

## Statutory foster care service inspection report

Health Information and Quality Authority  
Regulation Directorate monitoring inspection  
report on a statutory foster care service under the  
Child Care Act, 1991



<b>Name of service area:</b>	North Dublin Service Area
<b>Dates of inspection:</b>	10 - 13 June 2019
<b>Number of fieldwork days:</b>	Four
<b>Lead inspector:</b>	Erin Byrne
<b>Support inspector(s):</b>	Jane McCarroll Lorraine O'Reilly Sharron Austin Tom Flanagan
<b>Type of inspection:</b>	<input checked="" type="checkbox"/> <b>Announced</b> <input type="checkbox"/> <b>Unannounced</b> <input type="checkbox"/> <b>Full</b> <input checked="" type="checkbox"/> <b>Focused</b>
<b>Fieldwork ID:</b>	<b>MON-0026955</b>

## 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 and Youth Affairs, 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 Office of 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.

## About monitoring of statutory foster care services

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 continual improvement so that children have better, safer services.

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

As part of the HIQA 2019 monitoring programme, HIQA is conducting focused inspections across 17 Tusla service areas focusing on **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**. These focused inspections will be announced, and will cover six of the national standards.

This inspection report sets out the findings of a monitoring inspection against the following themes:

<b>Theme 1: Child-centred Services</b>	<input type="checkbox"/>
<b>Theme 2: Safe and Effective Services</b>	<input checked="" type="checkbox"/>
<b>Theme 3: Health and Development</b>	<input type="checkbox"/>
<b>Theme 4: Leadership, Governance and Management</b>	<input type="checkbox"/>
<b>Theme 5: Use of Resources</b>	<input type="checkbox"/>
<b>Theme 6: Workforce</b>	<input type="checkbox"/>

## 1. Inspection methodology

As part of this inspection, inspectors met with the relevant professionals involved in the child in care service and with children in care, young people availing of the aftercare service and with foster carers. Inspectors observed practices and reviewed documentation such as care files, and relevant documentation relating to the areas covered by the relevant standards.

During this inspection, the inspectors evaluated:

- the social worker role
- assessment of children in care
- matching of children in care and foster carers
- care plans, placement plans
- safeguarding processes
- the leaving and aftercare service.

The key activities of this inspection involved:

- the analysis of data submitted by the area and questionnaires completed by 63 children in care and eight young people in aftercare
- meeting with or speaking to 18 children, and with eight young adults availing of the aftercare service
- interviews/meetings with the area manager, the principal social workers for the children in care, the manager for aftercare and the chairperson of the foster care committee
- home visits to seven foster care households
- focus groups involving children in care social workers, child protection social workers, fostering social workers, team leaders for the long-term children in care team, aftercare workers and with foster carers

- review of the relevant sections of 68 files of children in care as they relate to the theme
- phone calls/meetings with three parents of children in care.

## **Acknowledgements**

HIQA wishes to thank the staff and managers of the service for their cooperation with this inspection, the children in care who completed questionnaires, and the children in care, parents of children in care, young people in aftercare and foster carers who met with or spoke to inspectors.

## **2. Profile of the foster care service**

### **2.1 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 and Youth Affairs. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency (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 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 chief operations officer, who is a member of the national management team.

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

## 2.2 Service Area

According to data published by Tusla in 2018, the North Dublin service area had a population of children aged 0-17 years of 100,654.\*

The area is under the direction of the service director for Tusla, North Dublin East Region, and is managed by an area manager. There were two principal social workers in the area, who had responsibility for the foster care, child in care, leaving care and aftercare services.

The long-term children in care team, and the leaving care and aftercare team were based in Airside Business Park in Swords. The child protection teams, who had responsibility for the care of children in care until they were transferred to the long-term children in care team, were located between Swords and Blanchardstown offices within the service area.

At the time of the inspection there were 299 children in foster care in the area. Of these, 102 children were placed with relatives and the remaining 197 children were placed with general foster carers, 30 of whom were placed with private foster carers.

The organisational chart in Appendix 2 describes the management and team structure as provided by the Tusla service area.

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\*Annual Review on the Adequacy of Child Care and Family Support Services Available – 2016 (Tusla website, July 2018)

### 3. Summary of inspection findings

The Child and Family Agency (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 produce these outcomes consistently.

This report reflects the findings of the focused inspection, which looked at the role of the social worker, the assessment of children's needs, care planning and statutory reviews, matching, safeguarding and child protection, and preparation for leaving care and adult life.

In this inspection, HIOA found that, of the six national standards assessed:

- two standards were substantially compliant and,
- four standards were moderate non-compliant.

Children who met with or spoke with inspectors were mostly positive about their experience in foster care and their social workers. Most children, where appropriate, had knowledge and awareness of the planning and review of their care and the majority of children who attended reviews felt listened to. Where children were in receipt of an aftercare service they spoke highly of it and reported that the service helped them prepare for their future; however, a significant number of eligible children had not been referred to aftercare and this was a cause of anxiety and stress for them. Less than half of children who participated in this inspection knew how to make a complaint.

At the time of inspection 90% of children in care in the North Dublin service area had an allocated social worker and all foster carers had an allocated fostering social worker. Safeguarding measures had been put in place to ensure where children were not allocated to a social worker that they were visited by a member of the team. While safeguarding visits for all children had been completed in the months prior to inspection there had been significant gaps in visits to some of these children over the previous two years. Records of statutory visits required improvement as many were poor quality and in a large number of files reviewed records of visits were absent.

A small number of parents who came to meet with inspectors described a poor experience in their dealing with the social work department. They found that communication with social workers was very difficult. Foster carers similarly, three of four, said they had difficulties accessing children's social workers for information and

this was a cause of frustration at times. All foster carers had allocated fostering link workers and said that the support they received from their link social workers was “brilliant”.

There was good coordination of input of other professionals and agencies within the area for children with a disability but availability of services was an issue and delays existed for some children requiring specialist services. There were established integrated case management team meetings occurring in the area. Managers from the Health Service Executive disability services and Tusla attended these meetings monthly during which planning for these children was discussed.

Records in respect of each child were maintained both on an electronic system and a paper file within the area. The national child care information system (NCCIS) was not yet fully embedded into practice and the area was still heavily dependent on local registers for oversight and monitoring. Inspectors found that records were not up to date, relevant information was missing and the majority of files did not contain chronologies. In the majority of cases where information was sought these records were awaiting completion by social workers.

Social workers carried out assessments of the needs of children placed in foster care and these were recorded in a variety of ways. Assessments were found to be good quality, timely, comprehensive and multi-disciplinary with participation by children and families where appropriate. However, evidence of medical examinations upon admission to care was not available on all children's files where required.

Care planning and reviews for children in care required improvement within the area and interventions to address these known deficits had begun to be implemented prior to this inspection. Not all children had an up-to-date care plan and child in care reviews were not taking place within statutory timeframes for all children. The quality of care plans varied and improving quality had been identified as a key priority within the area.

The management team within the area had implemented a number of measures in an effort to improve compliance with statutory requirements in relation to reviews of children's care and were aware of the risk of cases awaiting allocation drifting without regular reviews therefore, had close oversight of interim measures to ensure all children were safe and risks were identified.

In the majority of child in care review minutes examined, all aspects of the child's care was reviewed, there was input from all relevant parties and consultation with children prior to their child in care reviews was evident. Inspectors found that where

a child's placement had ended unexpectedly or was at risk of ending the care review processes were prompt. Children did not routinely attend child in care reviews; however, reported that they were encouraged to attend by their families and social workers. Children articulated difficulties associated with the high turnover of social workers impacting on their engagement in the care planning processes. Relaying of decisions and distributing copies of children's updated care plan following child in care reviews was not routine practice in the area.

Quality of care plans examined varied but in the majority (89%) of care plans recorded consideration of all of children's care needs. Placement plans were not being developed as required and were absent on the vast majority of files reviewed by inspectors.

This inspection identified that reviews of the voluntary consent given by parents for children to be admitted into the care of Tusla was not routinely occurring. The area held the view that consent was implied when there was no wish to formally revoke consent expressed by a parent. However, this inspection found that even when children were in long term care, with no plan to return home to the care of their parents, no care order was sought and no valid record of consent by parents maintained in many cases. This matter was escalated by HIQA to the area manager following inspection and appropriate assurances were received including a timeframe for completion of required actions to address this issue.

This inspection found that there was a good process for matching children to foster carers in place in the area. However, there was a shortage of foster carers, a high number of children placed outside the area and a waiting list for children awaiting a foster care placement. Placements for teenage children were difficult to find and in many instances it was necessary to use out of hours emergency placement services for these children. Actions to tackle these issues had been implemented in the area. Recruitment of carers within North Dublin service area was a priority and a recruitment campaign had begun.

North Dublin service area followed the process for long-term matching children with their carers as outlined within National Standards for Foster Care however, in practice this process was not timely and did not ensure compliance with standards.

Management of complaints, allegations and serious concerns against foster carers was good but not always timely. Initial assessments of allegations were completed as required, the quality of assessments was good and immediate steps were taken to ensure that children were safe where required; however, two of seven

assessments examined were found to have taken more than six months to conclude. Assessment of serious concerns were comprehensive, they were correctly categorised and managed and investigated in line with Tusla Policy. Where necessary serious concerns in which allegations of abuse were subsequently identified were addressed through an initial assessment process and appropriately notified to the foster care committee. Safety plans were in place where required in all but one case reviewed by inspectors. Assurances were sought and received from the area manager following this inspection in relation to one safety plan which was found did not adequately safeguard the children concerned.

During the course of this inspection inspectors found one case in which historical allegations made by children in care some dating back to 2010, in relation to the foster carers had not been addressed. As a full assessment of the allegations required involvement of another service area, assurances were sought from the local area management team and the regional service director following this inspection. Appropriate assurances including a detailed schedule of investigation was provided by the service director in response.

Inspectors found that notifications were made to the foster care committee as required. Decisions of the social work department were reviewed by the committee and where necessary further information sought; however, responses were not provided in all cases and questions by the committee on decisions by social work teams were not responded to or addressed.

Information provided to children on how to make a complaint and management of complaints required improvement. Delays in addressing children's complaints existed and there was inconsistency in the processes for recording of complaints by social workers. Complaints which were resolved locally by social workers and recorded as case notes on children's files were not all recorded on the complaints register. As all social workers did not record verbal or informal complaints as a complaint it was not possible to trend issues of dissatisfaction with the service and data relating to complaints was not reliable.

Children and young people in receipt of aftercare received a good quality service and spoke very highly of it; however, there were delays in referring some young people. Inspectors found that two thirds of those eligible within the area had not yet been referred to aftercare, despite some having already turned 17 years old.

Issues outlined above and other issues identified during the inspection are contained in the action plan which can be found at the end of this report.

## 4. Summary of judgments under each standard and or regulation

During this inspection, inspectors made judgments against the National Standards for Foster Care. They used four categories that describe how the national standards were met as follows. We will judge a provider to be compliant, substantially compliant or non-compliant with the regulations and or national standards. These are defined as follows:

- **Compliant:** a judgment of compliant means that no action is required as the provider or person in charge (as appropriate) has fully met the standard and is in full compliance with the relevant regulation.
- **Substantially compliant:** a judgment of substantially compliant means that some action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.
- **Non-compliant:** a judgment of non-compliance means that substantive action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

National Standards for Foster Care	Judgment
<b>Theme 2: Safe and Effective Services</b>	
<b>Standard 5:</b> The child and family social worker	Non-compliant Moderate
<b>Standard 6:</b> Assessment of children and young people	Substantially Compliant
<b>Standard 7:</b> Care planning and review	Non-compliant Moderate
<b>Standard 8:</b> Matching carers with children and young people	Substantially Compliant
<b>Standard 10:</b> Safeguarding and child protection	Non-compliant Moderate
<b>Standard 13:</b> Preparation for leaving care and adult life	Non-compliant Moderate

## What children told us and what inspectors observed

An inspector met with 15 children in their foster homes during this inspection. In addition inspectors received 72 questionnaires from children and young adults expressing their views of the foster care service, met with or spoke with 11 additional children and young adults during focus groups or telephone calls throughout the course of this inspection.

