital. The oversight of unallocated cases in eight of the 11 service areas was generally good. While practice varied from one service area to another, the oversight of unallocated cases usually involved regular reviews of the cases by team leaders or principal social workers and the allocation of a duty social worker or a

social care worker to visit a child and to carry out specific tasks. However, in three service areas, Carlow/Kilkenny/South Tipperary, Mid West, and Dublin South West/Kildare/West Wicklow, either the oversight of unallocated cases was poor or the systems in place to ensure that statutory duties were carried out were ineffective.

A follow-up inspection was subsequently carried out in the Carlow/Kilkenny/South Tipperary service area given the level of non-compliance and ongoing high numbers of unallocated children in care. The follow-up inspection in October 2020 found that there were 30 children in care in the area without an allocated social worker; down from 72 in May 2019. Children continued to experience changes in social workers in the months prior to inspection and children's own views shared with inspectors was reflective of this. However, some improvements had been made with regard to ensuring children had one consistent professional in their lives. Social care leaders were allocated to five of the seven children whose files were reviewed. Inspectors found that this allocation meant that children experienced a consistent professional in their lives and their care plans were implemented by social care staff overseen by social work team leaders.

The other three service areas with high numbers of unallocated cases were monitored through requests for updates to their compliance plans, and requests for provider assurance reports. These showed that these areas had consistently reduced their number of unallocated children in care, or put measures in place to address the risks. For example, the update from the Mid West in April 2020 showed that they now had 97% of children in care allocated. Provider assurance reports from Dublin South West/Kildare/West Wicklow in August 2020 indicated that 90% of children in care had an allocated social worker and further assurances received in September 2020 showed that, by this time, 97% of children in care had an allocated social worker. An update from the Midlands service area received in May 2021 outlined that, while children in care were awaiting allocation, each child had an identified social care leader who completed regular safeguarding visits, with oversight by a social work team leader, and any immediate needs arising were responded to.

The frequency of statutory visits to children in their foster homes is prescribed in the regulations *(Child Care (Placement of children in foster care) Regulations, 1995 and Child Care (Placement of children with relatives) Regulations, 1995)*. The frequency varies according to the length of time a child has been in their placement. Inspectors looked back over a two-year period to establish if statutory visits to children had taken place in line with the regulations. Although some service areas reported that all children had been visited in line with regulations, inspectors found this not to be the case in any of the service areas over the two-year period. There was good practice in some service areas, such as Donegal and Galway/Roscommon, where statutory visits were in line with regulations for 2019 and 2020. In several other

service areas, improvements had been made in the frequency of statutory visits in the months prior to the inspections. Poor practice was in evidence in a small number of service areas. For example, in Carlow/Kilkenny/South Tipperary, 64% of children's files reviewed for this purpose did not contain evidence that the children were visited in line with regulations. In Cork, this figure was 46%.

The oversight of statutory visits was inadequate in many of the service areas. There were four service areas where the oversight of statutory visits was effective. In Donegal, social workers maintained a calendar on the front of each child's file. Cavan/Monaghan tracked visits using the child-in-care register.[3] In Dublin South Central, social work team leaders returned monthly data to the principal social worker in relation to statutory visits who maintained a tracker which detailed when children were visited. In Mayo, oversight was maintained through supervision and file audits. While some service areas were in the process of developing systems to track statutory visits, many areas had no effective system for the oversight of statutory visits.

Social workers worked in partnership with families and foster carers to ensure that children were facilitated to meet and keep in contact with their parents and siblings on a regular basis when this was in their best interests. Many children met their families in their foster homes. Social workers also supervised contact between children and their families when this was court-directed.

There was good practice in most service areas in ensuring that children with disabilities were provided with specialist services and that their care was coordinated. There was good evidence that joint meetings between Tusla and the Health Service Executive (HSE) were held on a regular basis. One service area, Carlow/Kilkenny/South Tipperary, did not consistently ensure that care of children with a disability was appropriately coordinated.

The standard requires that children's social workers explain the complaints procedure to children, provide written copies of that procedure to children, and assist children, where necessary, to complain about any aspect of their care. Tusla have produced child-friendly written information for children but it was not always evident that copies of this had been provided to children in care. While formal complaints were logged in all service areas and formal processes were in place to manage these, approximately half of the service areas did not have a system for logging informal and or verbal complaints made by children which meant that numbers of complaints by children and trends in relation to their complaints were not captured. In one area, Carlow/Kilkenny/South Tipperary, there was evidence

[3] Tusla is required by the regulations to establish and maintain a register with the particulars in relation to each child placed in foster care.

that several formal complaints had not been logged or responded to appropriately but they took action to address this following the inspection.

Improvement was required in case records in almost all service areas. Only one service area, Mayo, had case chronologies on all children's files, which was good practice. When used effectively the National Child Care Information System (NCCIS), Tusla's electronic case management system, facilitated better oversight of cases by managers. However, improvements were required to ensure a greater level of consistency across all 17 service areas. For example, there were no nationally agreed naming conventions or templates for documents such as records of statutory visits and no standardised chronologies that social workers could use. Templates were used for statutory visits in some but not in all service areas. NCCIS had not been completely embedded in some service areas. For example, Dublin South West/Kildare/West Wicklow continued to use both paper and electronic files. This meant that key information pertaining to children in care was not always readily available or easy to find on the child's file. This became particularly important early in 2020, given the necessity to access the child's file electronically as a result of working from home during the COVID-19 pandemic.

