Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Overview report on the inspections of statutory foster care services 2017 to 2018

February 2019

About monitoring of statutory foster care services

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

HIQA is authorised by the Minister for Children 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 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 (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.

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1. Introduction

In 2017 the Regulation Directorate within the Health Information and Quality Authority (HIQA) commenced a programme of thematic inspections of statutory foster care services provided by Tusla (the Child and Family Agency) across all 17 service areas.

Tusla is organised into four regions: the West, the South, Dublin Mid Leinster and Dublin North East. Each region is managed by a regional manager, known as a service director. The regions are divided into 17 service areas, each of which provides a foster care service.

The thematic inspections focused on the recruitment, assessment, approval, supervision and review of foster carers, as well as the arrangements in place for safeguarding and child protection of children in foster care placements. During 2017, a total of 14 Tusla service areas were inspected, and the remaining three service area inspections were completed by the end of April 2018.

These inspections identified varied practice and compliance both within and across regions. As a result, HIQA conducted regional follow-up inspections which examined the service areas with the highest levels of non-compliance. Desktop reviews of the remaining service areas were also carried out. This report summarises the overall findings from the 17 service area inspections, conducted throughout 2017 to 2018, and the regional follow-up inspections carried out in 2018. The inspection reports setting out the findings for each region are available on www.hiqa.ie.

2. Methodology

2.1 Thematic foster care inspections

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 Tusla and to report on its findings to the Minister for Children and Youth Affairs. HIQA monitors foster care services against the 2003 *National Standards for Foster Care.*

As part of the thematic programme of inspections, inspectors met with the relevant professionals involved in foster care services and with foster carers in each service area. Inspectors observed practices and reviewed documentation such as case files, foster carers' assessment files, and relevant documentation relating to the areas covered by the theme.

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

- assessment of foster carers
- safeguarding processes
- effectiveness of the foster care committees
- supervision, support and training of foster carers
- and reviews of foster carers.

The key activities of these inspections involved:

- the analysis of data
- interviews with area managers and principal social workers
- interviews with the chairperson of the foster care committees and review of minutes of the foster care committee meetings
- separate focus groups with fostering social workers, children in care social workers and with foster carers
- review of the relevant sections of foster carers' files as they related to the recruitment, assessment, approval, supervision and review of foster carers, and the arrangements in place for safeguarding and child protection of children in foster care placements.

2.2 Regional follow-up inspections

Following the completion of inspections in all 17 service areas, HIQA's Regulation Directorate commenced a programme of follow-up inspections to assess the extent to which the 2017 inspection findings had been successfully addressed.

One key finding of the initial inspections was the extent to which practice in statutory foster care services varied both within and across regions, reflecting the fact that learning was not always transferred between service areas, or indeed across regions. In light of this, follow-up inspections were carried out in each of the four regions,[1] thus placing a focus on the overall governance of each region rather than assessing practice as it pertained to individual service areas.

Based on the findings of the 2017 initial foster care inspections, and the reciprocal actions Tusla put in place to address the areas of concern identified, HIQA issued a self-assessment to each Tusla region. This self-assessment allowed Tusla managers with accountability for the delivery of safe and effective foster care services to return a statement of progress as it pertained to their areas.

The self-assessment required managers to assess:

- the extent to which progress had been made to address areas of non-compliance, concern and or risk as identified during the 2017 themed inspection,
- the area's assessment of their current level of compliance to the specific standards assessed in 2017 (see Appendix 1),
- their evidence to support their self-assessment findings,
- any outstanding actions the area has to implement,
- and a statement identifying the arrangements the area manager has in place to assure that appropriate actions to address areas of non-compliance and risk happened in a timely and effective manner.

Following receipt of the completed statement of progress from each service area, the information was reviewed by an inspector to assess each area's progress in becoming compliant with the relevant standards. This review included a particular focus on areas of practice that had received judgments of major and moderate non-compliances. Inspection fieldwork was conducted in the service areas where a significant number of major non-compliances had been found during the 2017

[1] The South, West, Dublin Mid-Leinster, and Dublin North East regional reports are published separately to this report on www.hiqa.ie.

inspections. Desktop reviews[2] were carried out for the remainder of the service areas.

Following the completion of the desktop reviews and the follow-up fieldwork, interviews were conducted with the service directors for each region. A service director leads and is responsible for the effective governance, leadership and operational management of a range of services including child protection and welfare services and foster care services within their respective region, with each postholder reporting directly to the Chief Operations Officer based in Tusla headquarters in Dublin. Service directors are supported in delivering their functions by geographically-based area managers who have specific responsibility for ensuring effective day-to-day management of their service areas.

Interviews with service directors allowed HIQA to:

- gather further information on the governance arrangements in place in each region,
- determine if the risks in the region were adequately addressed and managed,
- determine how they ensured consistency with national policies and drove improvements within their regions, in light of the challenges in relation to staffing resources reported in several areas,
- determine whether there was effective use of staffing and other resources to achieve this,
- and validate the level of progress made in the region to achieve compliance.