Children were positive about their experience in foster care. Children were offered the opportunity to provide comments on what they liked about their foster families and 55 children responded all indicating their happiness in their care placements. Examples of comments from children included:

"They treat me like I am actually their blood. They never give me special treatment and I am proud to call them my family. They are always here for me and of course we argue but that's how family is and I really love them"

"I really like where I live and would really love to permanently stay here. My foster family are taking care of me and my Brother. They always have our best interests at heart"

"We have a cute dog. We are with a nice family. My sister lives with me. I have a lot of toys and tons of clothes. Sometimes I get to choose what I want to do."

"They respect me and I have a choice in what's going on. I feel this is my home and I know I am safe here and I can stay here for as long as I want to"

"They are understanding, funny and make me feel like part of the family"

"I like everything here"

"I don't need to ask for anything because they always get me stuff and I feel safe here and I love it here. The best Grandparents."

"I like my bedroom, it has lots of toys"

"They look after us. We have nice clothes. Everything."

"I love living with my foster family because they are caring and loving. I have a lot of fun. They always make sure that I'm OK."

In addition, children indicated positive experiences in other ways, for example, some children said they had someone to talk to if they were unhappy or that they were aware of who to contact if they felt unsafe. For children living with relative foster carers and non-relative foster carers, the experience of being part of a family was important. A dominant theme of children's feedback was their feelings of belonging. Children said;

"They treat me like family"

"They respect me and I have a choice in what's going on. I feel this is my home and

I know I am safe here and I can stay here for as long as I want to."

"They are understanding, funny and make me feel like part of the family."

"They treat me like I am actually their blood...They are always here for me and of course we argue but that's how family is and I really love them."

Seventy four out of 79 children who returned questionnaires or were consulted or met with as part of this inspection told inspectors that they had an allocated social worker. Seventy out of 79 children gave positive feedback about their social worker. Many children described their social worker as "nice and kind." Other children said;

"I have always been lucky to have nice social workers. They have always done their best to make my life easier."

"She listened because we got a card from Da."

"She is funny and nice."

"My social worker is always available when I need her."

"This is my family and I love them with all my heart. I get to see my Mom every two weeks and the social workers do their best to make this happen."

The nine children who did not report positively on their experience of their social worker did so for various reasons including not feeling listened to and not being visited regularly. Two children also said that they "did not finish life story work" with their social worker. Some children also said that the consistency of social worker was important to them and that this helped to build trust and connection. Furthermore, a total of 12 out of 79 children reported that their social worker did not keep in contact with their family and make sure they see them regularly.

Most children, where appropriate, had knowledge and awareness of the planning and review of their care. The majority of children who attended reviews felt listened to. However, nine children reported that they did not have a care plan and 18 children did not know what a care plan was or if they had one.

Four of 12 questionnaire respondents between 16 and 18 years of age said they had an aftercare plan. All eight young adults (18+) who responded to the questionnaires had an aftercare worker and their feedback in relation to their experience of this service was very positive. All eight young adults felt that they were being listened to, and reported that their aftercare worker was helping them to prepare for their future.

Not all children were aware of the complaints process which was available to them. Of the 64 questionnaires which were completed by children, 42% or 27 out of 64 respondents were not aware how they could make a complaint.

## 5. Findings and judgments

### Theme 2: Safe and Effective Services

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs. In order to provide the care children require, foster carers are assessed, approved and supported. Each child receives the supports they require to maintain their wellbeing.

### Standard 5: The child and family social worker

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

The majority of children in care in the North Dublin service area had an allocated social worker at the time of inspection and all foster carers had an allocated fostering social worker. Data provided to inspectors prior to inspection showed that there were 24 (10%) children in care within North Dublin service area who did not have an allocated social worker and performance data published by Tusla showed that the area had an average of 98% allocation of social workers to children in foster care, throughout 2018.

At the time of this inspection the area had four vacant social work posts and one vacant social work team leader post which impacted on their ability to ensure all children were allocated a social worker. Both the area manager and principal social workers told inspectors that safeguarding measures had been put in place to ensure that all children were visited by a member of the team and where children were not allocated to a social worker, alternative safeguarding measures included children being met with in private by fostering social workers, visits by social care workers or leaders and or visits by an allocated project worker \*(project workers were qualified social workers whose professional registration was pending). The area manager told inspectors that a recruitment process had been put in place to fill social work vacancies as a matter of priority however this had proven difficult. Additionally, there were no available agency social workers to fill vacant posts. Principal Social Workers told inspectors about initiatives put in place to aid with staff retention, including; increasing opportunities for promotion and staff thank you days.

Inspectors found that high risk cases were prioritised for allocation and where necessary were overseen directly by social work team leaders until they could be allocated to a social worker. Child protection social workers held some cases relating to children in care, meaning that established relationships could be maintained for these children until children in care social workers could be allocated. In addition social care staff were at times allocated to cases where reviews or care plan updates were required in order to undertake the preparation and consultation work prior to child in care reviews, including meeting with children.

Inspector examined files of 19 children who were not allocated a social worker and found of the 19 children's files reviewed 9 (47%) had been unallocated for periods longer than six months, with two of these unallocated since 2017. Inspectors met with or spoke to some of these children and the majority were aware that they did not have a social worker; however some of the younger children who had social care worker involvement were unaware of the difference.

Twenty three files were reviewed for the purpose of examining the frequency and quality of statutory visits to children in foster care. Of 23 files reviewed, while safeguarding visits for all children had been completed in the months prior to inspection there had been significant gaps in visits to some of these children over the previous two years. For example, 13 children (57%) had received timely visits in line with regulatory requirements over the past two years, and 10 children (43%) had not. Significant gaps in visits by social workers were evident in these files ranging from 10 to 22 months without a visit to a child.

Inspectors reviewed records of statutory visits in order to make an assessment on the quality of the visit and found that in 22 cases examined for this purpose, half (11 of 22) were poor quality. In seven of 11 cases there were no records of visits on file, in four cases where records were available for review these were found to be brief and lacking necessary details including whether or not the child was seen alone or any discussion, decisions or actions required following the visit. During the course of the inspection, it was necessary to seek assurances from staff that visits had been undertaken where no records of these were available on file. Assurances were provided verbally by social workers or team leaders and information written in diaries or brief hand written notes were provided to support this.

Senior managers told inspectors that they were assured that children were being appropriately safeguarded through these statutory visits as records were reviewed and verbal reports on visits were received during supervision with social work team leaders. However, in the absence of good quality records particularly in relation to

cases where children were unallocated and in light of the high turnover of social workers in the area, the ability to oversee and monitor children's safety was compromised.

Principal social workers and the area manager told inspectors that the issue of poor recording of statutory visits had been identified previously. A template for recording of these visits which included prompts for social workers to address all areas required during statutory visits and record same had been implemented in the area in January 2019. While inspectors saw this template on some files it was not being routinely used to record details of statutory visits. The principal social workers told inspectors that where a case was allocated to a social care leader or worker for the purpose of completing safeguarding visits, records of these visits were monitored by social work team leaders during case supervision sessions.

Social workers told inspectors that they did not use the template routinely and said that visits with children were usually for specific reasons so all sections of this template would not be discussed or completed. Social workers acknowledged the need for statutory visits however, cited demands of other work as the main factor contributing to overdue visits or absence of records of visits when they do take place. Social workers reported that where they were allocated to children while they may not have seen them alone or in their foster care placement as frequently as was required they did see children regularly through access or family events. The principal social workers told inspectors that, through the internal database maintained within the area, they had oversight of timeliness of statutory visits. Inspectors reviewed the data base which recorded statutory visits and found that while it recorded the most recent visit, it did not include a record of previous visits therefore could not provide assurance that visits were timely in line with regulations, nor provide any assurance as to the quality of the visits undertaken.

Questionnaires distributed to children asked them to comment on visits by social workers, when asked if their social worker visited regularly 65 children responded. Of 65, 24 (37%) said 'yes', 17 (26%) said 'no' and 24 (37%) children answered 'sometimes'. Children were asked if their social workers met them on their own, of 65 children's responses to this question, 26 (40%) answered 'yes', 20 (31%) answered 'no' and 16 (25%) answered 'sometimes', three children did not answer this question. Inspectors met with young people and young adults availing of the aftercare service and they told us that the "turnover of staff is the biggest issue", these young people told inspectors that they had frequent changes in social workers throughout their time in care and this was very difficult for them. One young person explained "the constant turnaround of social workers and aftercare workers creates

a sense of instability....and breaks the trust. If I could change anything it would be the inconsistency”.

Principal social workers in the area were fully aware of the risks and potential impact on children associated with having frequent changes in social workers. Principal social workers told inspectors that consistency for children, enabling them to build relationships with a social worker, was a priority within the area and the risks associated with assigning unfamiliar staff to engage with children was at the forefront of decision making processes when it was necessary to de-allocate or re-allocate a child's case. Creative options had been considered and implemented within the area for some children with the view to minimising the impact of changes in social workers. Inspectors saw examples of these creative interventions including, utilising social work staff who had moved to different posts within the department but who would have had previous knowledge and an established relationship with a child, to engage with a child, complete statutory visits and child in care reviews.

Social workers maintained good links with families and they encouraged and facilitated contact between children and their families, when this was deemed to be in the best interest of children. In their responses to questionnaires the majority of 61 children, 40 (66%) said that their social worker kept in contact with their families and made sure they saw them regularly, 12 children (20%) said that this did not happen, three children (5%) said that this happened 'sometimes'. The remaining six children (9%) did not respond to this question.

Inspectors sought to meet with parents as part of this inspection and asked for their views in relation to this aspect of the social work role. Three parents came to meet with inspectors and each told us that communication with social workers was very difficult. Two parents told inspectors that contact with their children was regularly compromised due to failure by social workers to effectively facilitate visiting arrangements. One parent told inspectors that their child's care needs had been compromised due to failure to make appropriate arrangements for assessment and delays in responding to requests or completing required paperwork.

As part of this inspection inspectors also sought to meet with foster carers to seek their views on the role of the social worker and four foster carers came to meet with inspectors. Three of four foster carers who met with inspectors also said that there were often difficulties in accessing social workers to confirm or verify arrangements or seek answers to questions or queries in relation to the children and or their parents. Three foster carers said that requests for information such as key medical information or information for children about their families, was not provided efficiently by social workers and often required several follow-up requests before

such things were resolved. One carer had not had this experience and said that all relevant information had been provided to them. Foster carers told inspectors of their frustrations in relation to lack of communication from children's social workers and said that they could spend days trying to speak with a child's social worker at times. One carer provided an example where they had sent email communication to social workers and social work team leaders outlining concerns for the children in their care and had not received any response. Another carer had sought specific therapeutic intervention for a child in their care and again had not received a response from the child's social worker. All foster carers had allocated fostering link workers and said that the support they received from their link social workers was "brilliant".

There was good coordination of input of other professionals and agencies within the area for children with a disability but availability of services was an issue and delays existed for some children requiring specialist services. Social workers coordinated care and input from other professionals in care planning for children where this was required. The area had established integrated case management team meetings in November 2018 during which cases requiring input from various agencies and services were discussed. A manager from the Health Service Executive disability services attended these monthly meetings with the Tusla area manager and the on-going or anticipated needs of children requiring input of other professionals and agencies were reviewed as they arose and discussed for the purpose of timely planning for children as required.

Social workers told inspectors that while they welcomed the introduction of a consistent forum in which children with specialist needs were discussed it was often challenging to coordinate these services. Social workers said that while there was an expectation that a child in care was prioritised for services such as mental health, this was not always the case in practice and it was at times necessary to access privately funded services to fill gaps. The area manager confirmed that delays in availability of necessary services for children in care meant that Tusla did provide privately funded services for these children; however, acknowledged that there had been improvements in coordination and planning for children with a disability or requiring specialist services and better collaborative cross agency working relationships were being established. Social workers identified that the integrated case management meetings involving the HSE meant that children with a disability were being identified to other relevant agencies and services much earlier and their needs discussed on an on-going basis which had improved timeliness of access to services for some children.

In eight of nine case files relating to children with a diagnosed disability and/or illness, children had an allocated social worker. One child who had not had an allocated social worker since August 2018 had an allocated social care worker who provided consistent intervention and support to this child and their family. Despite not being allocated a social worker, there were regular visits by the social care worker overseen by a social work team leader. Inspectors found strong advocacy by the social work team for specialist resources and supports including putting privately funded services in place for this child while they awaited required interventions from statutory services.