6.2 Standard 6: Assessment of children and young people

Standard 6: Assessment of children and young people

An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

Judgement	No of Areas	Service Areas
Compliant	11	**Kerry, Mid West, Midlands, Donegal, Dublin North City, Dublin South West/Kildare/West Wicklow, Waterford/Wexford, Mayo, Louth/Meath, Dublin South Central, Galway Roscommon**
Substantially Compliant	6	**Sligo/Leitrim/West Cavan, Dublin South East/Wicklow, Cavan/Monaghan, Carlow/Kilkenny/South Tipperary, North Dublin, Cork**

There was a high level of compliance with this standard across all 17 service areas. Eleven service areas were judged to be compliant with six service areas substantially compliant with the standard.

As part of the assessments of need, children were met with alone by the social workers, when this was appropriate. The views of the children, their families and others involved in their care were sought and listened to. In this way, they were facilitated to participate in the assessment process.

The assessments were comprehensive and, where appropriate, multidisciplinary. They considered the emotional, psychological, medical, educational and other needs of children.

In five service areas, the time frames within which assessments of need were completed required improvement and, in two service areas, not all children had medical assessments on their admission to care.

Each service area submitted data prior to inspection outlining the numbers of children who had been admitted to care in their area in the previous two years.

Inspectors found that child and family social workers ensured that the assessments of these children's needs were carried out prior to placement in most cases. Timely assessments were carried out for the majority of children who were admitted in an emergency.

Two service areas, Midlands and Mayo, were reported as having stand-alone assessment of need documents but these were not completed in all cases. In other service areas, assessments of need were outlined in a variety of documents, including placement request documents, court reports, case conference reports, initial assessments, and care plans.

6.3 Standard 7: Care planning and review

Standard 7: Care planning and review

Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

Judgement	No of Areas	Service Areas
Compliant	1	**Dublin South Central**
Substantially Compliant	3	**Mayo, Louth/Meath, Galway/Roscommon**
Non-compliant Moderate	10	**Sligo/Leitrim/West Cavan, Kerry, Cavan/Monaghan, Mid West, Midlands, North Dublin, Donegal, Dublin North City, Dublin South West/Kildare/West Wicklow, Waterford/Wexford**
Non-compliant Major	3	**Dublin South East/Wicklow, Carlow/Kilkenny/South Tipperary, Cork**

Tusla has a legal duty to ensure every child it places in foster care has a written up-to-date care plan which is reviewed in line with the frequency set out in the Child Care (Placement of Children in Foster Care Regulations) 1995. Well-managed child-in-care reviews seek to actively involve children (as appropriate to their age and understanding) and their families and support them to express their views about future care arrangements. This includes 'best interest' decisions as to whether the child will remain in foster care or return to the care of their parents or guardians.

Reviews provide an important check that the child's placement remains suitable, is working well for them and continues to meet their individual needs. They should provide assurance to all parties that the agreed outcomes for the child are being appropriately delivered and that any required changes, including additional supports, are promptly identified and addressed.

Out of all the standards inspected in this Phase 2 inspection programme, performance was weakest nationally against this standard. Three service areas, Dublin South East/Wicklow, Carlow/Kilkenny/South Tipperary and Cork, were rated non-compliant major, and a further 10 service areas were rated non-compliant moderate. Given that individual care planning and review arrangements are fundamental to promoting good outcomes for children in care and supporting their safety, wellbeing, development and identity, inspection findings indicate the need for Tusla to ensure local arrangements deliver a consistently high standard of social work practice in this area.

Four of the service areas were found to be either compliant or substantially compliant with this standard, with Dublin South Central fully compliant and Mayo, Louth/Meath and Galway/Roscommon substantially compliant. The key features of these service areas were that their management systems were effective in ensuring care plans and child-in-care reviews were kept up-to-date for all children in care, with almost all reviews taking place in line with the frequency set out in regulations. Good quality, comprehensive care plans were in place on children's records. There was evidence of the active involvement of children and their views and wishes shaping case discussion and decision-making. Review minutes were well maintained and shared with relevant others. Due consideration was given to the provision of additional support for children with complex needs or disabilities. There was effective identification and support for foster care placements at risk of breakdown. Taken together, these approaches supported a child-centred, responsive approach to meeting children's needs over time.

The quality, content and timeliness of care plans and child-in-care reviews for children in foster care overall was variable. At the time of the inspections, nine service areas had a backlog of care plan or review activity, with the other eight service areas generally ensuring timely review and updating of children's care plans or having only a small number of children waiting.

Care plans in the better performing service areas were generally child-centred, up-to-date and comprehensive. Good quality care plans provided a clear picture of children's wishes and needs with important details about their interests, needs and what family life was like for them. They also clearly set out any additional supports required by the child, their family and foster carers.

The features of those service areas performing well included:

- Direct involvement and recording of the voice of children, enabling them to shape and be well-informed about their future care arrangements. This involved social workers working closely with children to help them understand what a care plan was and why it was important. Good practice was seen in Louth/Meath where children's views and wishes were captured in 'child-friendly' bubbles within records to enhance their engagement. This approach provided a colourful, simple, child-friendly way of ensuring children were at the heart of the process. In the Midlands, a social worker, with children's input, had designed a phone application for children to make completion of review forms easier and more fun.

