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

Name of service area:	Cork
Dates of inspection:	28th September- 1st October 2020
Number of fieldwork days:	4
Lead inspector:	Sue Talbot
Support inspector(s):	Lorraine O'Reilly Ruadhan Hogan Grace Lynam Olivia O'Connell Susan Geary Una Coloe – 2 days Sharron Austin – 1 day
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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 compliance 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 2019-2020 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:

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Health and Development	☐
Theme 4: Leadership, Governance and Management	☐
Theme 5: Use of Resources	☐
Theme 6: Workforce	☐

1. Inspection methodology

As part of this inspection, inspectors spoke to relevant professionals involved in the child in care service, with children in care and young people availing of the aftercare service and with foster carers. Inspectors observed practice and reviewed documentation such as care files and relevant documentation related 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 and placement plans
- safeguarding processes
- the leaving and aftercare service.

The key activities of this inspection involved:

- analysis of performance data submitted by the service area
- analysis of questionnaires completed by 285 children and young people
- telephone conversations with 12 children and three young adults availing of the aftercare service
- telephone conversations with 17 foster carers
- telephone conversations with one parent, and review of one parental questionnaire
- interviews with the area manager, the child in care manager, four principal social workers responsible for child protection and children in care, the principal social worker for aftercare and two aftercare managers
- remotely run interviews with representatives of frontline social workers and team leaders responsible for child protection and children in care representing the four social work departments in Cork

- remotely run interviews with representatives of aftercare workers, the area's complaints officer and two independent chairpersons of child in care reviews
- review of the relevant sections of 69 children's individual care records
- observation of a child in care review conducted by telephone
- observation of the aftercare drop-in service
- analysis of a range of service planning, risk management and governance documents underpinning provision for children in foster 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, and foster carers who 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 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

Cork is the largest county in Ireland. The total population of Cork was 542,868 in 2016 (census data). There were 134,015 children and young people under 18 years of age.

The Child and Family Agency in Cork is managed as four distinct social work departments, North Lee, South Lee, North Cork and West Cork. Each social work department has its own duty/intake and long term teams. The inspection focused on the work of the long term teams responsible for children in foster care. Social workers in the long term teams carry mixed caseloads of child protection and children in care work. The exception to this is South Lee, which has a dedicated children in care team.

The Cork service area is under the direction of the service director for Tusla South Region, and is managed by an area manager who is assisted by a Child Care

Manager. There are five principal social workers whose roles encompass both child protection and children in care statutory work. In addition, there is a principal social worker for aftercare services and a principal social worker for the Fostering Resource Unit, responsible for the recruitment, ongoing support and review of foster carers. The organisational chart provided by the service area (page 57 of this report) outlines the management and team structure and levels of activity in 2019 and 2020. There are a number of planned changes and restructuring of management arrangements with a proposed implementation date of early 2021.

At the time of this inspection, the Child and Family Agency in Cork had 715 children in foster care. The vast majority of children (691) were placed within the Cork service area. There were 498 children in general foster care, including 28 children placed with private fostering agencies. A total of 217 children were placed in relative foster care settings. Sixty children were identified as having a disability and 105 children were over 16 years of age.

The vast majority of children - 660, were on Full Care Orders. A total of 16 children were on Interim Care Orders, and 39 children were in voluntary care at the time of the inspection. Twenty children had been discharged home from foster care in the last 12 months.

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, HIQA found that, of the six national standards assessed:

- One standard was compliant
- Two standards were substantially compliant
- Three standards were non-compliant, all three of which were major non-compliant.

The inspection methodology was amended because of the restrictions due to the COVID-19 pandemic. Inspectors were unable to make visits to meet children and their foster carers face to face. Instead, telephone calls were conducted with a sample of children aged 12 years and older, and inspectors spoke to the foster carers of a sample of children under 12 years of age. Questionnaires were issued by the service area to all Cork children in foster care. A total of 285 questionnaires were returned.