Following the follow-up inspections and interviews with service directors, regional reports were issued to each service director for feedback and factual accuracy check as part of due process.

[2] A desktop review is the process of analysing and risk assessing all of the available information about the service area including the service area's self-assessment, Tusla's published metrics, any other solicited or unsolicited information available to the inspector and a follow-up telephone interview with the area manager.

3. Profile of the foster care service

3.1 The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency, or 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 (Tusla) with effect from 1 January 2014.

Tusla has responsibility for a range of services, including:

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

Child and family services are organised into 17 service areas and are managed locally by area managers.

The areas are grouped into four regions as follows:

- The Dublin Mid Leinster region comprises 4 service areas: Dublin South Central; Dublin South West, Kildare West Wicklow; Dublin South East Wicklow; and the Midlands
- The South region comprises 4 service areas: Cork; Kerry; Waterford/Wexford; and Carlow, Kilkenny, South Tipperary
- The West region comprises 5 service areas: Mayo; Galway and Roscommon; Donegal; Sligo, Leitrim, West Cavan; and the Mid-West
- The Dublin North East region comprises four service areas: North Dublin; Dublin North City; Louth Meath; and Cavan, Monaghan.

Each of the four regions are managed by service directors. The service directors report to the Chief Operations Officer, who is a member of Tusla's national management team.

Foster care services provided by Tusla are inspected by HIQA in each of the 17 service areas. Tusla also places children in privately run foster care agencies and has specific responsibility for the quality of care they receive. At the end of October 2018, Tusla's quarterly metrics reported that a total of 5,587 children were living in either general or relative foster care provided by Tusla. Most of the children, 72% or 4,012, were in general foster care and 28% (1,585) of children were placed with relatives. A further 406 children were placed with foster carers provided by private foster care providers. The number of children in care at the end of the reporting period with an allocated social worker was 5,069 (91%). The number of relative foster carers who were not approved at the end of the reporting period was 221, of which 79% (175) had a child placed with them for more than 12 weeks.[3]

4. Summary of thematic inspection findings 2017 to 2018

4.1 Introduction

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

This chapter provides a summary of the findings of the thematic programme of inspection which focused on the extent to which the service areas' processes for the recruitment, assessment, approval, supervision and review of foster carers, and the arrangements in place for safeguarding and child protection of children in foster care placements, met the relevant *National Standards for Foster Care*, 2003.[4]

4.2 Summary of thematic inspection findings 2017 to 2018 per standard

Inspection findings are presented under the following standards:

- 4.2.1 Standard 10: Safeguarding and child protection
- 4.2.2 Standard 14a: Assessment and approval of non-relative foster carers
- 4.2.3 Standard 14b: Assessment and approval of relative foster carers
- 4.2.4 Standard 15: Support and Supervision
- 4.2.5 Standard 16: Training
- 4.2.6 Standard 17: Reviews of foster carers
- 4.2.7 Standard 23: The Foster Care Committee

[3] Data taken from Quarterly Service Performance and Activity Report Quarter 3 2018 and Monthly Performance and Activity Data 2018 October (YTD) published by Tusla.
[4] Judgments were made against four descriptors: Compliant; Substantially compliant; Non-compliant – major; Non-compliant – moderate.

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

4.2.1 Standard 10: Safeguarding and child protection

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

Components of safeguarding and child protection are outlined throughout the *National Standards for Foster Care*. These safeguarding measures include, amongst others, placing children with foster carers who have undergone a rigorous process of assessment and approval; with carers who are provided with regular supervision and support; with carers who, through support and training, are helped to understand and equipped to practice safe care; and where all expressions of concern or allegations of abuse by children are taken seriously and acted upon in line with Children First: National Guidance for the Protection and Welfare of Children (2017).

Inspections in 2017 and 2018 found a number of examples of good safeguarding practice that supported foster carers to protect children from harm and abuse. In areas where good safeguarding practice was evident, allegations and concerns were managed in a timely way in line with Children First (2011); immediate action was taken where necessary to protect children; regular strategy meetings were held to support good communication between link workers, child in care social workers and their respective team leaders. Children were interviewed on their own. While the majority of allegations were notified to foster care committees, these did not always occur within the five-day time frame required by Tusla's national policy. Serious and adverse incidents were promptly notified and well-managed and, similarly, complaints were well-managed and informed by managerial oversight. Foster carers were provided with a schedule of training dates and options for e-learning programmes were provided to foster carers to facilitate full participation.