- Strong management support for the development of practice, equipping frontline staff with relevant tools, supervision and support. In Dublin South Central, social workers used standard templates for recording care plans, and reviews were rarely delayed. Staff had attended a workshop to help them better understand what a high quality care plan looked like. Social work team leaders provided monthly statistics to principal social workers and the area manager regarding their performance in delivery of child-in-care reviews, with evidence of significant progress made due to social workers having manageable caseloads. The Midlands has instigated an escalation system whereby the principal social worker was informed if a review had to be postponed or cancelled on two occasions. This helped ensure good management oversight of the impact of any delays for children. Audits of care plans had been effective in helping assess progress in driving quality improvement.

Inspectors identified significant concerns, including historical backlogs, in relation to care planning and review arrangements in Cork that were escalated to the regional service director. Such delays spanned less than a month overdue to several years, with significant differences in practice seen between its four local social work departments. These marked variations in practice had not been effectively managed. Cork, the service area with the largest number of children in care, had 248 child-in-care reviews that were overdue (almost a third of its child in foster care population some dating back over a four year period to 2016), and reported that only 66 children's care plans were not up to date. Inspectors queried the accuracy of this data, and also raised governance concerns with Tusla senior managers given the risks and a lack of evidence of an effective service improvement plan to address this significant backlog. A satisfactory compliance plan was subsequently received from the area which outlined plans to address the risks in relation to the Cork foster care service, including provision of additional resources, and the development of an area-wide child-in-care review team. The Mid West, the area with the second largest number of children in care nationally, had 71 reviews and care plans that were

overdue. Dublin North City reported it had 41 overdue reviews, and 67 care plans that were out of date. At the time of the inspection, it was taking action to streamline its care planning and review processes to ensure the data for reviews and care plans was appropriately aligned. Carlow/Kilkenny/South Tipperary had 191 overdue child-in-care reviews at the time of the initial inspection in May 2019. When the follow up risk-based inspection was undertaken in October 2020, the area still had a backlog of reviews that could not be accommodated within the existing review schedule. For example, 28 children were known to require a review in October 2020, but the schedule for reviews was full until March 2021. The area was seeking to appoint a further reviewing officer to address the ongoing backlog.

Inspectors found some service areas did not make best use of NCCIS, Tusla's electronic child care information system, to alert staff and managers when care plans and reviews were due, and others did not have effective plans to address and prevent future backlogs of reviews.

Service areas had different models in place for chairing child-in-care reviews. Independent child-in-care reviewing officers were appointed in some localities. In others, the meetings were chaired by team leaders, or a mixture of both. The key to service effectiveness appeared to be a whole-system approach with good advance planning and scheduling that considered not only organisational capacity to hold reviews that were due, but ensured capacity for contingencies, such as children recently admitted to care, placement breakdown or allegations against foster carers. Service areas' capacity to hold reviews promptly in response to significant changes in risk or a child's care situation varied. The need for timely reviews is essential in these circumstances.

Overall, priority was given to supporting foster care placements that were at risk of ending; with additional support or review at times of increased stress evident in most service areas. Good practice was seen in Donegal and the Sligo/Leitrim/West Cavan area where reviewing officers compiled a report of learning from disruption meetings which they shared with senior managers.

Stringent public health measures in response to the COVID-19 pandemic in March 2020 meant the majority of child-in-care reviews after that date were undertaken remotely through teleconference. Inspectors observed a number of reviews and found that chairpersons managed the process well and they worked hard to ensure the review meeting was sensitively undertaken and holistically addressed children's needs. Service areas recognised the significant pressures on children in care, their foster care families and birth families.

While there was generally good engagement by children in completing feedback forms in advance of their child-in-care review, levels of attendance and support for children and young people at their reviews remained an area for further

improvement in almost all service areas. The lack of appropriate, child-friendly accommodation for hosting meetings was highlighted as a specific deficit in some service areas. Not all children were given feedback on the decisions of their reviews, nor were changes to their care plan always discussed with them. This feedback was poorly evidenced on children's records in some service areas. Improvements were required to ensure changes made to care plans are routinely shared with children, their families and foster carers in a timely manner.

A minority of service areas had made efforts to ensure meetings were flexible to accommodate young people's wishes or other commitments such as school. Some service areas had considered the appropriateness of the venue and whether the child or young person wanted to attend all or part of their review in order to promote a child-centred, inclusive experience for children. For example, in Mayo, as the social work departments premises was not child friendly, where possible they held the review in the foster carers home, while in the Midlands social work offices were located in new buildings which had been made child-friendly through the involvement of a children's participation group in the area. In one office, children worked with an artist and their paintings were hung in hallways and offices. An art competition for children was being held in another part of the area with a view to including the children's work in the offices and meetings rooms there. However, other service areas such as Donegal continued to struggle to find child-friendly venues to hold review meetings. In addition, as reviewing officers or team leaders generally worked from 9am to 5pm, holding reviews during school hours did not always promote attendance by school-going children. Foster carers generally reported positively about their involvement in care planning and reviews. However, the engagement of the child, the child's parents and family overall remained an area for further development.

Inspectors found that the focus on long-term planning for children was not sufficiently explored or explicit within care plans and reviews. Some children who had been in care for periods in excess of six months, who were unlikely to return home were at risk of drifting in care. There had not been timely decision-making in relation to issues such as adoption, enhanced rights or family reunification. Review of parental consent and the use of voluntary care agreements was not always considered and updated as an integral part of child-in-care review arrangements. Gaps in practice in the management, review and updating of parental consent to voluntary care were identified in eight service areas. Care plans and child-in-care review actions would benefit from clearer timescales and accountabilities to help prevent risk of delay or drift in putting agreed actions in place.