Data provided by the area showed that there were three complaints made by children during the 12 months prior to this inspection. These were reviewed by inspectors and found to have been resolved. However, delays in addressing children's complaints existed. In questionnaires returned to HIQA by children, 54 children responded to the section in relation to complaints. Of 54, 24 children (44%) said that their social worker had explained to them how to make a complaint, 30 answered no that their social worker had not. Of those 54 children who responded 13 said that they had made a complaint and 8 of 13 said that they were happy with the outcome of their complaint including statements such as, "It was dealt with straight away and I was happy she listened to me" and "It was resolved quickly". One child was not happy with the outcome of a historical complaint and four children who said they had made a complaint did not answer this question.

Principal social workers told inspectors that making improvements in the complaints process, in particular making all children aware of how to make a complaint, had been a feature of their area service improvement plan. Principal social workers said that between September and December 2018 this goal of their service improvement plan was completed; all children were informed about the complaints procedure with confirmation that this was completed to be placed on each child's file. As cited above more than half or 30 of 54 children who completed this section of questionnaires said that they had not been informed about how to make a complaint by their social workers suggesting implementation of this service improvement goal was not fully effective within the area.

Records in respect of each child were maintained both on an electronic system and a paper file within the area. The national child care information system (NCCIS) was not yet fully embedded into practice and dual systems for maintaining children's individual records as well as trackers to support oversight and governance were in place. The operation of two systems meant that navigating children's information was time consuming and at times difficult. Records were not up to date, relevant information was missing and the majority of files did not contain chronologies. It

was necessary for inspectors to seek information from social workers regularly, where records or relevant information could not be located or were absent from both electronic and paper files. In the majority of cases where information was sought these records were awaiting completion by social workers.

Social workers told inspectors that the electronic system was complex to navigate and it slowed down work. Inspectors found that there were no individual folders for records such as those of statutory visits or for significant issues such as allegations. This made it difficult and time consuming to locate specific documents. It was not possible for example to tell from the system how many social workers a child may have had during the past two years and this information would have to be retrieved from other sources.

The area manager told inspectors that the task of migrating data from their previous electronic system to the national child care information system was a massive one. She said that the area was still heavily dependent on local registers and the operation of the dual system for oversight and monitoring. The area manager told inspectors that not all staff members were yet active on NCCIS and despite actively attempting to recruit a staff member to coordinate the roll out of NCCIS in the area they had not been successful in filling this position.

Inspectors found a number of other issues with record keeping in the service area. For example, case notes were absent or not up to date, dates of statutory visits recorded on a statutory visit sheet but no records or notes of the visit on file, significant gaps in records particularly where children were unallocated for a period and information relating to one child incorrectly filed on a different child's file. Records on NCCIS were scanned and stored as case notes without a consistent naming convention, hard copy evidence such as signatures of parents, children, foster carers and social workers were not always uploaded to the system and processes and systems in place to evidence or record oversight by a manager, for example a care plan being signed by a social worker team leader, were not adequate.

All children did not have an allocated social worker, were not visited in line with regulations and there were delays in accessing specialists services for some children who required them. Children's complaints were not always dealt with promptly and not all children had been made aware of how to make a complaint. The management of children's records required significant improvement to ensure they were up to date and that children's information was easily accessible. Of most significance, frequency of changes in social workers and inconsistent professionals

involved in their lives impacted negatively on children in care. For these reasons the area was judged to be moderately non-compliant with this standard.

### **Judgment: Non-Compliant Moderate**

#### **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.

Social workers carried out assessments of the needs of children placed in foster care. While North Dublin service area did not use a stand-alone document to record assessments of need, children's needs were recorded in a variety of ways including initial assessments, care plans and social work reports for court or child protection conferences.

Inspectors reviewed six files for the purpose of examining the quality of needs assessments and found them all to be of good quality, they were timely and comprehensive with multi-disciplinary input. Where appropriate, participation by children and their families was evident.

Data provided by the area indicated that there were 161 children placed in foster care in the past 24 months and 87 children moved placement within the past 24 months. Inspectors reviewed five files related to children who were admitted to their placement in 2019, four children who were admitted to care and one who had a recent placement move. Assessments of need were evident on all five files in varying formats and all were completed promptly in line with national standards for foster care. Two children's assessments of need were contained within court reports prepared by social workers for the purpose of supporting care order applications and inspectors found that these children's care plans were updated with relevant information following their admission to care. One child who was admitted to care in emergency circumstances had an assessment of need commenced on the day of admission to care and this was recorded within a comprehensive care plan. Another two of five children files reviewed had comprehensive assessments of need on file recorded within their care plans which were initiated immediately following admission to care or move to a new placement and completed appropriately.

Inspectors found that where children were received into care in a planned way their assessments of need were completed in advance within comprehensive initial

assessments and or placement requests which guided social workers in matching children to the most appropriate foster care placement to meet their individual needs.

However, inspectors found in two of these five cases where children required medical examinations upon admission to care there was no evidence on the child's file that this had taken place.

While assessments of need were of good quality and completed as soon as practicable, not all children had a medical examination as required upon admission to care. It is imperative that assessments of need should include a medical examination, except where there is available information and reports on a child to satisfy the social worker that this is not necessary, in which case this should be clearly indicated within a child's needs assessment. For this reason, the area was judged to be substantially compliant with this standard.

### **Judgment: Substantially compliant**

#### **Standard 7: Care planning and review**

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

Care planning and reviews for children in care required improvement within the area and interventions to address these known deficits had begun to be implemented prior to this inspection. This inspection found that not all children had an up-to-date care plan and child in care reviews were not taking place within statutory timeframes for all children. The quality of care plans varied and the need for a more thorough examination on quality including up skilling and training for new staff was acknowledged by principal social workers and the area manager and identified as a key priority for improvement in the coming months.

The area had established, along with Dublin North City service area, monthly meetings to examine the quality and consistency of care planning and child in care review processes. These meetings involved participation from all relevant principal social workers as well as representatives from quality assurance, workforce learning and development and the foster care committee. Inspectors reviewed minutes of these meetings which detailed discussion in relation to gaps in quality, timeliness and participation, as well as failure to send a written account of decisions following reviews to children, parents and where appropriate foster carers. A review of tools designed for engaging with and recording the views of children, parents, foster carers, schools, medical and other professionals in the care planning process had

been undertaken with the intention of ensuring consistency across the region. This review was on-going at the time of this inspection.

Data provided by the area prior to inspection indicated that 45 children's reviews were overdue. Social workers and social work team leaders were responsible for scheduling and chairing child in care reviews. Inspectors reviewed 30 files for timeliness of child in care reviews and found that 12 (33%) had not been completed within timeframes required by regulations. Eleven of the twelve cases had had a review in 2019 and one occurred in November 2018 however, prior to this there were lengthy gaps between the most recent and the previous child in care reviews. While all had recent reviews of their care, 12 cases looked at by inspectors for timeliness of these reviews found that three were overdue by 3-4 months, the remaining eight cases had not until recent months, been reviewed since 2017 meaning this was the first review of a child's care in more than two years.

The management team within the area had implemented a number of measures in an effort to improve compliance with statutory requirements in relation to reviews of children's care, these included: the introduction of administrative support to the social work teams, the inclusion of child in care reviews as a standing item to be discussed and recorded as part of supervision and an electronic data base tracking all statutory requirements including care planning and child in care reviews. This data base was accessible by social work team leaders and overseen by principal social workers.

Principal social workers told inspectors that they monitored the child in care database regularly in order to ensure it was kept up to date as an additional safeguard. They told inspectors that they discussed outstanding and overdue child in care reviews regularly during supervision and had implemented alternative arrangements for children who did not have an allocated social worker. Some arrangements included allocating reviews to be completed by senior social work staff who had previous involvement with children and families and were known to them, and inspectors found evidence of this on some of the files reviewed. Principal social workers and the area manager were acutely aware of the high number of cases awaiting allocation which were at risk of drifting without regular reviews and updating of care plans and had close oversight of interim measures to ensure all children were safe and risks were identified.

Social workers told inspectors that the introduction of administrative support to the team had greatly assisted them in clearing backlogs and keeping up to date with required paperwork. The administrative support staff had implemented a system whereby when a social worker requested a review, the administrative support staff

scheduled the reviews and issued invitations to key people such as the child, parents, foster carers, social workers, link workers and child in care staff, advocates and other professionals such as teachers, mental health professionals, disability key workers and social care workers, who were involved in the child's care. In addition, minutes were finalised by administrative support staff and these informed children's updated care plans.

In the majority of child in care review minutes examined, 27 of 28 (96%), input from all relevant parties and consultation with children prior to their child in care reviews was evident on their care files. Of 28 files reviewed for the purpose of assessing quality of child in care reviews inspectors found in the majority 25 of 28 (89%) all aspects of the child's care was reviewed. Children's health, education and placement needs were reviewed routinely as well as supports in place and arrangements for family contact.

Inspectors found that where a child's placement had ended unexpectedly or where significant events arose which threatened their placement, the care review processes were more prompt. Inspectors reviewed three such cases, one a review following an unplanned ending and two related to placements at risk of ending and found them to be good quality. Data provided by the service area indicated that in the 12 months prior to inspection 20 reviews had taken place specifically due to a risk of placement breakdown or due to an unplanned ending of a child's placement. Inspectors found when a child's placement was at risk of breaking down, that strategy meetings were routinely and promptly convened and planning as well as oversight of such cases was prioritised. Inspections saw a number of examples where complex issues or significant events such as an allegation or serious concern relating to risks within their placement or a child frequently leaving their placement without permission requiring a missing from care reports to An Garda Síochána were prompt and effective actions were taken to address risks. Child protection and welfare social workers told inspectors that they worked collaboratively with the children in care teams. When situations arose where circumstances for a child became difficult, if they had a familiarity with that child or family they would frequently step in to bridge a gap between social workers and support a child and their family through changes or difficulties.

As part of this inspection children's experience of child in care reviews and care planning were sought through questionnaires which were sent to all children in foster care in the service area and by visiting and speaking with children within their foster care homes. Children articulated the difficulties associated with the high turnover of social workers and said how the absence of a relationship with newly appointed social workers prior to a review, impacted on their engagement in the

care planning processes. Children did not routinely attend child in care reviews; however, reported that they were encouraged to attend by their families and social workers.

Of 61 children who returned questionnaires as part of this inspection and completed the section in relation to care planning and reviews, 25 (41%) said that they had either attended or been invited to attend their child in care review while 36 (59%) said that they had not. Of 55 children who responded to the question of whether or not they felt listened to, 39 (71%) said 'yes' or 'sometimes', ten (18%) children answered 'don't know' and six (11%) children said that they did not feel listened to.

Forty four children who completed questionnaires in relation to the outcomes of their child in care reviews, in answering whether or not decisions from reviews were explained to them by their social worker, 34 (77%) said that decisions were explained and 10 (23%) said that they were not. In focus groups with foster carers, as well as meetings with parents, inspectors found that informing children of decisions and distributing copies of children's updated care plan following child in care reviews was not routine practice in the area.

Inspectors examined 31 care plans and found that all were up to date. Similarly as was found in relation to child in care reviews and statutory visits, inspectors found that all care plans had been updated within the six months prior to inspection and or promptly following a change in placement, unplanned ending or admission to care. However, gaps prior to the most recent updates of children's care plans existed as not all care plans had been reviewed as required in the two years prior to inspection. Of 31 care plans examined, while they all had been updated prior to this inspection, 12 of them had not been updated in line with statutory requirements, with delays ranging from one month to more than a year overdue, meaning some children in long term care did not have their care plans reviewed for periods of more than two years. In one care file examined for quality of care planning and review the child was found to have had their care plan updated twice in seven years since 2012. While these findings demonstrate non-compliance with statutory requirements in relation to the care planning and review for children in care, improvements were evident and interventions had been put in place prior to this inspection by senior management within the service area to address delays and these were seen by inspectors to be effective.

The majority, 28 of 31 (90%) care plans examined were found to have recorded consideration of children's care needs including family contact, education, health, supports including specific supports for children with additional needs or children with a disability and there was evidence of consideration of suitability of foster care

placements to meet the children's needs recorded. In the remaining 3 (10%), there were gaps identified with respect to consultation with relevant professionals in preparation for a review of children's care and clear decisions were not recorded in all cases. Consideration of long term care needs including discussion of the option of family reunification where applicable was not evident in all cases through child in care review minutes and or documented within children's care plans.