All children in care in the Cork service area had an allocated social worker at the time of this inspection. Some social workers experienced ongoing challenges in workload management, balancing emergency-related child protection activity with other urgent work such as preparing for court hearings for children in care. Inspectors found significant drift and delay in statutory visits to some children in care. This meant they had limited contact with, or experienced lengthy delays in being seen or spoken to by their social worker. Data provided by the service area indicated that at the time of the inspection 156 children had not been contacted/visited by their social worker in line with the regulations (almost 22% of children placed in foster care).

When children were visited, there was some creative child-centred practice with evidence that children were seen or spoken to privately, and during the period of the recent Covid-19 lockdown, some innovative practice was seen. As the public health restrictions from the point of the first lockdown have eased, there had been a steady return to face-to-face statutory visiting in line with public health advice. Children's awareness of and use made of the complaints process was mixed.

Supervision arrangements did not consistently meet the standards of practice and frequency set out in Tusla's guidance. Relevant case records had not been routinely uploaded onto NCCIS – Tusla's national electronic information management system - by caseholders in a timely manner. These deficits in day-to-day operations carried organisational risks and impacted on the effectiveness of management oversight and scrutiny of practice. Service managers had recognised these deficits in organisational performance and had recently developed guidance and a checklist for statutory visiting. This was starting to have a positive impact in improving the frequency of contact and the quality of recent records.

Social workers and their managers ensured children's contact with their family and friends was safe and appropriately managed in line with public health advice, during the Covid-19 pandemic.

The quality of assessments of children's needs carried out by social workers overall was adequate; although not all had been completed within six weeks following an emergency placement. Children's assessments did not sufficiently explore the identity and care needs of children from diverse racial or cultural backgrounds nor adequately consider this within the fostering matching process. Care records of children with diagnosed disabilities or complex health needs provided a holistic focus on their needs. However, there were delays and gaps in service operating procedures to ensure children entering care benefited from full health screening with timely referral for specialist assessments/interventions. The service area had escalated these concerns to the Department of Children, Equality, Disabilities, Integration and Youth for onward discussion with the Department of Health. Assessment of the emotional impact for children following an unplanned ending of their foster care placement was an area of social work practice that required strengthening.

Social workers sought additional support from play therapists and social care leaders to undertake individual work with children. This included helping them understand why they were in care and to safely explore their wishes and feelings about changes in their family relationships and personal circumstances. Foster carers provided

positive feedback on the support they had received through a trauma-informed approach in caring for children with emotional or behavioural needs.

Individual care planning and review processes to enable the care and developmental needs of children to be actively planned for, managed and monitored were not effectively or consistently delivered across the service area. There were marked inequities in the experience of children and the capacity of social work departments to prioritise this work. One social work department had a lengthy 'overdue' waiting list for child in care reviews dating back to 2016.

The levels of management oversight and scrutiny of child in care review practice varied significantly. Records denoted significant breaches in relation to the expected frequency of reviews set out in the Child Care Regulations (1995). These included a widespread failure to comply with the required timeframes; with critical gaps in practice such as late or no review of children following an emergency placement, unplanned endings or their placement with new foster carers. When reviews did take place they provided an important check of the needs and direction of care for the child, their foster carers, wider family members and partner agencies.

Comparatively high numbers of children (reported as 66 by the service area) did not have an up to date care plan. This impacted on the timeliness of permanency planning for children, including review of the legal arrangements for children in care. Feedback from some children and foster carers indicated that care plans were not available, or were not being effectively used to continuously promote the safety and wellbeing of children in foster care. There were gaps in some children's understanding of what a care plan was, and the sufficiency of help they had been given in preparing for their care review.

Care plans reviewed by inspectors were comprehensive and provided a clear picture of children's needs; but some actions did not to provide clear direction and timescales for delivery. The service area did not use placement plans for children in foster care. Action was needed to ensure practice was in line with nationally expected standards.

Following the inspection, HIQA escalated concerns about systemic weaknesses in the child in care review processes in the area, specifically:

- the backlog of reviews with 248 overdue,
- inconsistency in review practice, and the
- sufficiency of the child in care audits and action plans recently put in place.

The service area's response did not provide adequate assurance that these concerns would be addressed with the urgency that was required. As a result, a meeting was held with the Service Director for the Region to highlight these concerns.