Challenges remained in ensuring children could promptly access appropriate equipment or additional therapeutic supports such as speech and language therapy, occupational therapy or psychology professionals. Variable approaches to funding or

meeting children's additional needs were evident, which carried the risk of inequalities in access to service provision. Service areas acknowledged further work was needed to help children with learning disabilities to contribute to the development and review of their care plans.

Almost all service areas did not use placement plans as required by the standards. Galway/Roscommon's approach to placement planning was advanced compared to other service areas. There was potential for the focus of placement planning to be enhanced as many just referred to contact arrangements with the child's birth family, and did not outline the way in which a child's needs would be met on a day-to-day basis, as recommended in Tusla's Alternative Care Handbook.

Compliance plans submitted to HIQA following these inspections provided assurance that inadequate practice would be addressed, although some service areas were reliant on additional resources to achieve this, such as social work staff, and additional foster carers. HIQA continues to monitor area's ongoing progress against these plans, and this ongoing monitoring may include follow up inspections.

However, these inspection findings highlights the need for more effective management oversight of the care planning and child-in-care review process, with timely sign-off of care plans, and distribution of good quality child-in-care review minutes. As well as ensuring that the quality of the review meeting and the subsequent care plan is such that it includes all that is required to ensure a comprehensive care plan is implemented for each child in care, Tusla also needs to establish a system to interrogate and validate the data provided to them from each area in relation to this statutory requirement since the data provided in one area did not indicate the significant size of the problem, nor raise concerns at a national level.

6.4 Standard 8: Matching carers with children and young people

Standard 8: Matching carers with children and young people

Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

Judgement	No of Areas	Service Areas
Compliant	3	**Donegal, Louth/Meath, Galway/Roscommon**
Substantially Compliant	9	**Sligo/Leitrim/West Cavan, Kerry, Mid West, Midlands, North Dublin, Dublin North City, Waterford/Wexford, Mayo, Dublin South Central**
Non-compliant Moderate	4	**Dublin South East/Wicklow, Cavan/Monaghan, Carlow/Kilkenny/South Tipperary, Dublin South West/Kildare/West Wicklow**
Non-compliant Major	1	**Cork**

In selecting foster carers to meet the needs of an individual child, consideration should be given as to whether the foster carers have the capacity to meet the assessed needs of that particular child. This process is called 'matching'.

Thirteen of the 17 service areas had either placement officers or matching meetings to formally consider the children's needs and the skills and abilities of the proposed foster carers in order that the best match possible could be found. The remaining four service areas — Dublin South East/Wicklow, Dublin South West/Kildare/West Wicklow, Cork and Dublin South Central — had neither matching meetings nor placement officers and evidence of the matching process was not available on the children's files in all cases. Even when there was a formal matching process, evidence of the matching process was not always available on the children's files.

Inspectors found that there were five service areas, Sligo/Leitrim/West Cavan, Waterford/Wexford, Mayo, Louth/Meath and Galway/Roscommon, where good evidence of the matching process was found on children's files or provided to inspectors separately.

Two service areas lacked robust formal matching processes. In Dublin South East/ Wicklow, there was no formal matching process in place and there was a shortage of foster carers. In the Cork area, 35 children were awaiting a foster care placement at the time of inspection and there were concerns about the capacity and sustainability of fostering arrangements and the impact this was having for children. Social work practice in matching children with appropriately skilled and experienced foster carers, including long-term matching, was under-developed. Strategies to effect change and improvement were largely ineffective in preventing delays and tackling poor experiences for children at a significant point of crisis in their lives.

Social workers generally looked initially to the children's extended family network first to see if a suitable placement could be found. The percentage of children placed with relatives varied from area to area and from a low of 15% in Donegal to a high of 44% in Dublin South West/Kildare/West Wicklow.

The majority of service areas, 11 out of 17, were reported as not having a sufficient number of foster carers, which reflected a national shortage of foster carers within the Tusla system. This resulted in some children being placed with private foster care services outside their local area, sometimes being at a distance from friends and family and having to change schools. In some cases, given the shortage of placements, children were placed with Tusla foster carers who already had other children placed with them, resulting in placements where the number and mix of children was not in line with the national standards.

It is good practice that, before a child is placed with foster carers, the child is given the opportunity to meet their proposed foster carers and their views are sought regarding the suitability of the proposed placement. The reports of 15 of the 17 inspections commented that, in many cases, children who replied to questionnaires told inspectors that they did get to meet their proposed fosters carers and their views were sought, which is good practice. In some cases, children were too young to be consulted or they needed to be placed quickly in an emergency situation.

Since the capacity of foster carers to meet the needs of children is not always apparent at the beginning of a placement, the suitability of long-term matches between children in care and foster carers should be considered and approved by the Foster Care Committee once it is planned that a placement is likely to be for at least six months' duration. Only in two of the service areas, Donegal and Louth/Meath, were there systems in place to ensure that long-term matches were progressed in a timely manner. In the remaining 15 service areas, there were

backlogs in long-term matching. In some service areas, such as Cavan Monaghan (with 104) and Dublin South West/Kildare/West Wicklow (with 58), there were large backlogs and no plans in place to address this issue. Compliance plans submitted by these service areas provided clear commitments in regard to plans to address these backlogs.