Inspectors observed one child in care review, which was attended by the child's parents, an allocated social care worker, a social work team leader, a fostering link worker and a foster carer. The review covered the main aspects of the child's care including aftercare, the views of the child's parent present were sought immediately prior to the review and the social care worker, who had recently been allocated as the child did not have an allocated social worker, provided updated information from the child's school. The views of the child's parent were addressed and the parent's dissatisfaction with lack of support from the social work department acknowledged. Decisions were agreed as well as people responsible and timeframes for completion. It was referenced during the review that the child did not wish to attend and their views were represented by their parent and foster carer.

Most children who had complex needs and or a disability received specialist supports as required. Inspectors reviewed files of nine children with varying levels of disability for the purpose of examining the quality of care planning and review. Inspectors found that while all care planning was not completed within timeframes required by regulations, in eight of nine there was good quality care planning, co-ordination of services and review of children's needs. Care arrangements for one child with significant and complex needs including specific mobility and learning needs were not adequate. A review of required interventions and specialist's supports did not adequately consider all of the child's needs and better co-ordination of services for this child was needed. Assurances were sought by HIQA and received on plans to address this child's complex and long-term needs.

In all cases where applicable, children participated in their care planning and review process and for two children who were over the age of 16 inspectors found that there was good input, planning and co-ordination from relevant services in preparation for their leaving care and adult life.

Almost half of all case files examined during the course of this inspection, 32 of 69 (47%), were related to children in care under the voluntary consent of their parent and/or parents and the inspection found that voluntary consents were not routinely reviewed. Despite voluntary consent in many cases having been signed by parents for specific timeframes which had lapsed, some for years, these had not been

updated nor was there evidence of discussion with parents in relation to consent recorded as part of the review of children's care. The service support manager, who worked as part of the area management team explained to inspectors that in cases where parents were actively involved in a child's care and care planning, their continued consent was implied when there was no wish to formally revoke consent expressed by a parent. However, this was not recorded as part of children's care records and there was no valid record of consent retained in many cases.

As a result of this poor practice for some children where parents did not remain actively involved in their care or were no longer in a position to provide voluntary consent there were no alternative measures put in place to mitigate against associated risks for example, if a child required a passport, or medical treatment; when a parent was not actively involved or in a position to provide consent such things could be unnecessarily delayed. Despite in the majority of cases there being no active consideration of reunification of these children with their parents, no plans to seek care orders were being pursued. Furthermore, the absence of certainty for a child in long term care whose parents were not engaged or involved in their care, had not been given due consideration.

This matter was escalated to the area manager following inspection due to the potential risk associated with children in foster care placements without a clearly defined legal care agreement. An immediate audit of the admission to care forms of all children in voluntary care was requested with a view to ensuring that, in each case, voluntary consent forms were completed in full, the probable duration of the placement was clearly outlined, the consent provided was signed by the parents, was up-to-date and that the legal status of each child was subject to on-going formal review in line with the regulations. The audit undertaken by the area found that of 134 children in voluntary care within the area 30 required action to ensure voluntary consent was in place as required. The audit found 17 were out of date, 11 were incomplete or unspecific in relation to probable duration of care specified and required review to ensure clarity and two care order applications were initiated as the parent who provided the voluntary consent on file had since died. In addition to the above, details of improved mechanisms for reviewing and auditing of voluntary consent arrangements to ensure continued compliance in the future were also outlined.

The findings in relation to case management were for the most part of good quality. In 26 (87%) of 30 files reviewed for evidence of case management and oversight, inspectors found this was appropriate. However, in four cases, the quality of case management was inadequate or there was no evidence of this on file.

Placement plans were not completed as required; in eight files reviewed for the purpose of examining placement plans only one had a placement plan on file. The development of placement plans is a key feature of the standard on care planning and review, and a key social work task following the admission of a child to care. A placement plan should outline the specific needs of a child in their current placement and set out the way in which a child's needs will be met day-to-day and the way in which the placement will contribute to meeting the child's needs as outlined in their care plan.

While care planning and reviews had been prioritised for improvement within the area and progress was evident some issues remained. Not all children had an up-to-date care plan and child in care reviews were not taking place within statutory timeframes for all children. Parents and foster carers did not receive timely records of decisions from reviews and placement plans were not being developed as required. This inspection identified that reviews of the voluntary consent given by parents for children to be admitted into the care of Tusla was not routinely occurring. For these reasons, the area was judged to be in moderate non-compliance with this standard.

**Judgment:** Non-Compliant Moderate

### **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.

A shortage of foster carers compromised the ability of social workers to match children to carers at times but there were clear mechanisms in place to identify the most appropriate available match and plans to address the shortage of foster carers were in place. Social workers and principal social workers who met with inspectors confirmed that every effort was made to match children to foster carers who could best meet their needs. There were a significant number of children placed outside of the North Dublin Social work area with 98 children in statutory foster care placements and 29 children in privately provided foster care placements, totaling 127 or 42% of all children placed outside of the area. Social workers told inspectors that the placement of some children outside the area was logistically very difficult to manage, in that statutory visits and facilitating the child to see their family was complex. In addition, the absence of links with services within unfamiliar areas created challenges.

The area had a waiting list for children awaiting a foster care placement. Data provided by the area indicated that there were 12 children awaiting a foster care

placement, 11 of which were in other care placements and one child who was at home at the time.

Principal social workers told inspectors that the recruitment of additional carers within North Dublin service area was a priority and there was a plan developed to guide this recruitment over 12 months. This plan included targeting specific catchment areas where carers were few or the need for placements was high by increasing and promoting the option of becoming a foster carer in schools and clubs in these areas. This recruitment campaign to date had yielded good results and was set to continue. In the 12 months prior to inspection five new carers had assessments completed, four had been approved and an additional three assessments were waiting to start.

There was a process for matching children to foster carers in place, in that placement requests were sent by children's social workers to the fostering team and these included detailed information in relation to the child and their needs. A database of requests was kept by the fostering social work team leader in the area and she maintained an up to date, good knowledge of the availability of statutory and non-statutory foster carers and would suggest the best option based on availability of carers and the presented needs outlined in detailed placement requests from children's social workers. Principal social workers told the inspector that there was regular communication between teams and regular detailed discussions in relation to available placements and children who required a placement. Social workers with in-depth knowledge of children would discuss their needs and preferences for a foster care placement taking into consideration all of the children's needs including, education placements, location of family and any additional or specific needs which may exist and that these would then be matched with the best available carer(s).

Inspectors saw evidence of strategy meetings convened where children were at risk of a placement breaking down which were attended by the child's social worker, social work team leader as well as the fostering social worker and social work team leader. Children's social workers told inspectors that there was good collaborative working between both teams where a child was at risk or required a placement to meet specific or complex needs, availability of placement options which might meet the presenting needs of children were discussed in detail. Joint working was a priority from the point of identifying a child's placement being at risk to moving children to a new placement.

Social workers who met with inspectors said that placements for teenage children were often more difficult to find in particular when these children were received into care in an unplanned way or required a foster care placement in an emergency. Social workers explained that the out of hours emergency placement services were required in many instances for these children where a foster care placement could not be identified at short notice. Social workers explained that this was far from ideal for these children given their difficult circumstances and the challenges associated with placing children in an out of hours emergency service. Additionally, social workers said that this can cause further difficulty in court during care proceedings as judges have questioned the validity of admitting a child to care where there are no available foster care placements for that child.

The area tried to ensure that children maintained their contacts with their local community when they were admitted to foster care. Of the children who answered the section of questionnaires related to this topic, 43 of 59 (73%) said that they had sufficient contact with family and friends. Twenty two children said that they had to change school when they moved to their new foster home while 36 did not. Children were asked if they felt their background and culture was understood and respected within their foster care homes and 54 children responded. Of 54, 51 (94%) said 'yes', one 'sometimes' and two children answered 'no'.

Exploration of family options was a priority for all social workers in the area, every effort was made to identify carers familiar to children or within their immediate or extended family and network. Principal social workers told inspectors that Section 36 or relative foster care placements were always explored as preferred options for children and data provided indicated that 103 or 38% of all children in statutory care were placed with relative foster carers who would have been familiar with the children and their family backgrounds prior to placement. The area had seen a significant increase in relative foster care assessments and principal social workers had completed a business case seeking an additional fostering link worker to complete these assessments however, this post had not been approved.

Children who met with inspectors said that they were happy in their foster care homes. Thirty six of 61 children (59%) who answered questions in relation to their move to their foster carers said that they had met with their foster carers before going to live with them. Thirty seven children said they were asked how they felt about moving to their foster care placements, 11 said they were not asked and 13 children did not know. Children were offered the opportunity to provide comments on what they liked about their foster families and 55 children responded all indicating their happiness in their care placements, indicating they were appropriately matched to their foster carers.

When children were placed with carers and it was envisaged that they would require medium to long term care, social workers endeavored to match all children to foster carers with the capacity to meet their needs. As it was not always possible to assess this capacity in the initial stages of a child's placement, the process for matching a child long-term with their foster carers is set out within the regulations and standards for the placement of children in foster care.

Once a child is settled in their foster care placement for periods of more than six months then a decision to seek approval of the foster care committee to long-term match children with their carers is taken. North Dublin service area followed this process however, in practice this process was not timely and did not ensure compliance with standards as there was a waiting list of children awaiting approval of long-term placements. Data provided by the area indicated that 27 children were long-term matched in the 12 months prior to inspection and 100 children in care were awaiting long-term approval. Inspectors reviewed six examples where children had been long-term matched with their carers and found the quality of assessments and reports supporting the process were good. However, delays in pursuing long-term match approvals were significant and most children were placed with their foster carers for years before the process had begun.

A high number of children were placed outside of their catchment area of origin and not all long-term matches were approved according to required timeframes, and 100 children were awaiting long term approval, for this reason, the area was judged to be substantially compliant with this standard.

**Judgment:** Substantially compliant

#### **Standard 10: Safeguarding and child protection**

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

Management of complaints, allegations and serious concerns against foster carers was good. These incidences were found to be responded to by social workers and appropriately categorised. However, while initial assessments were completed in relation to allegations and were found to be of good quality, appropriately assessing needs and risks to children concerned, these were not all concluded within timeframes outlined in standard business processes.

Inspectors reviewed a total of 12 allegations, six of which related to foster carers, six did not. Inspectors found that the process for investigating allegations was implemented as required in that allegations were assessed and notified as required by Children First (2017) but, these assessments were not always timely or completed in line with Tusla standard business processes. Of 12 examples reviewed 10 had been referred by the social work department recently, in the two years since June 2017, the remaining two related to historical allegations which remained open and under investigation at the time of this inspection.

Inspectors reviewed initial assessments on a sample of seven allegations received since June 2017, four which related to children in care but were not allegations against their foster carers and three allegations against carers. Inspectors found that the social work response to allegations was good. Initial assessments were completed as required and a sample of seven completed initial assessments found the quality of all assessments to be good. The quality of content within assessments was good and immediate steps were taken to ensure the safety of children, where required. Children were met with appropriately, risks were clearly identified, parents or guardians were consulted, strengths and existing safety factors had been considered and appropriate action was taken to safeguard children where required. In all cases, children's parents had been informed and the outcome of the initial assessment was clearly documented including next steps. In four of seven records of allegations reviewed a safety plan was required and in each case an adequate safety plan was in place. However, in two of seven assessments examined while prompt action was taken to safeguard children there were delays, both taking more than six months to conclude initial assessments.

Data provided by the area indicated that, in the 12 months since May 2018, there were six allegations and 16 serious concerns received in relation to foster carers. In nine of these 22 instances, allegations or concerns against carers were upheld following investigation by the social work department. Inspectors reviewed a sample of ten serious concerns in relation to foster carers which had been received in the two years prior to this inspection and found again that social work responses were good. Assessment of serious concerns were comprehensive, included meeting with children, collaboration between the fostering and children in care social work teams and good management oversight of the assessment of concerns. Serious concerns were correctly categorised and they were managed and investigated in line with Tusla's "Interim protocol for managing concerns and allegations of abuse or neglect against foster carers or relative (S36) carers" (2017). They were investigated jointly by the fostering and children in care social work teams and strategy meetings were held as required. Where necessary serious concerns in which allegations of abuse were subsequently identified were addressed through an initial assessment in line

with the standard business processes and appropriately notified to the foster care committee. Five of ten serious concerns reviewed required a safety plan and this was appropriately in place for four of five. Inspectors reviewed one safety plan which was deemed inadequate; assurances were sought and received from the area manager following the inspection that effective measures had been taken to ensure the safety of the children concerned.