Feedback from children and young people via questionnaires and telephone contact indicated that many were happy and thriving in their foster care placement and had a strong attachment to and sense of identity with their foster carers and other children living in their household.

Inspectors however, identified serious and growing concerns about the capacity and sustainability of fostering arrangements in the Cork service area and the impact this was having on children. Records sampled by inspectors indicated a poor experience for some children who had been taken into care in an emergency or whose foster care placement had broken down. Inspectors found that the service area's capacity to match children to foster carers best placed to meet their individual needs was severely compromised. The significant shortfalls in foster care capacity had been flagged as a major concern on the area's risk registers since 2018 with evidence that concerns about the safety and sustainability of organisational capacity was escalating. There was not a robust strategic response yet in place to address this area of escalating risk, despite this being recognised as an issue by senior managers for a considerable period of time. Seven of the service area's 'Need to Know' escalations in relation to children in foster care over the last two years were due to there being no placement available at a time of urgent need for the child. One social work department had recorded 15 instances where there was no foster care placement when needed in 2019.

Relatively high numbers of children were placed in foster homes above the numbers recommended and approved by the Foster Care Committee in line with the Foster Care Standards (2003). Children were also being placed in different foster homes to their siblings due to lack of available capacity. There was insufficient oversight of the impact for children in these situations given the challenges in organisational capacity in achieving the required frequency of child in care reviews.

Service delivery processes for identifying children's needs and matching them to foster carers with appropriate knowledge and skills were under-developed with records providing limited details to inform decision-making about the selection process.

Following the inspection HIQA escalated the lack of capacity with Tusla senior managers given that management actions to date had not addressed these organisational risks in a timely way. HIQA was not assured that the service area had

the capacity to address this longstanding issue with the urgency required. HIQA met with the Regional Service Director following the inspection to highlight this concern and the need for a concrete plan for addressing these longstanding areas of escalating risks to children and the organisation.

The service area had appropriate guidance and systems in place for identifying and addressing serious concerns, allegations and complaints about children in foster care. Senior managers had taken action to strengthen organisational learning and governance of risks to children in foster care. Risks to the welfare of children, the viability of the placement and foster carers' capacity to keep children safe were considered. Safety plans were appropriately detailed and signed by relevant people. However, safeguarding practice in line with Children First procedures was not consistently undertaken or recorded in a timely manner at all stages of the investigation process.

The vast majority of children were aware of what they needed to do to keep safe and said their social worker had discussed this important area of personal safety with them. Some case records denoted a high standard of child-centred practice which clearly captured their concerns and what they wanted to see happen to help them keep safe.

The Aftercare national policy was implemented in full in the area; with good tracking of the outcomes of young people as they moved into adulthood. Young people reported very positively about the help received and availability of their aftercare workers. The weekly drop-in service was well used and valued by young people and provided responsive and ongoing support for young people in shared work to complete their aftercare assessments or plans as well as provide targeted support for specific issues of concern to the young person. The quality of assessment of need and after care plans coupled with the engagement of young people was good. The service area had given high priority to expanding the range of housing provision and was alert to any risks of homelessness to young people.

The service area's initial Compliance Plan submitted following the issuing of the draft report did not adequately provide assurances regarding the quality and standards of service improvement planning required to drive improvement in the areas where systemic organisational risk and deficits in organisational performance and practice had been identified. An additional follow up meeting was held with Tusla's Director of Services and Integration and the area manager to highlight concerns in relation to the capacity and governance arrangements in the area and to explore what additional support could be provided to the service area. A satisfactory compliance plan was subsequently received and this is attached to 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
Theme 2: Safe and Effective Services	
Standard 5: The child and family social worker	Non-compliant Major
Standard 6: Assessment of children and young people	Substantially Compliant
Standard 7: Care planning and review	Non-compliant Major
Standard 8: Matching carers with children and young people	Non-compliant Major
Standard 10: Safeguarding and child protection	Substantially Compliant
Standard 13: Preparation for leaving care and adult life	Compliant