However, 12 out of 17 service areas were found to be in major non-compliance with the safeguarding and child protection standard. While a number of these service areas had elements of good safeguarding practice, the findings of major non-compliance related to circumstances that presented a risk to children. Such risk included when an insufficient number of safeguarding visits were carried out by social workers to unallocated foster carers, including poor management oversight of the frequency of these visits, some of which were outstanding for many months. Not all allegations were dealt with in line with Children First — this included delays in completing initial assessments or convening strategy meetings; and insufficient safety planning in place, while allegations were being investigated.

Not all young adults over 16 years of age had received Garda Síochána (police) vetting.[5] A number of foster carers did not have their Garda vetting updated in more than three years, as per Tusla's policy. While all new general foster carers were required to attend foundational training prior to their approval to foster, which included safe care practices; a significant number of well-established general and relative carers who had been fostering for many years, had not received updated training.

4.2.3 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[6] prior to any child or young person being placed with them.

4.2.4 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.[6]

A consistent finding of compliance or substantial compliance, across all 17 service areas inspected, was that assessments of general foster carers were comprehensive, detailed and of good quality, providing comprehensive analysis of the applicants' capacity to provide foster care for children and young people. Good oversight by social work team leaders was also evident. The process in place for ensuring that Garda vetting was carried out on all new foster carers and significant adults was robust. All general foster carers had participated in foundational training before approval. Findings of substantial compliance generally reflected the fact that foster carers were not consistently invited to attend the foster care committee meetings when their assessments were being considered, and that assessments were good, but were not always carried out within the 16-week time frame required by the National Standards. This delay was generally attributed to a lack of staffing resources to complete assessments within the 16-week time frame.

[5] As per page 34 of Tusla's Foster Care Committees – Policy, Procedures and Best Practice Guidance 2017 and page 89 Tusla Alternative Care Practice Handbook.
[6] 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).

However, findings in relation to the assessment and approval of relative foster carers significantly differed from those of general foster carers. The majority of assessments of relative carers that had been completed and presented to the foster care committees were of good quality. However, reflecting previous inspection findings of 2016, improvements were required in relation to the timely commencement and completion of assessments of relative carers.

Inspections found that seven of the 17 service areas were in major non-compliance with Standard 14b. Non-compliance generally related to the slow progress being made in completing the assessment and approval of relative foster carers, and that governance arrangements and additional measures, which had been put in place (such as commissioning a private foster care agency to undertake assessments) to address outstanding relative assessments, had not been as effective as necessary. As a result, some children were living in unapproved relative foster care placements longer than was necessary and should the application be unsuccessful, removing the child from the placement after months or years, presented an untenable situation for all, but most especially, the child in question.

4.2.5 Standard 15: Support and Supervision

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.

Seven of the 17 service areas did not provide an acceptable level of support and supervision to foster carers and were found to be in major non-compliance with the standard. This judgment related to the fact that, while some foster carers in these areas did receive good support and supervision, others were not allocated social workers and, therefore, received poorer quality support and supervision.

Inspectors found that only four service areas had ensured all foster carers had an allocated social worker, and there was generally, but not always, a correlation between the allocation of a social worker and the provision of good support and supervision to foster carers. In the remaining 13 areas, where shortages of social work staff was cited as the reason foster carers were unallocated, the supervision and support provided to foster carers was of mixed quality. Foster carers who were allocated a social worker in these areas usually received regular home visits and telephone calls, good support and some formal supervision where their needs and any issues of concern could be explored. When foster carers did not have an allocated social worker, they generally received a minimum number of home visits and less support and supervision than they required.

In 11 of the 17 service areas, a good range of support services was available for children with complex needs in foster care placements. Respite services were also generally available in these areas. In at least three areas, the availability of respite services was limited or there were delays in the provision of other support services in the community.

Twelve areas provided support groups for foster carers (although three of these areas provided them only in one part of their service area). Regular support groups provided opportunities for foster carers to meet other foster carers and staff, share experiences, receive and give support, and, sometimes, take part in training sessions. One area had also established an innovative group for the foster carers' own children. However, five of the 17 areas did not provide support groups for their foster carers and foster carers who wanted or needed to avail of such support had to rely on a national organisation for foster carers who may or may not have groups in their area.

As crises in families or foster care households often occur in the evenings or at weekends, foster carers sometimes need additional support at these times. However, there was no national out-of-hours service for foster carers and, in 15 of the 17 areas, this meant that there was no support available outside of office hours to foster carers, who may have no other recourse except to phone An Garda Síochána. Two of the 17 areas provided some out-of-hours cover, with one area providing a service during holidays and another service providing an out-of-hours service to a limited number of foster carers who were participating in a structured training and learning programme in the area.

4.2.6 Standard 16: Training

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

All of the 17 service areas had a structured programme of foundational training for prospective foster carers, and 16 of the 17 areas had a structured programme or plan of training events that provided foster carers with opportunities to attend training at various times throughout the year.