In the sample of files reviewed for the purpose of assessing the quality of response by the area to an allegation of abuse by foster carers inspectors found one case which had not been appropriately managed and historical allegations made by children in care in relation to the foster carers had not been addressed, some allegations dating back a number of years remained outstanding. Deficits in the management of historical allegations relating to these carers had been identified by the social worker allocated to the children concerned and the process of pursuing a full assessment of concerns was underway. Inspectors found that there had been years delay in assessing these allegations and in examining the related files inspectors identified that allegations made related to another social work service area therefore required close collaboration between both social work departments in order to fully assess potential risks. While efforts had been made to begin the process of assessment, responses to requests and communication between the two social work departments had not been timely or effective.

Assurances were sought from the principal social worker during the course of inspection fieldwork in relation to the plan for ensuring progression of the assessment of these allegations and a proposed schedule for investigation was provided to inspectors. As previous meetings between the two social work departments had not resulted in an appropriate investigation of these matters, following this inspection, further assurances were sought from the regional service director that urgent cooperation would be prioritised between both North Dublin and Dublin North City social work departments in relation to these allegations and that all identified gaps in information on the case would be made available in a timely manner to enable the investigation to proceed in line with the proposed schedule. In addition, HIQA sought assurances that all necessary steps would be taken to identify any potential risks to other children and or to notify relevant foster care committee(s) of the allegations that are under investigation where appropriate. Monitoring and oversight arrangements from the service director's office which ensured no further delays occurred were also requested. Appropriate assurances including a detailed schedule of investigation was provided by the service director in response.

Inspectors found that where there were allegations or serious concerns relating to foster carers the area notified the foster care committee as required. The inspector met with the chairperson of the foster care committee in order to seek clarification in relation to the role of the committee with respect to safeguarding. In particular, clarification was sought with respect to oversight and monitoring of arrangements in place for children in placements where there had been or was an on-going assessment of serious concerns. In addition, data provided to inspectors identified eight foster care households where the number of children placed within the foster care families exceeded the number permitted in their approval and the safeguarding measures in place for these placements was also explored.

The chairperson of the foster care committee told inspectors that decisions such as number of children within a foster care household exceeding standards, long-term match proposals for foster carers, or allegations and serious concerns against foster carers were all notified to the committee routinely. The process for notification involved, a social worker forwarding all relevant information to inform the committee of a particular allegation or concern or to support a decision made in relation to long-term match or placement of children outside of approval status. For example, in relation to a long-term match; social workers would submit a pack of information including the child's care plan, foster carer assessment, school reports, and evidence of up-to-date garda vetting. The chairperson explained that all of this information came to the committee through the office of the secretary of the foster care committee who ensured that all necessary documentation was included prior to acceptance of a referral for discussion and consideration by the foster care committee.

Decisions were then reviewed by the committee and where necessary further information may be sought. Where information was referred to the committee but a social worker was not present at the committee meeting to respond if questions arose, then questions or queries were returned directly to the social worker seeking a response. Details of information requested were then tracked on a monthly basis by the secretary of the foster care committee and if not returned after two months this information would be requested again. In addition, any outstanding information or responses required by the foster care committee were discussed during six weekly governance group meetings which were attended by the principal social workers, area manager and the chairperson of the foster care committee.

This inspector reviewed minutes of foster care committee meetings and found that reviews of referred cases and information were comprehensive and detailed. Information sought and queried facts or details were all documented within the minutes including additional information required from social workers by the foster

care committee. This inspector queried information in relation to a number of cases. One case referenced above, which was escalated to the area manager for assurances as to the measures in place to ensure the safety of the children concerned, had been referred to the foster care committee in May 2018 for the purpose of a foster care review and again following receipt of a serious concern in April of 2019. On both occasions the foster care committee sought additional information and highlighted concerns in relation to the capacity of the carer and long term needs of the children based on the information provided by the social worker however, no follow up was evident through the minutes of the foster care committee or the foster care file.

The chairperson of the foster care committee reviewed the details in relation to a number of similar cases in which minutes from the committee noted requests for additional information including cases where details of safeguarding measures had been queried by the committee but had not been returned. The chairperson of the foster care committee explained that while there have been some improvements in this regard at times information was not returned and questions by the foster care committee in relation to decisions by the social work teams remained unanswered.

The chairperson of the foster care committee said that a training day had taken place with children in care and fostering social workers in November 2018 and early 2019, which focused on providing clarity on the role of the committee. She explained that during this training session social workers were informed about what was required of them and also what required improvement. The area manager and principal social workers explained to inspectors that the foster care committee played an active role in service improvement including commenting and feedback on the quality of care plans and reports provided. A meeting had taken place between the principal social workers and the chairperson of the foster care committee in relation to care planning with the view to collaborative working regionally to ensure consistent and standardised care planning practices.

As cited previously data provided by the area showed that there were three complaints made by children during the 12 months prior to this inspection. These were reviewed by inspectors and found to have been resolved; however, delays in addressing children's complaints existed. One of three complaints reviewed had taken over a year to resolve however the child concerned received an apology from the social work department as part of the resolution to their complaint. The majority of children who answered questions in relation to complaints were happy with the outcome of their complaints.

Social workers told inspectors that the complaints process was clear to all and that their first step was always to try to resolve complaints or dissatisfactions locally; however there was inconsistency in the processes for recording of complaints by social workers. Children in care social workers told inspectors that they resolved complaints and dissatisfactions locally with children on a regular basis however only recorded formal complaints. Social workers from the child protection and welfare team explained that they too would always try to resolve issues locally however; any issue which required an intervention to resolve it would be recorded as part of the complaints register. Social workers said that this was also true of compliments and provided an example explaining that even a verbal compliment or complaint would be notified to the relevant people to be placed on the compliments and complaints register.

Inspectors found that this inconsistency was evident through review of children's files, complaints which were resolved locally by social workers and recorded as case notes on children's files were not all recorded on the complaints register. As all social workers did not record verbal or informal complaints as a complaint it was not possible to trend issues of dissatisfaction with the service that had been brought to their attention by children in the area and data relating to complaints was not reliable.

As cited previously within this report not all children had a consistent social worker allocated to them and while safeguarding measures ensured that they were visited by a member of the social work department, these measures did not mitigate against the risk associated with children failing to establish meaningful relationships with an allocated social worker. Of 26 files reviewed for consistent allocation of a professional to a child over the last two years, nine (35%) did not have a consistent professional involved. Assigning staff for the purpose of visits or preparation for care planning or reviews while serving a purpose is not reliable at ensuring children who may be experiencing abuse or neglect would disclose their concerns to a familiar professional. This risk as previously stated was a key priority for the management team within North Dublin social work department and familiarity or previously established relationships between professionals and children was a key consideration in implementing controls where children did not have an allocated social worker. Social workers presented as having appropriate knowledge and skills and were committed to safeguarding and protecting children. All foster care households had an allocated link social worker and teamwork and collaboration was common practice across teams in the area. Of 59 children who responded to the question of whether or not their social worker had told them who to talk to if they felt unsafe, 48 (81%) answered 'yes'.

Inspectors found that while there were good responses to allegation and serious concerns in the area safeguarding of children required improvement. There were delays in responding to complaints and allegations were not always brought to a conclusion within required timeframes. The foster care committee which is a mechanism in place to provide oversight and additional safeguarding for children in foster care was not being utilised appropriately in this regard as valid concerns identified by the committee were not always followed up. Other risks which had been identified in the area such as high turnover of social workers for children and delays in care planning and reviews of children's care were at the forefront of governance priorities and planning within the area. Creative solutions to mitigate against risks were in place however, this did not ensure that there was effective safeguarding and oversight of children's overall care.

**Judgment:** Non-Compliant Moderate

### **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.

This inspection found that children in receipt of aftercare received a good quality service, with comprehensive assessments of needs completed and good aftercare plans that considered all of their needs. Young people availing of the service spoke very highly of it, they reported that they felt listened to by their aftercare worker and said their opinion was heard. However, there were significant delays in referring young people who were eligible to the aftercare service. Fifty young people in foster care in the area were eligible to avail of the aftercare service. As soon as a young person is assessed as eligible, a referral should be made to the aftercare service in line with best practice. Thirty three children (66%) had not yet been referred, and some of these young people had already turned 17 years old. Of the 17 young people in foster care referred to the aftercare service, 14 had an allocated aftercare worker. The area reported that the remaining three young people would be allocated an aftercare worker when they turned 17 years old.

Twelve young people aged 16 years and over who resided in foster care completed questionnaires as part of this inspection. Of twelve questionnaires returned nine young people had an aftercare worker and aftercare plan, five said they did not and three young people declined to answer this question. Nine of 12 young people that responded had an allocated social worker, two did not and one young person declined to complete this section. Each of the four young people who had an

aftercare plan answered 'yes' when asked if they had a say in completing their plans. Two of twelve young people who returned questionnaires also requested to speak with inspectors. Both of these young people one of whom was over 17 and a half, were within the large number of young people who had not yet been referred to the after care service. Both young people were seeking advice and support from inspectors as to their best course of action to ensure their aftercare needs were addressed. Both of these young people were provided with information and advice as to their rights and with their permission, their concerns were relayed directly to the management team in the service area to be addressed. Assurances were received that both young people would be contacted directly by the social work department.

The aftercare service in the area was well-established and the service was provided by an aftercare manager and five aftercare workers. Four of the aftercare workers were Tusla social care leaders and one was a social care worker. Each worker carried a caseload of approximately 23 children and there was no waiting list of referred children awaiting a service.

The work of the aftercare team was informed by the Tusla national aftercare policy and associated guidance, and inspectors found that the policy was implemented in full in the area. Young people could be referred from 16 years and were allocated an aftercare worker when they were 17 years old. Young people with complex needs were referred to the aftercare steering committee at 16 years. All referrals examined by inspectors were found to have involvement of young people and were signed by the young person, social worker and social work team leader. The aftercare manager maintained a record of referrals including the date the referral was received and decisions in relation to allocating to an aftercare worker were based on the young person's individual needs.

Inspectors reviewed eight files of children over the age of 16 for the purpose of examining the quality of aftercare service provision. All eight young people were assessed as being eligible for the aftercare service, seven had been referred and one had not. Six of the seven referred young people had an allocated aftercare worker. One young person had been referred to the service two weeks prior to the inspection and did not have an allocated aftercare worker at the time of inspection. The one young person who had not been referred to the service was 17 years old did not have an allocated social worker, had not been visited by a social worker since 2017 and therefore the young person was not receiving a service in line with regulations. Inspectors found that all six young people who were allocated an aftercare worker had met with their worker who explained what the service could offer them.

Of the seven files reviewed by inspectors found that five of seven had completed assessments of need. Two young people aged 17 years who were recently referred to the service did not have completed assessments of need at the time of the inspection. Inspectors reviewed the five completed assessments of need for the purpose of examining quality and found that all five aftercare assessments were completed with the young people, had been completed within four to six months of allocation to an aftercare worker and all were assessed to be of good quality. In each of the five aftercare assessments all aspects of the young person's needs had been addressed and four of five were completed by the time the young person reached 17.5 years old. Inspectors found that for one young person their assessment of need was not completed in a timely manner in line with national standards however, they had only been referred to aftercare at 17.5 years old.

From the files reviewed, five of the seven young people referred to the aftercare service had an aftercare plan that was completed jointly with the young person. Inspectors found that the five aftercare plans addressed all aspects of the young person's needs, were based on the assessment of need and were developed in consultation with the young people. All aftercare plans were of good quality and were developed in consultation with key people. The aftercare plans had multidisciplinary input when assessed as appropriate and all five plans were signed by the young person. Young people with complex needs were referred to the aftercare steering committee at sixteen years old. From the files reviewed, two young people who required them, received appropriate multidisciplinary input either through the aftercare service or an alternative support service more suited to the young person's needs.

The aftercare manager and young people told inspectors that there was a weekly aftercare drop-in support service in the office where the inspectors were based which was available to young people, foster carers and other people supporting young people. During the inspection, the drop-in service time slot was used for an inspector to meet with young adults aged 18-22 years old to obtain their views on the aftercare service. All eight young people who attended spoke positively about the service. All eight young adults had an allocated aftercare worker and an aftercare plan. They were actively involved in planning for their future. One young person commented "don't change" anything about the service and others agreed with this view. The young adults used words such as "supportive" and "practical" to describe the service and said workers "always answer calls".