What children told us and what inspectors observed

During the inspection, inspectors spoke to 12 children living in foster care in Cork. Inspectors also spoke to three young adults availing of the aftercare service. Inspectors received a total of 242 questionnaires from children aged 5-16 years of age and 43 from children aged over 16 years. In addition a questionnaire was received from one parent and another parent was spoken to by phone.
The vast majority of children and young people provided positive feedback about their relationships with foster carers and others within their home. Many had developed strong attachments to their foster families having lived with them for long periods of time. Children living with relative carers spoke highly of the care provided by grandparents or other relatives. Children's comments included:

- *"I like everything. It's a perfect family. I fit right in like a puzzle piece into a puzzle."*
- *"I get on with everyone so well. I feel like I am one of them. I feel so loved and wanted by all of them."*
- *"They are very understanding and loving. I don't really refer to them as foster, they are my family."*
- *"I really like this place, but sometimes I miss my parents but am getting used to living here. I even made some friends at school here. My foster carer is really nice and is a really good cook."*
- *"They are such nice people who listen and care about me. They treat me like one of their own. They let me have my freedom and live my life while also following a routine. We are practically like family now. They are involved in my life and I can trust them with anything."*

Children said they liked their house, garden and bedroom. They also spoke positively about their school and the subjects they liked; and said their foster carers always listened to them. Children spoke about other important things that mattered to them including family members, friends and pets. They detailed some of the activities they enjoyed doing such as playing musical instruments, walking in the country, horse riding, holidays, and having nice dinners.

Most children and young people who completed the questionnaires spoke highly of their social worker:

- *"My social worker is kind, nice and helpful." "Listens to me." "Gets how I feel."*
- *"If I have a problem, she helps me." "I feel comfortable with her."*
- *"My social worker is amazing. Best social worker I ever had."*
- *"He talks to me as an individual, he never avoids questions, and if I ask, he'll tell me honestly."*

- *"If I need anything I can ring her and she gets back to me very quickly."*
- *"He listens to what I have to say. No complaints. He has given us his work mobile number so that we can just text him when we need something."*
- *"If I am not happy with something she can help sort it out."*

In some cases, children's responses were qualified by when they had last seen them or if they had experienced a change of social worker:

- *"Social workers should make contact and visit more often- would help build better relationships where kids can talk more easily with their social workers."*
- *"My social worker didn't listen to me. She never came to see me for months when I was asking when I was so sad. "*
- *"The social worker changes a lot." "I don't really know her."*

Altogether 134 children said that their social worker visited them regularly, 99 stated they sometimes visited, and 32 said they did not regularly visit them. A total of 148 children said their social worker met with them on their own, 50 said they sometimes did, and 70 said their social worker did not meet with them on their own.

When asked about knowing about their rights as children and young people in care, some expressed awareness, while others were less certain.

- *"I think my rights are about knowing there is support if I need it, and I can speak up if I want to. It's about my choice and what I think is best."*
- *"Everything is working well now- I'm older and I know my rights."*
- *"I wouldn't really remember someone talking to me about my rights. Not sure what that means."*

Almost all children said their social workers listened to them. A total of 234 children and young people reported that their social worker listened to them, 16 said they sometimes did, and 11 said they did not listen to them. Altogether 218 children and young people said their social workers asked what they liked and did not like, 27 said they sometimes did, and 9 said they had not been asked. A total of 166 children said their social worker gave them chances to make important decisions, 24 said they sometimes did, 41 children said they had not been given chances to make important decisions.

Most children said that they had been helped to keep in touch with their family and friends, and that the level of contact they had was sufficient. A total of 195 children and young people said their social worker had helped them to keep in touch with their family and friends, 30 said they sometimes did and 33 said they

had not been helped to keep in touch. When asked if they saw enough of their family and friends, 215 children said yes, 20 said sometimes, and 29 said they did not have the level of contact they wanted.

Altogether 110 children said they had to move schools when they moved to a new foster home, 157 children said they did not need to. Schools provided important continuity for children in terms of their friendships and academic progress.

A total of 232 children said they felt their background and culture was respected, 11 said sometimes, 6 said no, and 33 were unsure.

Altogether 214 children said their social worker ensured they saw other professionals when they needed to, 12 said they sometimes did, 28 said no and 26 were unsure.