Every area had staff who were committed to organising training events and developing training opportunities. In particular, there were two good examples of service areas in which foster carers were provided with the opportunity to participate in accredited courses. These provided foster carers with opportunities to experience well-researched teaching, a learning environment with other foster carers, and the option of an academic qualification as well. Eleven of the 17 service areas carried

out a training needs analysis or engaged in some form of consultation with foster carers about their training needs. This resulted in a considered response to the needs of the foster carers and the provision of training opportunities that foster carers themselves identified as necessary.

In all of the service areas, there were a number of foster carers who were very committed to their own development and to attending training. Efforts to ensure that there was a good quality programme of training, and that all foster carers attended regular training, varied across the service areas. It was clear that 11 of the 17 service areas had training strategies in place.

Ten out of the 17 service areas were either compliant or substantially compliant with the training standard. In the remaining seven service areas, there was little or no management oversight of training, or analysis of overall attendance records. The quality of individual training records in foster carer files was poor in seven areas. Foster care reviews represented an opportunity for service areas to review the training histories and training needs of foster carers, but there were nine service areas where at least 50% of the foster carers had not had a review in more than three years.

4.2.7 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.

Inspections found that 14 of the 17 service areas had a backlog of foster carer reviews and were in major non-compliance with the standard. In four of the 17 areas, at least eight out of every 10 foster care households had not had a review in over three years. Since reviews of foster carers provide the fostering service with the opportunity to consider the foster carer's performance, and assure themselves that foster carers have the capacity to continue to provide adequate and safe care, the absence of a robust system of reviews was of concern. Reviews also provide an opportunity to update Garda vetting, health and safety assessments and medicals, as well as considering other issues such as supports, training needs and changes in circumstances within the family. Where there were significant backlogs in the review of foster carers, inspectors escalated this issue to Principal Social Workers and Area Managers, and sought written plans and assurances that the backlogs would be addressed in a timely way.

Where there have been serious concerns or an allegation against foster carers, it is good practice and is in accordance with the standards that an additional foster carer review is carried out. However, such reviews were not carried out in four areas and,

in an additional seven of the areas, they were not routinely carried out but had been completed following some concerns or allegations.

There was a lack of consistency regarding the elements of the foster carer reviews that were carried out. For example, only in eight of the 17 service areas was it clear that the children in the foster carers' homes were consulted and had their views expressed in the reviews. In six of the 17 areas, it was clear that updated Garda vetting and medical assessments, and health and safety checks on the foster carers' homes were an essential element in foster carer reviews; however, in one of these six areas, the reports of reviews were not approved by the foster carer committee. In 10 of the 17 areas, reviews considered the training needs of carers and had made recommendations in relation to future training needs. However, in four areas, consideration of foster carers' training needs was either of a poor quality and or not consistently a part of all reviews.

In eight, or almost half, of the areas, the quality of review reports was found to be consistently good. In the remaining nine areas, the quality of review reports varied and included some reports that were comprehensive, others that were incomplete, and some that were poor.

4.2.8 Standard 23: The Foster Care Committee

Health boards[7] 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.

Twelve of the 17 Tusla service areas have one foster care committee (FCC), four areas have two FCCs and one service area has three FCCs. Each FCC makes key decisions around recommending the approval or removal of foster carers from the panel of foster carers in the area.

While FCCs made clear decisions and were generally effective in their work, only five of the 17 service areas were either fully or substantially compliant with the relevant national standard. Ten service areas were moderately non-compliant and two service areas were found to be in major non-compliance. Inspectors found that, in 14 of the 17 service areas, FCCs were not fully implementing the national policies, procedures and guidance. Inspectors found that nine of the 17 services areas had no formal training arrangements to ensure FCC members were fully trained in all aspects of their functions. In addition, inspectors found that Garda vetting or updated Garda vetting was not in place for all FCC members in eight service areas.

[7] 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).

FCCs have a responsibility to track and oversee all allegations against foster carers as part of their role in safeguarding children in foster care and ensuring that foster carers are suitable for their roles. It was of concern to HIQA that, in 12 of the 17 service areas, FCCs did not have a robust system in place for tracking and overseeing these allegations. This meant that the FCCs were not in a position to hold the foster care service to account if this was required.

FCCs are also required to produce an annual report on the activities of the FCC but inspectors found that no annual report was produced in five of the 17 service areas.

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

Health boards[8] 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.

Three of the 17 service areas were found to be compliant with this standard. However, in 14 of the 17 service areas, there was an insufficient number of foster carers to meet the needs of children in care.

In 11 service areas, more foster carers had left the foster care panel in the previous 12 months than had been approved as new foster carers in that time. At least four of the 17 service areas did not have a formal recruitment strategy, and at least six of the 17 areas did not have sufficient capacity to progress the timely and regular recruitment and assessment of new foster carers.