All young people aged sixteen years and over referred of the service had a separate aftercare file. The files were presented with a clear table of contents and inspectors

found that they had all relevant up-to-date information about the young people. There was evidence of file audits and supervision records in the aftercare files. Young people signed consent forms for information to be shared and retained.

The aftercare manager informed inspectors that team meetings and regional aftercare managers' meetings took place once per month. The aftercare manager told inspectors that the regional aftercare managers meeting played a key role in ensuring that the new aftercare policy was implemented. As part of this forum, the area was taking part in a pilot project that clearly outlined strategic objectives for tracking the performance of the aftercare service. The objectives covered areas such as establishing support services, informing young people, interagency collaboration, communication with stakeholders and monitoring and evaluating the service. The project task list noted an overall complete status of 85.05% at the time of the inspection. The vast majority of tasks were noted to be completed or on track.

The aftercare steering committee met four times per year. Members of the committee included disability services, mental health and housing and membership was reviewed regularly. Minutes of these meetings reviewed by inspectors showed that the steering committee had a key role in planning for the child's future and that different agencies took responsibility for different aspects of the child's care.

An aftercare forum involving young people met four times per year. Inspectors found that the area was proactive in trying to encourage young people to engage with the service and offered support through events, such as a bowling party, summer barbecue, Halloween party and Christmas party.

Inspectors were provided with a copy of the Review of Adequacy Report 2018 and Service Plan 2019, completed by the aftercare manager. It noted that three young people were housed by the aftercare team and Tusla in conjunction with housing agencies were in the process of securing a further two apartments. Young people suitable for the 'Capital Assistance Scheme' could be nominated by their aftercare worker and aftercare manager. The scheme provided rented accommodation for people with additional needs, including young people leaving care. Young people nominated attended the steering committee to seek final approval of their application. It also noted that in 2018, all 126 young people availing of the aftercare service had completed assessments and aftercare plans. The aftercare manager advised that aftercare briefings had occurred with children in care teams and fostering teams to create more awareness about aftercare services.

There were examples of good practice in relation to the aftercare service in this area. The aftercare manager and young adults spoke about a newly developed

support group in the area. In 2018, the aftercare service and young people identified a gap in the service and in 2019, the aftercare service formed a parents group for young people leaving care called the aftercare parents support group (T.A.P.S). Two of the young adults who attended the group met with an inspector and provided positive feedback about the group. The aftercare service had clear objectives for 2019 which were already being met. For example, setting up the parent support group and holding meetings with various groups to inform them of the aftercare service. Briefings on after care were also provided to foster carers. In addition, the aftercare manager told inspectors that she maintained records and statistics on young people who had left care and were provided with an aftercare service and submitted monthly returns to the national office. This data was provided to inspectors, examples of which are detailed below;

Of 91 young adults (18 – 22 years) who were receiving an aftercare service at the time of the report (quarter 2, 2019), the percentage in education or training is as follows:

- 27 (30%) were still in second level schools
- 21 (23%) were in post-leaving cert courses
- 8 (9%) were in third level college or university and
- 8 (9%) was in accredited training

The accommodation arrangements of the 91 young adults in the 18-22 years age group were as follows:

- 54 (59%) remained with their former foster carers
- 16 (17%) were in residential care
- 6 (7%) were living independently
- 5 (6%) were with birth family or extended family
- 10 (11%) were in 'other' (five in homeless accommodation, one in prison, one in supported accommodation and three were staying with friends/others/whereabouts unknown)

The service area had a written policy on aftercare provision which outlined the aspects of support and entitlement for children and young people leaving care. The area also had good practice in relation to the aftercare provision following the receipt of a referral for a young person. However, as cited above the majority of eligible children (66%) had not been referred to the aftercare service. As a result not all young people had assessments outlining their leaving care needs two years prior to leaving care as per the legislation nor did all young people aged 17.5 years have an aftercare plan. The service was not meeting the requirements of the legislation

and children received a delayed service that did not give them the required time to adequately prepare for leaving care.

**Judgment:** Non-compliant Moderate

## Appendix 1 – Standards and regulations for statutory foster care services

<b><i>National Standards for Foster Care (April 2003)</i></b>
<b>Theme 1: Child-centred Services</b>
<p><b>Standard 1: Positive sense of identity</b> Children and young people are provided with foster care services that promote a positive sense of identity for them.</p>
<p><b>Standard 2: Family and friends</b> Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.</p>
<p><b>Standard 3: Children’s Rights</b> Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and have their views, including complaints, heard when decisions are made which affect them or the care they receive.</p>
<p><b>Standard 4: Valuing diversity</b> Children and young people are provided with foster care services that take account of their age, stage of development, individual assessed needs, illness or disability, gender, family background, culture and ethnicity (including membership of the Traveller community), religion and sexual identity.</p>
<p><i>Child Care (Placement of Children in Foster Care) Regulations, 1995 Part III Article 8 Religion</i></p>
<p><b>Standard 25: Representations and complaints</b> Health boards* have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.</p>

\* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

## ***National Standards for Foster Care (April 2003)***

### **Theme 2: Safe and Effective Services**

#### **Standard 5: The child and family social worker**

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

*Child Care (Placement of Children in Foster Care) Regulations, 1995  
Part IV, Article 17(1) Supervision and visiting of children*

#### **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.

*Child Care (Placement of Children in Foster Care) Regulations, 1995  
Part III, Article 6: Assessment of circumstances of child*

#### **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.

*Child Care (Placement of Children in Foster Care) Regulations, 1995  
Part III, Article 11: Care plans  
Part IV, Article 18: Review of cases  
Part IV, Article 19: Special review*

#### **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.

*Child Care (Placement of Children in Foster Care) Regulations, 1995  
Part III, Article 7: Capacity of foster parents to meet the needs of child*

*Child Care (Placement of Children with Relatives) Regulations, 1995  
Part III, Article 7: Assessment of circumstances of the child*

### ***National Standards for Foster Care (April 2003)***

#### **Standard 9: A safe and positive environment**

Foster carers' homes provide a safe, healthy and nurturing environment for the children or young people.

#### **Standard 10: Safeguarding and child protection**

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

#### **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.

#### **Standard 14a — Assessment and approval of non-relative foster carers**

Foster care applicants participate in a comprehensive assessment of their ability to carry out the fostering task and are formally approved by the health board\* prior to any child or young person being placed with them.

*Child Care (Placement of Children in Foster Care) Regulations, 1995*

*Part III, Article 5 Assessment of foster parents*

*Part III, Article 9 Contract*

#### **Standard 14b — Assessment and approval of relative foster carers**

Relatives who apply, or are requested to apply, to care for a child or young person under Section 36(1) (d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board.

*Child Care (Placement of Children with Relatives) Regulations, 1995*

*Part III, Article 5 Assessment of relatives*

*Part III, Article 6 Emergency Placements*

\* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

***National Standards for Foster Care (April 2003)****Part III, Article 9 Contract***Standard 15: Supervision and support**

Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.

**Standard 16: Training**

Foster carers participate in the training necessary to equip them with the skills and knowledge required to provide high-quality care.

**Standard 17: Reviews of foster carers**

Foster carers participate in regular reviews of their continuing capacity to provide high-quality care and to assist with the identification of gaps in the fostering service.

**Standard 22: Special Foster care**

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

**Standard 23: The Foster Care Committee**

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

*Child Care (Placement of Children in Foster Care) Regulations, 1995*  
*Part III, Article 5 (3) Assessment of foster carers*

*Child Care (Placement of Children with Relatives) Regulations, 1995*

\* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

***National Standards for Foster Care (April 2003)***

*Part III, Article 5 (2) Assessment of relatives*

***National Standard for Foster Care ( April 2003)*****Theme 3: Health and Development****Standard 11: Health and development**

The health and developmental needs of children and young people in foster care are assessed and met. They are given information, guidance and support to make appropriate choices in relation to their health and development.

*Child Care (Placement of Children in Foster Care) Regulations, 1995*  
 Part III, Article 6 Assessment of circumstances of child  
 Part IV, Article 16 (2)(d) Duties of foster parents

**Standard 12: Education**

The educational needs of children and young people in foster care are given high priority and they are encouraged to attain their full potential. Education is understood to include the development of social and life skills.

***National Standards for Foster Care ( April 2003)*****Theme 4: Leadership, Governance and Management****Standard 18: Effective policies**

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

*Child Care (Placement of Children in Foster Care) Regulations, 1995*  
 Part III, Article 5 (1) Assessment of foster carers

**Standard 19: Management and monitoring of foster care agency**

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

*Child Care (Placement of Children in Foster Care) Regulations, 1995*  
 Part IV, Article 12 Maintenance of register

\* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

*Part IV, Article 17 Supervision and visiting of children*

**Standard 24: Placement of children through non-statutory agencies**

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

*Child Care (Placement of Children in Foster Care) Regulations, 1995  
Part VI, Article 24: Arrangements with voluntary bodies and other persons*

***National Standards for Foster Care ( April 2003)***

**Theme 5: Use of Resources**

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

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

***National Standards for Foster Care ( April 2003)***

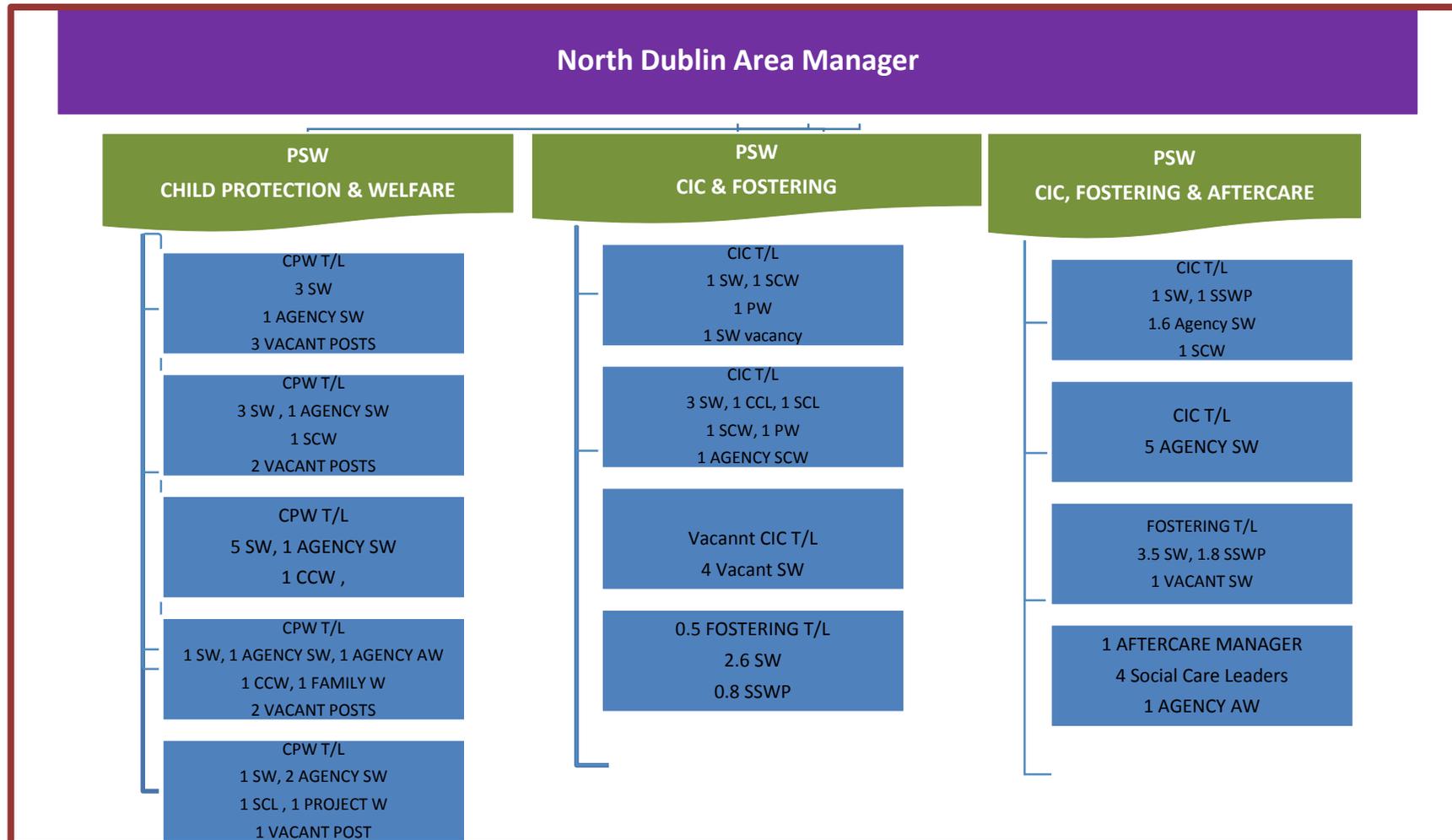
**Theme 6: Workforce**

**Standard 20: Training and Qualifications**

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

\* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

**Appendix 2: Organisational structure of Statutory Alternative Care Services, in North Dublin Service Area\***



\* Source: The Child and Family Agency

## Action Plan

This Action Plan has been completed by the Provider and the Authority has not made any amendments to the returned Action Plan.