Some good practice was evident in the area of matching. For example, in Donegal, all children who could meet their prospective foster carers were given the opportunity to do so and there were no children who were awaiting approval of their long-term matches. Waterford/Wexford and Louth/Meath service areas used matching templates to set out the key criteria that were considered in the matching process. This allowed the foster care department to clearly document the needs of the child and the suitability of prospective foster carers to meet these needs.

In another example of good practice, the Galway/Roscommon service area had completed a review of foster care services for Traveller children in care in May 2020. The report noted that 61% of Traveller children in care were cared for by Traveller foster families compared with 3% in 2014. It also noted that the fostering department would continue with recruitment campaigns and proactively recruit, train and assess general foster carers from the Traveller community so that Traveller children coming into care could continue to live within their own culture.

6.5 Standard 10: Safeguarding and child protection

Standard 10: Safeguarding and child protection

Children and young people in foster care are protected from abuse and neglect.

Judgement	No of Areas	Service Areas
Compliant	2	**Mayo, Galway/ Roscommon**
Substantially Compliant	7	**Dublin South East/Wicklow, Midlands, Dublin North City, Dublin South West/Kildare/West Wicklow, Louth/Meath, Cork Dublin South Central**
Non-compliant Moderate	5	**Kerry, Carlow/Kilkenny/South Tipperary, North Dublin, Donegal, Waterford/Wexford**
Non-compliant Major	3	**Sligo/Leitrim/West Cavan, Cavan/Monaghan, Mid West**

Of the 17 service areas inspected, more than half (nine) were either compliant or substantially compliant with the standard. Two service areas, Mayo and Galway/Roscommon were compliant. This standard was also covered during Phase 1 of the thematic programme of foster care inspections and the Phase 2 programme found that significant improvements had been made in this area. During the Phase 1 inspection programme, 12 out of 17 service areas were found to be in major non-compliance with the safeguarding and child protection standard.

In both Phase 1 and Phase 2 inspection programmes, the management of concerns, allegations and complaints against foster carers and also the management of child protection concerns against persons other than foster carers were reviewed.

In addition, Phase 2 focused on the standards related to children in care and reviewed additional issues such as:

- children's social workers having appropriate knowledge and skills
- safety planning for children

- safeguarding visits to children
- training and guidance for foster carers in the protection of the children in their care.

There were two main aspects to compliance with this standard, child protection and safeguarding.[4]

In the area of child protection, service areas were assessed with regard to their management of concerns, allegations and complaints against foster carers and the implementation of the *Interim Protocol for managing concerns and allegations of abuse or neglect against Foster Carers and Section 36 (relative) Foster Carers* (Tusla, April 2017) was key to this. Service areas were also assessed with regard to how they ensured that the investigation of child protection concerns and allegations against people other than the foster carers were managed in accordance with *Children First: National Guidance for the Protection and Welfare of Children* (2017). The service areas that were judged to be compliant had good systems in place for managing concerns and allegations appropriately and in a timely manner. They also demonstrated good management oversight, whereby managers had systems for tracking the progress of investigations and for ensuring that the correct procedures were followed throughout and that any delays were addressed.

With regard to safeguarding in the service areas judged to be compliant, social workers presented as having the appropriate knowledge and skills, they demonstrated commitment to safeguarding and protecting the children to whom they were allocated, and they were clear about the processes to be followed. In these service areas, foster carers had been provided with training which equipped them to protect the children in their care and to report any child protection concerns that arose in line with their role as mandated persons under the legislation. Other key features of compliance were education for foster carers on a range of safeguarding issues, good safety planning when children were at risk, and the separate allocation of social workers to foster carers and to the children in care, who visited the foster care households regularly and developed relationships with the foster carers and the children.

During Phase 2 of the programme, some good practice was evident in the oversight of allegations and concerns against foster carers, with managers in 13 of the 17 service areas reported as tracking the progress of these investigations. Examples of serious concerns about foster carers may include inappropriate use of sanctions, misuse of allowances and or concerns about the foster carers' care of the child. An allegation refers to any suspected case of child abuse or neglect. However, oversight

[4] Safeguarding is the action that is taken to promote the welfare of children and protect them from harm. Safeguarding means: protecting children from abuse and maltreatment; preventing harm to children's health or development; ensuring children grow up with the provision of safe and effective care.

of allegations made by children in care against persons other than their foster carers required improvement as inspectors reported that managers did not track the progress of these investigations in nine of the 17 service areas.

In three service areas, Sligo Leitrim/West Cavan, Cavan Monaghan and Mid West, not all allegations made by children in care were investigated in line with Children First (2017) and safety planning was not adequate for all children who required a safety plan. In each of these service areas, inspectors escalated a number of cases to the area manager and received assurances that the cases in question had been reviewed and appropriate action taken. In seven service areas, *the Interim Protocol for managing concerns and allegations of abuse or neglect against Foster Carers and Section 36 (relative) Foster Carers* (Tusla, April 2017) was not followed in all cases and, in 11 service areas, investigations into allegations by children in care were not always timely and in line with Children First (2017).