Staff in 13 service areas told inspectors that there was a shortage of suitable placements for children in their area. During the inspection process, three service areas in the one region had between 50 to 100 children in care placed with private foster carers. Placements for teenagers were identified as a key requirement in eight of the 17 areas, and three areas identified a shortage of placements for children with complex needs. In nine or over half, of the 17 areas, no regular formal review of the foster care panel was occurring to ensure that there was an appropriate number and range of foster carers with the capacity and the skills to provide suitable placements.

There was no formal retention strategy for foster carers in place in 11 service areas. In addition, Tusla did not actively evaluate the reasons why foster carers were leaving; for example exit interviews with foster carers leaving the service were not routinely carried out in three of the 17 service areas. In six other service areas, exit interviews were either not consistently carried out or the content of these interviews was not formally analysed.

[8] 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).

5. Regional follow-up inspections

5.1 Introduction

Between February 2018 and July 2018, HIQA conducted follow-up inspections in the nine service areas, across the four Tusla regions, where the highest risks were found during the 2017 thematic foster care inspections. These were:

- West region:
  - Sligo/Leitrim/West Cavan
  - the Midwest
- Dublin Mid-Leinster region:
  - Dublin South Central
  - Dublin South East/Wicklow
- Dublin North East region:
  - Dublin North
  - Dublin North City
  - Cavan/Monaghan
- South region:
  - Carlow/Kilkenny/South Tipperary
  - Cork.

Desktop reviews were conducted in the remaining five areas: Kerry, (South region), Galway/Roscommon and Mayo, (West region), Midlands, (Dublin Mid-Leinster region) and Louth/Meath, (Dublin North East region). As such, 14 service areas were reviewed in the regional follow-up inspections.

The remaining three service areas, Donegal, Waterford /Wexford and Dublin South West/Kildare/West Wicklow, were not included in this series of follow-up inspections as thematic inspections of these service areas were carried out in early 2018, and therefore any actions to address non-compliances were at the early stages of implementation.

The purpose of the follow-up inspections was to:

- identify improvements within regions,
- determine whether regions had taken timely action to address significant risks,
- examine the extent to which learning from each area inspection had been transferred and shared across the region, and indeed nationally,
- and drive consistency and quality improvement in the provision of foster care services nationally.

The follow-up inspections found that progress to address non-compliances varied considerably within each region. While some areas had made good progress in progressing their action plans and achieving compliance with the standards, other areas had made little or no progress, resulting in risks remaining.

Where specific risks were identified during the follow-up inspections, these were escalated in line with the Regulation Directorate's escalation policy to Tusla.

The progress made by each of the 14 areas within the four regions is reported in the four regional reports published alongside this overview report.[9]

5.2 Key findings on progress

> *"Good care is safe care. A good foster care service, that is, one that complies with the requirements of the Child Care Regulations 1995 and these Standards, is likely to have to deal with fewer child protection concerns and fewer allegations of abuse."* [10]

The thematic and follow-up inspections inspected and assessed compliance against nationally mandated standards which, if being met, would provide assurances to the Executive and Board of Tusla, the Department of Children and Youth Affairs and the general public as to the regional arrangements in place to ensure the quality and safety of foster care services.

Supervision and support of foster carers is one key element of ensuring robust safeguarding arrangements are in place for children in foster care. The allocation of a link social worker to foster carers therefore is key to safeguarding children in care.

Other critical aspects include:

- comprehensive assessments of foster carers, and in particular timely assessments of relative foster carers
- appropriate arrangements for the placement of children with relatives in an emergency situation
- the provision of appropriate training to foster carers so that they are knowledgeable about how to recognise and respond to the possibility of abuse or neglect, and that they are clear on their roles as mandated persons[11]

[9] South region report, West region report, Dublin Mid Leinster region report, Dublin North East region report.
[10] Page 54 *National Standards For Foster Care*, 2003.
[11] Schedule 2 of the Children First Act 2015 specifies that foster carers registered with Tusla are mandated persons. Mandated persons have two main legal obligations under the Children First Act 2015: to report harm of children, above a defined threshold, to Tusla and to assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.

- the ongoing review of foster carers' capacity to provide safe quality care to children
- responding to allegations made by children to ensure they are managed in line with relevant legislation, national guidance and policies, and that appropriate and timely action is taken to protect them when deemed necessary
- having systems in place such as a robust Garda vetting processes, to ensure that all adults and persons over 16 years of age who have significant contact with children in care have received Garda vetting.

While good supervision and support was provided to foster carers in some of the 14 areas, the judgment of moderate or major non-compliance, at the time of the 2017 thematic inspections, reflected the number of foster carers who were not allocated a link social worker. This subsequently had a negative impact on the quality of safeguarding of children placed with these foster carers and the service's ability to effectively support foster carers.