<b>Provider's response to Report Fieldwork ID:</b>	MON 0026955
<b>Name of Service Area:</b>	Dublin North
<b>Date of inspection:</b>	10, 11, 12, 13 June 2019
<b>Date of response:</b>	23 <sup>rd</sup> August 2019

These requirements set out the actions that should be taken to meet the identified child care regulations and *National Standards for Foster Care*.

## Theme 2: Safe and Effective Services

### Standard 5 – The child and family social worker

#### Non-compliant Moderate

**The provider is failing to meet the National Standards in the following respect:**

1. Not all children had an allocated social worker
2. Children did not receive visits in line with statutory requirements. The system for monitoring statutory visits and ensuring that they were carried out in line with regulations was not effective
3. Records of statutory visits were missing or poor quality
4. Not all children knew how to make a complaint
5. Social workers did not record all verbal/informal complaints made by children. The area had no mechanism in place to collate complaints made by children for the purposes of analysing them to drive improvement.
6. The electronic system for the storage of children's case files and associated documents was complex for social workers to navigate and did not facilitate timely access to specific documents and
  - a) *there were different practices within the area regarding the naming and storing of specific documents*
  - b) *there were no chronologies on children's case files*
  - c) *key information on children in the area was not always accessible within their care records.*

#### **Action required:**

Under **Standard 5** you are required to ensure that:

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

#### **The following action have taken place or are planned to take:**

##### **1. Not all children had an allocated social worker**

- a) This has been risk escalated to the regional and national offices.
- b) North Dublin is employing social care workers and project workers, as a temporary measure, to ensure children are in receipt of a safe service, safeguarding visits are take place and children's voices are heard. These workers are managed by a Social Work Team Leader.
- c) There are rolling recruitment initiatives at national, regional and local levels to

increase the number of Social Workers in Tusla.

- d) Staff retention initiatives are being implemented such as increasing the number of Senior Social Work Practitioner posts in the Area in an effort to preserve institutional knowledge, retain skilled staff and provide a career pathway for social workers.
- e) There is on-going contact with Tusla Recruit and Agency recruitment Services to hire additional social workers.
- f) North Dublin was selected as one of five Areas nationally to be part of a Human Resources Taskforce. The Area Manager chaired the first meeting on 14-08-2019. The meeting was attended by the National and Regional HR Managers. Meetings will continue on a monthly basis & will explore recruitment & retention strategies. This task will be completed by Area Manager and National Human Resources by 31-12-2019.

**2. Children did not receive visits in line with statutory requirements. The system for monitoring statutory visits and ensuring that they were carried out in line with regulations was not effective**

- a) Individual trackers for statutory visits have been adopted for each child to allow ease of monitoring for Social Workers and Team Leaders.
- b) Team Leaders are responsible for updating the Children in Care register of statutory visits completed by social workers. This task will be completed by 31-12-2019 in supervision sessions with social workers.
- c) Team Leaders will review the Children in Care register and agree timescales with Social Workers where gaps in statutory visits arise. This task will be completed by Team Leaders by 31-12-2019.
- d) Out of date statutory visits will be added to the Team Leader and Principal Social Worker pro forma supervision forms. This task will be completed by Team Leaders and Principal Social Workers by 30-11-2019.
- e) There is an escalation protocol to the Principal Social Worker in place if statutory visits are missed. This is completed by the Team Leader and timeframes for completion of the visits are agreed in supervision and reviewed thereafter.
- f) The QRSI Manager will review the Children in Care register on a monthly basis and circulate 'out of date statutory visits' to the Team Leaders and Principal Social Workers from the 30-09-2019.
- g) The Children in Care register will be reviewed at the Area Governance Group and any out of date visits will be highlighted for action and monitored for compliance. This task will be completed by Service Support Manager from the 30-11-2019 and at subsequent meetings thereafter.

**3. Records of statutory visits were missing or poor quality**

- a) The regional statutory visit template will be used to ensure quality recordings of statutory visits with children. This task will be completed by Social Workers and be reviewed by Team Leaders in supervision for quality assurance by the 31-12-2019.
- b) Statutory visits will be saved on NCCIS as an individual file using the regional statutory visit template from 31-10-2019.
- c) File audits of Children in Care files will take place by Team Leaders and Principal Social Workers. The first audit will be completed by the end of 30-11-2019. Findings of audits will be advised to the monthly Area Governance Group from the 31-12-

2019.

**4. Not all children knew how to make a complaint**

- a) All staff will complete an eLearning module focused on the local resolution of complaints and assisting staff to undertake local resolution by the 31-10-2019.
- b) The Children in Care register will be amended by the QRSI Manager to include children being informed of how to make a complaint.
- c) All Children in Care will be made aware of how to make a complaint and receive a copy of 'Tell Us'. This task will be completed by social workers by the 31-10-2019 and continue on a rolling basis thereafter.
- d) Team Leader, in supervision with social workers, will populate the Children in Care register. This task will be completed 31-12-2019 and continue on a rolling basis thereafter.
- e) The Children in Care and complaints registers will be monitored and reviewed at the Area Governance Group from the 31-10-2019 and at subsequent meetings.

**5. Social workers did not record all verbal/informal complaints made by children. The area had no mechanism in place to collate complaints made by children for the purposes of analysing them to drive improvement**

- a) Briefing sessions will take place with teams holding Children in Care cases on the appropriate recording of complaints and trends highlighted for service improvement purposes. This task will be completed by Team Leaders from the 31-10-2019 and bi-annually thereafter.
- b) Workers will be informed that the complaints register has been amended to include verbal/informal complaints made by children. This task will be completed by Team Leaders and Principal Social Workers by 31-10-2019.
- c) Updates on all active complaints will be provided to the Area Governance Group by Principal Social Workers from 30-09-2019 and at subsequent meetings thereafter.
- d) Complaints will be tracked and reviewed through the Area Governance Group and service improvements actioned by Principal Social Workers from 30-09-2019.
- e) All complaints will be analysed, with learning being brought to the Departmental Team Meetings. This action will be completed by the local QRSI Manager from the 31-12-2019 and in advance of subsequent meetings thereafter.

**6. The electronic system for the storage of children's case files and associated documents was complex for social workers to navigate and did not facilitate timely access to specific documents. There were different practices within the Area regarding the naming and storing of specific documents, there were no chronologies on children's case files and key information on children in the area was not always accessible within their care records**

***a) there were different practices within the area regarding the naming and storing of specific documents***

- i. Three workshops were arranged for Children in Care Teams in 2019 to support their use of NCCIS. Support continues to be available to all team members and is accessible on an individual basis.
- ii. NCCIS national office confirmed to the Service Support Manager that the NCCIS

Standard Business Process Practice sub group has developed practice documents, including naming conventions and categories for casenotes and attachments. They were presented to NCCIS governance group on 26-08-2019 and are expected to issue out to all Areas by 31-12-2019.

- iii. NCCIS Standard Business Process Guidance documents will be implemented by Social Workers, with coaching provided by Team Leader to small teams and in supervision. There will also be input at the Departmental team meetings no later than 31-03-2020.
- iv. The Area Manager has written to Chief Social Worker in Tusla that North Dublin be prioritised for an NCCIS user liaison officer to head up project to assist cleanse and move to paperless system. This task will be completed by Area Manager, 31-03-2020.

***b) there were no chronologies on children's case files***

- i. The Service Support Manager consulted with NCCIS Lead on the 27-08-2019 to determine if chronologies can be generated from the NCCIS data base. It was confirmed that this has been raised as a change request to the system design team. An agreed national chronology is required to determine what can be pulled from the NCCIS data base.
- ii. In the absence of automated chronologies on NCCIS, chronologies will continue to be recorded manually by the allocated social worker. This task will be completed by Social Workers by 31-03-2020.
- iii. An audit of outstanding chronologies will be completed and an action plan developed to ensure all Children in Care files have a chronology on file. This will be completed Social Workers and Team Leader by 31-10-2019.
- iv. Any additional staffing resources (e.g. social care workers, project workers student social workers, etc) will be requested to support teams in completion of file audits under a 'staff chronology blitz days'. Monitoring will take place through supervision by Social Workers/Team Leaders/Principal Social Workers by the 31-03-2020.

**c) key information on children in the Area was not always accessible within their care records**

- i. Team Leaders will provide training for current and new staff on file managements, under the sections provided on hard files. This will take place by the 31-10-2019.
- ii. The Area plans to move to a paperless service with the full implementation of NCCIS. This will occur when a 'User Liaison Officer' is appointed. Three attempts have been made to fill this post. The Area Manager will continue efforts to fill this post, with a completion date of 31-03-2020.

Proposed timescale:		Person responsible:	
1	31-12-2019	1	AM, National HR & PSWs
2	31-12-2019	2	TLs, PSWs, QRSI Manager and Area Governance Group
3	31-12-2019	3	TLs, PSWs and Area Governance

4	31-12-2019	4	Group PSW's, TLs, SWs, QRSI Manager and Area Governance Group
5	31-12-2019	5	PSWs, TLs, QRSI Manager and A.M. Office
6	31-03-2020	6	NCCIS national office, PSWs, TLs, SWs, Service Support Manager

**Standard 6 – Assessment of children and young people****Substantially Compliant****The provider is failing to meet the National Standards in the following respect:**

1. It was not clear that all children had a medical examination as required upon admission to care.

**Action required:**

Under **Standard 6** you are required to ensure that:

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.

**The following action have taken place or are planned to take:****1. It was not clear that all children had a medical examination as required upon admission to care**

- a) The Area Manager has written to the national office regarding the difficulties of accessing GPs for accessing medicals.
- b) All children will be considered for a medical and developmental examination on admission to care, except where the social worker in consultation with the Team Leader, are satisfied, having regard to available information and reports, that such an examination is unnecessary. This practice has been implemented and will be completed by Social Workers and Team Leaders from 30-09-2019.
- c) If a decision is made not to complete medicals, the rationale will be recorded on the child's file. This task will be completed by the social worker from the 30-09-2019.
- d) Any barriers to medicals will be raised at the monthly Area Governance Group by the Principal Social Workers and the Area Manager will take whatever actions are necessary to resolve the issue or find an alternative, as has been the case to date. This task will be completed by Principal Social Workers and the Area Manager from the 30-09-2019.

**Proposed timescale:**

1 30-09-2019

**Person responsible:**

1 AM, PSWs, SWs & TLs

**Standard 7 – Care planning and review****Non-compliant Moderate**

**The provider is failing to meet the National Standards in the following respect:**

1. Care planning was significantly delayed
2. The quality of case management records of social workers was not always adequate
3. There was no evidence on files that care plans were sent out to parents, foster carers and other relevant people
4. Plans put in place to address the backlog of child in care reviews contributed to poor experience of care planning for some children
5. Placement plans were not being completed in the area

**Action required:**

Under **Standard 7** you are required to ensure that:

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.

**The following action have taken place or are planned to take:**

**1. Care planning was significantly delayed**

- a) The pro forma supervision template for Children in Care Teams was amended in May 2019 to include the date of last statutory visit, date of last statutory review, date of care plan and outline of any child protection and welfare concerns.
- b) Additional resources from the Area Manager's Office are available to Chair Child in Care reviews to increase capacity for teams. It is the responsibility of Social Workers and Team Leaders to request assistance as required.
- c) There is increased governance of care plans with a code alerts system on the Children in Care register to highlight overdue Child in Care reviews.
- d) Team Leaders will review the Children in Care register and schedule review meetings in supervision with the social worker where required. This task will be completed by Team Leaders by 31-12-2019
- e) The QRSI manager reviews the Children in Care register and circulates out of date Care Plan and reviews to managers.
- f) Child in Care reviews and Care Plans are tracked at monthly Area Governance Group.
- g) A 5<sup>th</sup> Children in Care Team will be established. This will alleviate pressures on the other team leaders and thereby leading to better quality and more frequent supervision. This action rests with the Area Manager and the Human Resources taskforce for completion by 31-03-2020.