In only five of the 17 service areas was safety planning for children in care found to be adequate. A safety plan is a plan to address or mitigate a specific risk that exists in relation to a child. In foster care, a good quality safety plan should be developed by both the child-in-care social worker and the link social worker and should reflect the involvement of the child, where appropriate, and the foster carers. Parents, when this is appropriate, should also be consulted in relation to the safety plan or advised that one has been put in place. Risks should be clearly identified and the measures to keep the child safe should be clearly outlined. Arrangements to monitor and review the safety plan should be specified and a manager should maintain oversight of the safety plan. Good practice was evident in a number of service areas. In Mayo, for example, the service area decided that safety plans should be stand-alone documents in the children's files and this was evident in the majority of files reviewed. These plans were signed by the foster carers, the child-in-care social workers and the fostering link social workers and were of good quality. Safety plans were also evident within initial assessments and on emails recorded on children's files. In the service areas where safety planning was not of good quality, inspectors found that some children either did not have safety plans when they required them or the safety plans in place were of poor quality, containing little evidence of collaboration in their development or of arrangements for review and monitoring.

In all of the service areas, social workers presented as having appropriate knowledge and skills and were committed to safeguarding and protecting the children in care for whom they held responsibility. However, in some service areas and for a variety of reasons, there were delays in the children's social workers reporting allegations to the duty or intake team and there was a lack of a clear understanding of the Interim Protocol which meant that the protocol was not implemented in full in each case.

Every service area had a range of safeguarding practices in place to protect children from all forms of abuse. Good practice was evident in several service areas. For example, in the Sligo/Leitrim/West Cavan service area, all foster care households had an allocated link social worker and all children in care had an allocated social worker. Social workers visited children in their foster care homes and children told inspectors they felt listened to. Children in care had been given information on their rights and the service area promoted independent advocacy. Safe care plans were drawn up with foster carers to ensure that they all were clear about the boundaries around issues such as family routines, how affection was demonstrated, use of the Internet and about the way in which issues, such as bullying, would be dealt with.

However, in some service areas, safeguarding practices required improvement. For example, in Carlow/Kilkenny/South Tipperary, while the management of risk and associated safeguarding measures ensured children were visited, these measures were not reliable in regard to enabling children to disclose potential abuse. Ongoing difficulties with the retention of social workers presented significant difficulties in allocating a consistent social worker to children in care which reduced the likelihood that children would disclose their concerns or allegations to a familiar professional. This issue was risk escalated by the area manager to the Tusla Chief Operations Officer and measures were put in place to address this.

Children First (2017) designated foster carers as mandated persons who are required to report child protection concerns and, as a result, service areas had to ensure that their foster carers were aware of their responsibilities and how to discharge them. Tusla developed online training on this topic. However, while foster carers who met with or spoke to inspectors told them they had been made aware of their responsibilities, reports on seven of the service areas indicated that not all foster carers had received this training.

6.6 Standard 13: Preparation for leaving care and adult life

Standard 13: Preparation for leaving care and adult life

Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

Judgement	No of Areas	Service Areas
Compliant	8	**Sligo/Leitrim/West Cavan, Kerry, Cavan/Monaghan, Mid West, Midlands, Donegal, Louth/Meath, Cork**
Substantially Compliant	5	**Dublin North City, Waterford/Wexford, Mayo, Dublin South Central, Galway/ Roscommon**
Non-compliant Moderate	3	**Dublin South East/Wicklow, North Dublin, Dublin South West/Kildare/West Wicklow**
Non-compliant Major	1	**Carlow/Kilkenny/South Tipperary**

In 2017, Tusla developed a national aftercare policy which was in line with the Child Care Amendment Act 2015 and which provided a clear focus for the development of aftercare services in each local service area. A key feature of the new policy was the central role of young people in the development of their own aftercare plans. This inspection programme focussed primarily on the aftercare services provided to young people in the 16-18 years age range. A limitation of this inspection programme in regard to aftercare was that HIQA could not assess the quality of the aftercare service provided to 18-23 year olds as this falls outside the legal remit of our inspections.

Thirteen of the 17 service areas inspected demonstrated a high level of compliance with the national standards and, in these service areas, the new national policy was fully, or almost fully, implemented.

At the time of inspection, almost all service areas had a dedicated aftercare manager post. Two service areas, Dublin South West/Kildare/West Wicklow and Dublin SouthEast/Wicklow did not and Mid West had a vacancy for an aftercare manager in North Tipperary. Plans were in place at a Tusla national level to ensure that each service area had an aftercare manager by 2020 and that some of the larger service areas had more than one aftercare manager, according to their population of young people.

While all service areas had dedicated teams of aftercare workers, five of the 17 service areas, Dublin South East/Wicklow, Mid West, Dublin North City, Dublin South West/Kildare/West Wicklow, and Dublin South Central, also had contracts with external services to provide aftercare services in addition to that provided by their own teams.

A common finding on all inspections was that young people who were referred to the aftercare service and were allocated an aftercare worker were actively involved in planning for their future care. However, not all young people were referred to the aftercare service in a timely manner. Five service areas, Mid West, Carlow /Kilkenny/South Tipperary, North Dublin, Dublin South West/Kildare/West Wicklow and Galway/Roscommon, were reported as having a referral system that was not effective. This meant that not all young people were referred to the aftercare service when they reached 16 years of age and this sometimes led to delays in completing assessments and to delayed aftercare plans.

Assessments of need were completed on standardised national templates and were generally found to be comprehensive and of good quality. In one area, Dublin South East/Wicklow, the assessments were found to be of poor quality. In Galway/ Roscommon, assessments of need were not timely in two of six assessments reviewed and, in Waterford/Wexford, six of the 14 assessments reviewed were not completed in a timely manner.