5.2.1 Allocation of link social workers to foster carers – key findings of follow-up inspections

The follow-up inspections showed definite evidence of improvement in many service areas. Many areas had managed to ensure that all of their foster carers were now allocated a link social worker. While there remained a small number of unallocated foster carers in six of the 14 service areas at the time of the follow-up inspections, these areas had put in place other safeguarding arrangements for foster carers, such as ensuring statutory visits were being conducted, setting up a duty system to ensure they continued to receive a service if required, or allocating a social care worker to provide support while the carers were unallocated. One service area (Dublin North City) had amalgamated their processes with the child in care teams and had put in place a system to record visits to foster carers by the child's social worker, thus ensuring there was a coordinated approach to the provision of a service to the child and foster carers.

However, significant challenges in relation to social work staffing resources meant that there continued to be high numbers of unallocated carers in the Dublin Mid Leinster region (Dublin South Central service area) and the South region (Cork and Carlow, Kilkenny, South Tipperary service areas).

At the time of the follow-up inspection there were six staff vacancies in the Dublin South Central service area's fostering service. This meant that there were now significantly more foster carers that were unallocated a social worker, and the number of unallocated foster carers had risen from 56 foster care households in

2017, to 76 at the time of the follow up inspection in 2018. Some of the foster carers who were not allocated a social worker had allegations made against them, which raised a concern about the governance of the area, and the poor oversight and management of these.

5.2.2 Pre-placement procedures – key findings of follow-up inspections

Emergency checks of relatives prior to, or as soon as possible after, a child is placed with a relative is a key safeguarding requirement when placing children with relatives. The 2017 inspections found that there was a good system in place in the Louth/Meath area, which ensured all relevant checks were completed in a timely manner; that there was good communication between the fostering social workers and child protection or child in care social workers; and good joint oversight by the principal social workers from both teams in the placement of the child in an emergency. However, other areas did not follow the same process, and there were delays and gaps in many cases found during the 2017 inspections.

The 2018 follow-up inspections found that each area had made concerted efforts to ensure that this process was now more robust. However, inspectors found that service areas independently developed area-specific systems and protocols, with some systems and protocols approved and in operation, while others were still in draft format. Similar to the 2017 findings, inspectors again found that Tusla was failing to share good practice. As a consequence, Tusla was operating inconsistently across the 17 foster care service areas and within regions. For example, the Louth/Meath area had an effective process and robust systems in place for the placement of children with relatives in an emergency, but this was not replicated in other service areas within the Dublin North East region.

Similarly, some areas had set up working groups to examine their pre-placement procedures; however, such procedures had already been developed, approved and implemented in other areas. This reflected both a lack of shared learning and an inefficient use of resources between areas within regions, and between regions. One area's pre-placement protocol contained significantly more requirements than was set out in regulations, and this had led to further delays in emergency placements being approved, again showing a lack of consistency between areas.

5.2.3 Assessments of relative carers – key findings of follow-up inspections

The suitability of relatives as foster carers should be assessed as early as possible once the placement is made, to assess the suitability and safety of the placement, and if the placement is deemed unsuitable for any reason, then an alternative placement can be sourced as soon as possible.

Several areas had made progress in clearing their backlog of relative assessments. While there was now better oversight in all four regions, the lack of adequate staffing in several areas meant that they could not progress their backlog of relative assessments in a timely manner. This raised a risk, as these relatives already had children placed with them, and therefore required more urgent assessments.

5.2.4 Management of allegations and serious concerns – key findings of follow-up inspections

Twelve of the 14 service areas were found to have improved the oversight and management of allegations and serious concerns and adherence to the Tusla Interim Protocol for management of serious concerns and allegations during the follow-up inspections, reflecting a commitment across Tusla service areas to improving the management of serious concerns and allegations.

Two service areas, Carlow/Kilkenny/South Tipperary and Dublin South Central, however, had not made adequate progress and the management of serious concerns and allegations against foster carers remained significantly poor. As a result, allegations against foster carers had not been adequately addressed in a timely manner, and adequate safety measures, such as safety planning and supervision of foster carers by a link social worker, remained significant issues.

Inspectors escalated four individual cases in one of these two service areas. In the other service area, there remained significant delays in the assessment of allegations and serious concerns against foster carers, which were not being prioritised for assessment. This was also escalated to the service director for the area who provided assurance that all allegations against foster carers would be prioritised.

Overall, it is acknowledged that the remaining 12 of the 14 areas now have adequate oversight and monitoring systems in place, prioritise assessments of allegations against foster carers, follow clear protocols for the investigation of allegations and serious concerns, and have improved their systems to track the progress of investigations. This has all contributed towards making the services safer.

5.2.5. Foster care committees – key findings of follow-up inspections

Significant improvements were noted in the 2018 follow-up inspections in relation to the role of Foster Care Committees (FCC) in monitoring and overseeing the progress of investigations of allegations and serious concerns. All FCCs now had systems in place to ensure they tracked and followed up on notifications of allegations and serious concerns, and outcome reports. While the systems in some areas were effective and working well, the systems in other areas were at the early stages of

implementation. Therefore it was too early to tell how effective they would be or if they required further development.