**2. The quality of case management records of social workers was not always adequate**

- a) Team Leaders and Principal Social Workers will complete briefings with Social Workers holding Children in Care cases on the quality of case management records. This task will be completed by 31-10-2019.
- b) File audits will form part of quality assurance of case management records from 30-11-2019 and will be the responsibility of Team Leaders and Principal Social Workers.
- c) A new regional guidance document is under development regarding improving the quality of care planning for children in care. This will provide guidance to writing care plans, will standardise distribution of care planning, etc. It is expected this document will be available by 31-12-2019 and training will be provided by Team Leaders to all workers thereafter with a completion date of 31-03-2020.

**3. There was no evidence on files that care plans were sent out to parents, foster carers and other relevant people**

- a) Care Plans will be updated in accordance with the statutory review meeting and no later than six weeks from when the review took place. This will be monitored by Team Leaders in supervision with Social Workers.
- b) Team Leaders will review and sign off on Care Plans and Child in Care review minutes before dissemination by the Social Worker to the child, parents, foster carer/s and link worker, as appropriate. This will be clearly recorded on the child's files and noted on the social worker's supervision file. Reasons for not doing so are recorded on case files. This action will commence immediately, with an expected completion date of 31-03-2020. This task will be the responsibility of Team Leaders and Social Workers.

**4. Plans put in place to address the backlog of child in care reviews contributed to poor experience of care planning for some children**

- a) Plans are in place to restructure social work teams in the Department to minimise the change of social workers for children in contact with the service. This will be implemented by 31-03-2020.
- b) Child in Care reviews will be planned in a manner to ensure the Social Worker meets with the child in advance to assist with the child's form and ensure their voice is represented at the meeting. This is the responsibility of Social Workers and effective from 30-09-2019.
- c) Children are encouraged to attend their review and arrangements are made to facilitate attendance. Reasons for non-attendance at reviews will be clearly recorded on the child's file. This is the responsibility of Social Workers and effective from 30-09-2019.
- d) Children will be encouraged to contact EPIC and to bring a member as a support person to their review. This is the responsibility of Social Workers and effective from 30-09-2019.
- e) Feedback questionnaires will be designed to assess participant's experience of care planning meetings. Completed questionnaires will be reviewed by the Area Manager's office, with trends being brought to the Area Governance Group and

- discussed at the Departmental meetings. This will be implemented from 31-01-2020.
- f) Training inputs will be provided at Departmental meeting bi-annually, in accordance with the Child Care Regulations 1995 and Standard 7 of the National Standards for Foster Care. This task will be completed by Team Leaders and Principal Social Workers by 31-12-2019 and bi-annually thereafter.

#### 5. Placement Plans were not being completed in the area

- a) Placement plans will be completed for all new children received into care.
- b) To address the retrospective gap, children in care without placement plans will be completed at the next child in care review. Social Workers will be completed this task by 31-03-2020.
- c) Placement Plans will be tracked on the Children in Care register and be reviewed by the Team Leader and Principal Social Worker from 30-09-2019.
- d) Placement Plans will be reviewed on the Children in Care register by QRSI Manager on a monthly basis and gaps will be notified to Team Leaders and Principal Social Workers. This task will be completed by the QRSI Manager from the 30-09-2019.

Proposed timescale:		Person responsible:	
1	31-03-2020	1	AM & National HR
2	31-03-2020	2	PSWs, TLs & Service Support Manager
3	31-03-2020	3	PSWs & TLs
4	31-01-2020	4	PSWs & TLs
5	31-03-2020	5	PSWs, TLs, SWs and QRSI Manager

**Standard 8 – Matching carers with children and young people****Substantially Compliant****The provider is failing to meet the National Standards in the following respect:**

1. There was an insufficient number of foster care placements in the area.
2. There was a backlog of approvals of long-term matches.

**Action required:**

Under **Standard 8** you are required to ensure that:

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.

**The following action have taken place or are planned to take:**

1. **There was an insufficient number of foster care placements in the area**
  - a) The dearth of foster carers in North Dublin, necessitating the use of private foster care placements, has been risk escalated a number of times to the regional and national Tulsa offices.
  - b) A recruitment strategy is in place which includes carer participation at all events.
  - c) In June 2019 information stands were secured at two major festivals.
  - d) Fostering Recruitment Leads meet monthly at the recruitment Regional Assessment Team.
  - e) A national Tusla Fostering Awareness Campaign is planned for October 2019 with national & local recruitment events planned. Actions arising will be completed by Principal Social Workers by 31-12-2019.
2. **There was a backlog of approvals of long-term matches**
  - a) Amendments were made to the Children in Care Register in April 2019 to ensure that the completion of matching was more easily trackable.
  - b) The backlog of approvals of long-term matches will be completed by 31-03-2020. This task will be completed by Social Workers, Team Leaders and Principal Social Workers.
  - c) Quarterly Children in Care and Fostering Management meetings are planned, with matching a standing item on the agenda. The Child Protection & Welfare Principal Social Worker will also attend these meetings to ensure coordination of actions across teams who hold responsibility for children in care. This task will be completed by Principal Social Workers with the first such meeting taking place by the 30-09-2019 and quarterly thereafter.
  - d) Additional Foster Care Committee will be convened, if required, to consider long-term matches and avoid backlogs. This task will be completed by Chairperson of the Foster Care Committee from 31-12-2019.
  - e) The QRSI Manager to circulate outstanding long-term matches to be completed. This task will be completed by the QRSI Manager from the 30-09-2019.

f) Long-term matches will be reviewed by the monthly Area Governance Group.

Proposed timescale:		Person responsible:	
1	31-12-2019	1	PSWs
2	31-03-2020	2	PSWs, FCC Chairperson and QRSI Manager

## Standard 10 – Safeguarding and Child Protection

### Non-compliant Moderate

#### The provider is failing to meet the National Standards in the following respect:

1. Information and assurances sought by the foster care committee in relation to decisions by social workers were not routinely followed up or provided to the committee and questions remained unanswered.
2. Initial assessments of allegations were not completed in a timely way in line with Tusla standard business processes, in all cases.
3. Review and updating of safety plans following changes in circumstances did not occur in all cases.

#### Action required:

Under **Standard 10** you are required to ensure that:  
Children and young people in foster care are protected from abuse and neglect.

#### The following action have taken place or are planned to take:

1. **Information and assurances sought by the foster care committee in relation to decisions by social workers were not routinely followed up or provided to the committee and questions remained unanswered.**
  - a) On 07-06-2019, Children in Care Teams attended a workshop on managing and responding to child protection and welfare concerns. This increased awareness of the requirements in terms of content and timeframe for Initial Assessments.
  - b) Information and assurances sought by the Foster Care Committee in relation to decisions by social workers outstanding from more than two months will be notified to the Children in Care Principal Social Workers by the Foster Care Committee. This task will be completed by Chairperson of the Foster Care Committee with immediate effect and a completion date of 31-12-2019.
  - c) Outstanding information and assurances sought by the Foster Care Committee in relation to decisions by social workers will be a standing item on meeting between

the Principal Social Workers and Foster Care Committee Chairperson. This will be the responsibility of the Principal Social Worker and the Chairperson of the Foster Care Committee from 31-10-2019 and quarterly thereafter.

- d) A workshop on managing and responding to child protection and welfare concerns will be delivered bi-annually to ensure awareness of requirements across the whole department. The next session to be delivered at the Departmental meeting. This will be the responsibility of the Principal Social Worker and the Chairperson of the Foster Care Committee 30-11-2019.

## **2. Initial assessments of allegations were not completed in a timely way in line with Tusla standard business processes, in all cases**

- a) Initial Assessments of allegations for Children in Care will be tracked through the Serious Concerns/Allegations register. This task will be the responsibility to Team Leaders with immediate effect and a completion date of 31-12-2019.
- b) Where delays occur with Initial Assessments, Social Workers and Team Leaders will inform the Principal Social Worker as to the cause of same and a resolution agreed to progress the matter. This task will be the responsibility to Team Leaders with immediate effect and a completion date of 31-12-2019.
- c) A workshop on Initial Assessment, in line with Standard Business Processes, will be delivered at Departmental meetings bi-annually to ensure awareness of requirements across the whole department. This task will be the responsibility of the Principal Social Workers and take place from 31-01-2020.

## **3. Review and updating of safety plans following changes in circumstances did not occur in all cases**

- a) The Children in Care register has been amended to include a 'Safety Plan' section.
- b) Safety Plans will be included as a standing item on the Children in Care review agenda. This action will be completed by 31-10-2019 and is the responsibility of Social Workers and Team Leaders.
- c) It will be the responsibility of Team Leaders to update the Safety Plan section on the Children in Care register. This action will be completed following the initial Safety Plan and updated thereafter following any changes in circumstances. This action will be completed by Team Leaders by 31-12-2019.
- d) Strategy meetings will be convened when appropriate following changes in circumstances. This is the responsibility of Social Workers and Team Leaders with immediate effect and a completion date of 31-12-2019.
- e) Safety Plans will be disseminated to relevant parties by the Social Worker and no later than four weeks from when the plan is agreed.

<b>Proposed timescale:</b>		<b>Person responsible:</b>	
1	31-12-2019	1	TL, PSW and FCC Chairperson
2	31-01-2020	2	TL and PSW
3	31-12-2019	3	TL and PSW

**Standard 13: Preparation for leaving care and adult life****Non-compliant Moderate****The provider is failing to meet the National Standards in the following respect:**

1. Managerial oversight was not effective at ensuring timely referrals to the aftercare service for all eligible young people in the area.
2. Not all young people had assessments outlining their leaving care needs two years prior to leaving care as required.
3. Not all young people aged 17.5 years had an aftercare plan.

**Action required:**

Under **Standard 13** you are required to ensure that:

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.

**The following action have taken place or are planned to take:**

1. **Managerial oversight was not effective at ensuring timely referrals to the aftercare service for all eligible young people in the area.**
  - a) A flagging system is been developed to alert the Aftercare Manager & Children in Care Team Leaders prior to Children in Care reaching 16yrs to prompt a referral to Aftercare.
  - b) Aftercare referrals will continue to be tracked in supervision between Social Workers & Team Leaders, and between Team Leader and Principal Social Worker.
  - c) Since the inspection, 16 out of 33 young people eligible for Aftercare have been referred. The remaining 17, and all other eligible young people, will be referred by their Social Worker by 31-12-2019.
  - d) The Aftercare Manager attends the Children in Care Management meetings to identify & discuss referrals. This will continue on a monthly basis.
  - e) The Aftercare Manager will provide a monthly report to Aftercare Principal Social Worker on Aftercare referrals received and record any referrals outstanding.
  - f) The QRSI Manager will review the Children in Care register on a monthly basis and disseminates the names of all children eligible for Aftercare, who are not recorded as referred to the service, to the Team Leaders, Principal Social Workers and the Aftercare Manager. This task will be completed by QRSI Manager with immediate effect and a completion date of 31-12-2019.
  - g) Children in Care eligible for Aftercare who have not been referred to the service after three months of turning sixteen will be notified by the Team Leader to line manager Principal Social Worker. This task will be completed by Team Leaders with immediate effect and a completion date of 31-12-2019

h) The Child Protection and Welfare Principal Social Worker will be invited to attend in the Children in Care Management meeting to identify & discuss referrals of any relevant Child in Care cases held by them. This task will be undertaken by PSWs, with the next meeting scheduled for 26-09-2019 and monthly thereafter. A completion date of 31-12-2019.

**2. Not all young people had assessments outlining their leaving care needs two years prior to leaving care as required**

a) A revised Standardised Operating Procedure for Aftercare referrals was circulated to all teams, noting the change of referral 'from 16yrs' to 'at 16yrs' to ensure that all new and existing staff are aware of referral the procedure. This will be reissued by 31-12-2019 by the Principal Social Worker.

**3. Not all young people aged 17.5 years had an aftercare plan**

a) Since the inspection, 5 Aftercare Plans have been developed for 17.5yr olds with a plan in place to complete the remaining plans by 31-12-2019.

Proposed timescale:		Person responsible:	
1	31-12-2019	1	TLs, PSWs and QRSI Manager
2	31-12-2019	2	PSW
3	31-12-2019	3	SW, TL and Aftercare Manager