Aftercare plans were also completed on standardised national templates. An aftercare plan is a written plan that is prepared by the aftercare worker and the young person/young adult in conjunction with their social worker and other key people in their lives. The plan is based on the assessment of need and aims to outline clearly the supports required for the young person in their transition into adulthood.

The majority of aftercare plans reviewed by inspectors were described as comprehensive, good quality and timely. Practice across most of the service areas was for aftercare planning to begin for the majority of children at the age of 17 years in order that assessments of need and aftercare plans were completed by the age of 17 and a half years.

Inspectors found that young people involved in the aftercare service were receiving adequate support and were provided with the necessary skills for independent living. However, at the time of the thematic inspection, in one area, Carlow/Kilkenny/South Tipperary, not all young people who were eligible were receiving an aftercare service. The follow-up inspection to this service area later in 2020 found that significant progress had been made, and the area had moved from being major non-compliant to fully compliant in the intervening time.

There were many examples of good practice in aftercare services around the country. For example, every young person in aftercare in Sligo/Leitrim/West Cavan had an allocated aftercare worker. North Dublin had a young parents' group for young people in their aftercare service. Louth/Meath facilitated a group of young people to train as mentors to other young people coming into the aftercare service.

All service areas, with the exception of Mayo, had aftercare steering committees. These committees had multidisciplinary and multi-agency memberships and generally included representatives from the Tusla aftercare service, HSE services (such as the disability services, mental health services, addiction services), the local authorities, and regional representatives from an independent advocacy service.

Each committee provided a forum for planning, implementing and monitoring aftercare plans for young people in receipt of aftercare services who had complex needs.

Aftercare drop-in services were provided in service areas throughout the country. They served a number of functions in that they provided a point of contact for young people who were using the aftercare service and for people who had been previously in the care system. Young people could contact the drop-in service for support, advice, guidance or advocacy.

Aftercare managers in the majority of service areas produced annual reports of the adequacy of their services. Four service areas, Kerry, Mid West, Carlow/Kilkenny/South Tipperary and Waterford/Wexford had not produced an annual report. A further three service areas, Midlands, Dublin South West/Kildare/West Wicklow and Dublin South Central, had also not produced annual reports but had developed service plans for their aftercare services, taking into account the adequacy of their services and areas for improvement.

Tusla did not have an overall system in place to track the outcomes for young people who left care but all of the service areas inspected submitted monthly returns to the Tusla national office on referrals to their aftercare service, assessments undertaken, aftercare plans completed and the timeframes involved. They also provided useful data on the outcomes for young people involved in the aftercare services under the headings of education, finance, and accommodation.

7. Conclusion

This programme of inspection indicated that many service areas had made progress in achieving compliance with standards and improving the service provided to children in care. Well-governed and well-managed services had learned from previous HIQA inspections, their own internal auditing processes, and had transferred the learning from other service areas to improve their service. This is a significant step in ensuring that the services provided by Tusla to children in care are consistent and equitable.

As outlined, many service areas achieved high levels of compliance during this inspection programme with four service areas achieving compliance or substantial compliance across all of the standards. However, areas of non-compliance were identified in 13 services areas. Significant risks were identified in two service areas. One demonstrated improvements after a follow-up risk-based inspection, and the other will be inspected as part of HIQA's ongoing monitoring programme.

The significant message received from children in care was that when they had a long-term stable social worker, they received a good service. The majority of children spoke highly of their social workers and foster carers. However, not all children in care had an allocated social worker. Some children had experienced several changes in social workers, some had not yet met their social worker, and it had been some time since others had seen their social worker.

There remains an ongoing challenge for Tusla to recruit and subsequently retain an adequate workforce in order to deliver a high-quality, safe, consistent and equitable service to all children in care. While some service areas had addressed this by implementing alternative arrangements in an effort to reduce the impact of this on children in care in their area, other service areas were less effective in managing the statutory requirements for unallocated children in care. HIQA welcomes the Tusla initiative to commit to the recruitment of social work graduates from the upcoming 2021 academic programme.

The recruitment of foster carers also continues to be an issue in some service areas, and despite significant recruitment initiatives, service areas continue to struggle to ensure that there are adequate suitable placements for children in care in their area. The majority of services areas were reported as not having a sufficient number of foster carers, reflecting the national shortage of foster carers within the Tusla system.

The overarching high level of compliance found across 13 of the service areas in relation to their leaving care and aftercare service is also a significant and welcome improvement, as this is a critical time for vulnerable children. The commitment of

these service areas to planning and supporting children in their areas when leaving care was very evident.

HIQA's Phase 1 overview report published in 2019 identified that, throughout the thematic monitoring programme in 2017 and 2018, it became apparent that similar findings were arising in each service area. Despite these being highlighted early in 2017, the same findings were still evident in the 2018 inspections. Phase 1 found little consistency across service areas and practice varied in service areas within a region. The lack of shared learning and development of common systems across the country, within regions and between regions, was noted in the variety of different systems that had been set up nationally. In Phase 2 of this thematic programme, it was evident that many service areas had learned from previous inspections and findings. Of note is that four of the six service areas inspected in 2020 achieved either full compliance or substantial compliance in all six standards. These service areas demonstrated proactive learnings from the phase 2 inspections carried out in 2019, and there was evidence of significant efforts to drive improvements in these service areas. Regional initiatives that had been put in place following the Phase 1 programme, such as the 'Task and Finish Group' in the West which had been effective in the implementation of learnings from inspections by standardising identified good practices.