By the time of the 2018 follow-up inspections, all 14 service areas had put in place systems to monitor the progress of investigations of allegations and serious concerns, and were continuing to develop their systems.

5.2.6 Review of foster carers - key findings of follow-up inspections

Foster carers require reviews of their ongoing capacity to provide good quality safe care in order to ensure children continue to be safeguarded. The review process also allows other safeguarding practices to be completed, such as updating Garda vetting and completing health and safety assessments, therefore acting as an important aspect of safeguarding children in care.

The 2017 thematic inspections found non-compliance with this standard in all but two of the 14 service areas; the Midlands and Mayo. In the other 12 areas there had been a significant backlog in relation to the completion of foster carer reviews. The 2018 follow-up inspections found that, while some areas had made really good progress in completing their reviews, others had made very little progress, and there remained significant backlogs in some areas. Kerry had completely cleared their backlog, and Louth/Meath and Dublin North were on target to complete theirs within their planned time frames. Others had made good progress, such as Dublin South East/Wicklow, but not at the pace originally indicated in their action plan and this area still had a significant amount of work to do. While some areas such as the Midwest had made significant progress, and completed 118 reviews, there remained a further 118 reviews still outstanding. Cavan/Monaghan and Dublin North City had commenced a programme of tendering for a private provider to complete their reviews in an effort to address the deficit.

Three areas had made very poor progress, particularly due to social work staffing deficits; Dublin South Central, Cork and Carlow/Kilkenny/South Tipperary. The original action plans submitted by these three areas following the 2017 inspections had not been effective. By the time of the follow-up inspections there were still 234 outstanding reviews in regard to two of the areas inspected in the Dublin Mid-Leinster region, 371 in the Dublin North East region, 212 in regard to three areas in the West region, and 259 regarding two areas in the South region.

The oversight of reviews had improved in all areas. This meant that all 14 areas were now able to clearly identify the reviews that were due and when reviews were due to be completed. Managers were now able to maintain better oversight of the process and the challenges they faced in progressing outstanding reviews.

Many areas had set up systems to track the recommendations of reviews, and were carrying out audits to ensure that practice was consistent. The quality of reviews had also improved with many areas introducing new forms, systems and templates in order to improve consistency and drive improvement. However, once again, inspectors found that pertinent learning in relation to reviews was not being shared between service areas or within regions, and as a result many areas had formulated different tools and systems for use within their own specific service area.

5.2.7 An Garda Síochána (police) vetting and updating of Garda vetting – key findings of follow-up inspections

There was varied progress across the regions in relation to An Garda Síochána (police) vetting and updating of Garda vetting. Five areas now had effective systems in place for tracking and updating Garda vetting when required and ensuring all foster carers and household members aged 16 and over were vetted, and that their vetting was kept up-to-date. While similar improvements were noted in other service areas also, such as the development of more robust systems to track vetting, further work was required in some areas as a small number of adult household members still required vetting or updated vetting. However, these areas now had systems in place to identify these deficits, and were in the process of progressing them.

5.2.8 Training of foster carers in Children First – key findings of follow-up inspections

Training in Children First and the responsibilities of foster carers as mandated persons still required significant action. Only three areas had adequately addressed the training of foster carers in Children First. Many areas still had very high numbers of foster carers for whom training in Children First and mandated persons training had not yet been completed.

5.3 Conclusion

Throughout the thematic monitoring programme in 2017 and 2018 it became apparent that similar findings were arising in each service area, and despite these being highlighted early in 2017, the same findings were still evident in the 2018 inspections. There was little consistency across service areas, and practice varied in service areas within a region.

By taking a regional approach to the follow-up inspections, inspectors could examine the effectiveness of the overall governance of the foster care service. The lack of shared learning and development of common systems across the country, within regions and between regions was noted in the variety of different systems that had been set up nationally. While there were some individual examples of learning being

transferred from one area to another, such as the system for conducting foster care reviews in the Midlands service area being shared with other areas in the Dublin Mid-Leinster region, this was not done in a consistent or comprehensive way throughout the regions. This meant that inspectors found the same issues were coming up throughout the duration of the 2017 to 2018 thematic inspection programme, despite having already been highlighted at an earlier stage of the inspection programme in other areas within the same region.

Many areas had convened individual working groups to look at aspects of practice, such as the processes in place for placing children in an emergency. However, inspectors found that some of these working groups were operating in isolation within their respective region and or nationally. As a consequence, several staffing groups across several areas were looking independently at the same issues.

Furthermore, individual initiatives that were effective in some areas were not transferred to others, presenting a missed opportunity to implement initiatives already deemed to be successful to other areas. Cognisant of the reported staffing shortages, it is essential that Tusla review such operational practices and optimise staffing resources to prevent duplication of effort and inconsistency in practice.