National initiatives, such as the National Aftercare Implementation Project Group, had also been effective as evidenced by the high level of compliance with this standard. Some of the main aims of this group included the following:

- implementation of standardisation in aftercare service provision nationally
- development and implementation of a National Aftercare Implementation Project Plan
- implementation of the revised Aftercare Policy 2017 and associated best practice guidance documents
- work with aftercare service providers to identify resources required and to address any barriers to the delivery on Tusla business plan commitments
- support for new initiatives within the context of aftercare service provision and development of interagency cooperation and collaboration.

While there were improvements in many service areas in relation to oversight of key practice, and several examples of good initiatives, the opportunities to create further consistency across the service areas were not taken and still required development. For example, four service areas had implemented systems to track statutory visits to children, and while this is an example of improved governance, all four service areas implemented different methods to do so. While it is not necessary for all service

areas to use the same systems, the rolling out of an already tried and tested system across all 17 service areas would be a more efficient and cost effective way to promote good governance of a key statutory requirement, such as visiting a child in care, and to drive consistency in the service provided. Similarly, there were a variety of different processes for matching children to foster carers with the capacity to provide care to meet the child's assessed needs. There was no nationally agreed effective process in order to drive quality improvement in this key area, which potentially could identify the most suitable placements, and therefore prevent placement breakdowns.

Care planning and review processes also require a consistent approach both regionally and nationally. While compliance plans submitted to HIQA following these inspections provided assurances that inadequate practices would be addressed, some service areas were reliant on additional resources to achieve this. HIQA continues to monitor the ongoing progress of service areas against these plans, and this ongoing monitoring may include follow up inspections. However, these inspection findings highlight the need for stronger management oversight of the care planning and child-in-care review process, to ensure a comprehensive care plan is implemented for each child in care. Tusla also needs to establish a system to interrogate and validate the data provided to them from each area in relation to this statutory requirement.

Similarly, HIQA found that practice in relation to voluntary care agreements (VCAs) and ensuring they were up to date, and reviewed in line with Tusla guidance, varied between service areas. 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. Despite escalating concerns in the early part of the 2019 inspection programme in relation to VCAs which were out of date, or had significantly lengthy time frames, or were 'open-ended', there continued to be inconsistencies in how each service area ensured that practice in this regard was in line with Tusla guidance and best practice. HIQA brought this to the attention of the Tusla national office again in 2020.

While some good practice initiatives were found in isolation, there was room for further sharing of these initiatives to other service areas. When service areas implemented nationally agreed policies, processes and standardised forms, more consistent practice and a higher level of compliance was noted, as can be seen by the implementation of the aftercare policy leading to a higher level of compliance in 13 of the 17 service areas.

Further work is required by Tusla to continue to raise compliance with the *National Standards for Foster Care* across and within the services areas and to ensure that, where risks remain, these risks are appropriately managed. This will ensure all children in foster care have access to a safe, high-quality service that meets their needs.

8. Next steps

HIQA will continue to monitor service areas where there continued to be non-compliance found in 2019 and 2020, and will continue to request and risk assess compliance plan updates, and, when necessary, carry out further risk-based inspections.

The 2017 to 2018 foster care inspection programme, Phase 1, focused on the recruitment, assessment and approval of foster carers, foster care reviews, support, supervision and training of foster carers, including the arrangements in place for safeguarding and child protection.

The 2019 to 2020 inspection programme, Phase 2, focused on the arrangements in place for the assessment of need for children in care, and the care planning and review process, including preparation and planning for leaving care, matching carers with children and safeguarding.

The 2021 to 2022 thematic inspection programme, which commenced in May 2021, will focus on assessing the efficacy of governance arrangements across these foster care services, and the impact these arrangements have for children in receipt of foster care. This thematic programme will be the third and final phase of a three-phased schedule of inspection programmes monitoring foster care services. As this inspection programme is focusing on service quality improvement, only those service areas deemed to have previously had a high level of compliance with standards, will be included in this inspection programme. All other service areas will continue to be monitored and inspected in line with our risk-based monitoring approach.

Appendix 1 — Focused inspections by service area

Service area	Inspection dates
Sligo/Leitrim/West Cavan	28 January 2019 – 31 January 2019
Dublin South East/Wicklow	12 February 2019 – 14 February 2019
Kerry	25 March 2019 – 28 March 2019
Cavan/Monaghan	15 April 2019 – 19 April 2019
Mid West	29 April 2019 – 2 May 2019
Midlands	14 May 2019 – 17 May 2019
Carlow/Kilkenny/South Tipperary	21 May 2019 – 24 May 2019
North Dublin	10 June 2019 – 13 June 2019
Donegal	24 June 2019 – 28 June 2019
Dublin North City	12 August 2019 – 15 August 2019
Dublin South West/Kildare/West Wicklow	9 September 2019 – 12 September 2019
Waterford Wexford	3 February 2020 – 6 February 2020
Mayo	24 February 2020 – 27 February 2020
Louth/Meath	19 August 2020 – 26 August 2020
Dublin South Central	12 October 2020 – 16 October 2020
Galway/Roscommon	9 November 2020 – 12 November 2020
Cork	28 September 2020 – 1 October 2020

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