At the time of the follow-up inspections, each region was establishing regional forums to address the common issues found within the fostering service throughout their entire region. This is a welcome move, and should serve to ensure more consistent practice across the country. It is also important that the regions share good practice nationally to prevent regional inconsistencies in practice. In addition, service directors were now strengthening their own auditing and oversight systems in order to strengthen the accountability and reporting mechanisms in their region.

At the time of these follow-up inspections several welcome initiatives had commenced to improve governance in the regions, including:

- the establishment of Regional Fostering Forums (this group is called a committee in the South region)
- enhanced regional arrangements to increase audit activity
- formal service improvement plans to address service area risk
- formal regional governance arrangements and operational reporting structures to ensure the quality and safety of service delivery, the timely and effective identification and management of risk, and managerial oversight and accountability.

The impact of these initiatives will potentially be influenced by the workforce challenges reported throughout the inspection process. For example, the Dublin North East region had significant challenges associated with permanently filling managerial positions, and the interim service area manager and Foster Care Committee chair were holding additional responsibilities arising from a principal social worker vacancy at the time of inspection. The Dublin Mid Leinster and the South regions continued to experience vacancies, which they reported as negatively impacting on their ability to effectively address the risks identified during the 2017 inspections.

Notwithstanding these issues, many service areas had made significant improvements to address the findings of the 2017 inspections. While inspectors saw these improvements, many were too early in their implementation to assess their sustainability. It is imperative that Tusla now puts effective national arrangements in place to assure the efficacy of these regional structures and governance arrangements. In doing so, the Tusla executive must support each regional team, and ensure that good practice is effectively shared, limited resources are used to their optimum and human resource initiatives in the context of recruitment, retention and skill-mix strategies are expedited.

Further work is undoubtedly required by Tusla to consistently raise compliance with the *National Standards for Foster Care* across and within regions, and to ensure that where risks remain, these risks are appropriately managed. The specific findings in relation to the 14 areas are presented in the four regional reports published alongside this overview report.

6. Next steps

HIQA will continue to monitor areas where there continued to be major non-compliance found in 2018, and will continue to request and risk assess action plan updates, which may result in some risk-based inspections being completed.

It is hoped that the regional approach taken to the follow-up inspections will facilitate regions to promote the transfer of learning between service areas, and indeed nationally, particularly in advance of the implementation of Phase 2 of the programme of focused inspections of foster care services.

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

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

In order to ensure that regions promote learning throughout all service areas in their region, each region will have one area inspected in the first instance, and the subsequent inspections to the other areas in the region will consider whether learning has been transferred since the first inspection in the region.

Appendix 1 — Standards and regulations for statutory foster care services

National Standards for Foster Care **(2003)**
Theme 2: Safe and Effective Services
Standard 10: Safeguarding and child protection Children and young people in foster care are protected from abuse and neglect.
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.6 *Child Care (Placement of Children with Relatives) Regulations, 1995* *Part III, Article 5 Assessment of relatives* *Part III, Article 6 Emergency Placements* *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

* 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* (2003)**
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.
National Standards for Foster Care (2003)
Theme 4: Leadership, Governance and Management
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* *Part III, Article 5 (2) Assessment of relatives*
***National Standards for Foster Care* (2003)**
Theme 5: Use of Resources
Standard 21: Recruitment and retention of an appropriate range of foster carers Health boards6 are actively involved in recruiting and retaining an appropriate range of foster carers to meet the diverse needs of the children and young

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***National Standards for Foster Care* (2003)**
people in their care.

Appendix 2 - Thematic inspections per service area

Service Area	Fieldwork dates	Report Publication date
Dublin South East / Wicklow	7 February 2017	12 June 2017
Cork	20 February 2017	20 July 2017
Louth/Meath	7 March 2017	12 June 2017
Midwest	13 March 2017	15 August 2017
Sligo/Leitrim/West Cavan	10 April 2017	27 July 2017
North Dublin	24 April 2017	27 July 2017
Galway/Roscommon	15 May 2017	8 August 2017
Kerry	16 May 2017	8 August 2017
Carlow/Kilkenny/South Tipperary	13 June 2017	4 October 2017
Mayo	27 June 2017	20 September 2017
[14]Cork	31 August 2017	21 November 2017
Midlands	26 September 2017	17 January 2018
Dublin South Central	10 October 2017	5 April 2018
Cavan/Monaghan	6 November 2017	5 April 2018
Dublin North City	27 November 2017	5 April 2018
Waterford/Wexford	29 January 2018	21 June 2018
Dublin South west/Kildare/West Wicklow	6 February 2018	23 May 2018
Donegal	16 April 2018	4 September 2018

[14] Follow up to first focused inspection.

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For further information please contact:
Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7
D07 E98Y

Phone: +353 (0) 1 814 7400
Email: info@hiqa.ie
URL: www.hiqa.ie