A total of 199 children and young people said they had a care plan, 2 said they sometimes did, 20 said they did not have a care plan, and 56 were unsure. Altogether 150 children and young people said they had been spoken to about their care plan, 40 said sometimes, 66 said no, and 21 were unsure. A total of 113 children said their views were heard and included in their care plan, 5 said they were sometimes included, 22 said their views had not been included, and 43 children were unsure. Feedback from children indicated a mix of experiences:

- *"I am happy with my care plan."*
- *"My care plan was so long ago I forgot what I asked for."*
- *"I don't know what a care plan is."*

Children and young people's feedback on whether their social worker had helped them to prepare for their child in care review meeting or other meetings was also mixed. Altogether 147 children and young people said their social worker helped them to prepare for their child in care review and other meetings, 15 said they sometimes did, 78 children said they had not helped them, and 35 were unsure. When asked if their social worker explained the decisions from the child in care review, 166 said yes, 8 said sometimes, 47 said no, and 40 unsure.

A total of 136 children said their social worker had told them how to make a complaint. However, 125 children said they had not been told how to do this. A total of 38 children and young people said they were happy with the way their complaint was dealt with, 39 said they were not. Comments from children and young people included:

- *"I was happy when I made my complaint and how it was dealt with".*

- *"Made a complaint, but not sure if it was dealt with."*
- *"They ignore my complaints."*

The vast majority of children were aware of what they needed to do to keep safe. A total of 240 children and young people said their social worker had told them who they could talk to if they felt unsafe, 1 said sometimes, 23 said their social worker had not spoken to them about this, and 15 were unsure. Altogether 264 children and young people said they knew how to keep themselves safe, 22 said they sometimes did, 4 no, and 2 were unsure.

Forty three young people over the age of 16 responded to the questionnaire. Twenty seven reported that they had been allocated an aftercare worker who listened to them and helped them prepare for the future. Of these, 23 said they had an aftercare plan and that they had been involved in developing it.

Young people reported that they had been given good support from their foster carers and the aftercare service to help them develop independent living skills. Thirty four young people said they were able to look after their money and manage it, four said they were able to sometimes, and one young person said they were not able to. Thirty six young people said they were able to do their own shopping, one said they sometimes did, and two said they did not do their own shopping. Thirty three young people said they were able to cook their own meals, four said they sometimes did, and three young people said they were not able to. Twenty nine young people said they were able to do their own washing and cleaning, seven said they sometimes did, and three said they did not do their own washing and cleaning.

Thirty nine young people who responded to questionnaire said they were still attending school or accessing education. One young person said they were not at school.

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

- *"I'm happy with my aftercare plan." "She (my aftercare worker) explains things about aftercare very well."*
- *"Aftercare is amazing- they helped with college and everything. They always check in and everything's ok."*
- *"'It was hard making a decision to leave my foster home, but I have received great support, both financial and emotional."*
- *"All is grand. I had a good experience in care and with social workers".*

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.

On 12 May 2020 the Children in Foster Care Emergency Measures in the Public Interest- COVID-19 (Amendment) Regulations 2020 were signed into law. The new measures stated that Regulations 17 (1), (2) and (3) of the Child Care (Placement of Children in Foster Care) Regulations, 1995 should not apply for the duration of the emergency period. The emergency period was for three months initially, and has since been extended for another three months. Regulation 17 outlines the requirements for supervision and visiting of children in care by an authorised person. The amendment has meant that the requirement for visiting the children at home is temporarily suspended. In effect the change in the regulations has meant that instead of an authorised person visiting children in care, they are to be contacted at specified intervals determined by the date they were received into care.

Summary of inspection findings under Standard 5

The service area reported that at the time of the inspection all 715 children placed in foster care had an allocated social worker. A total of 280 out of 285 children and young people who responded to the questionnaire said they had a social worker. Some young people told inspectors they valued being able to text or call their social worker.

Data provided by the service area indicated that at the time of the inspection 156 children had not been contacted/visited by their social worker in line with the regulations (almost 22% of children placed in foster care). This included four children in private fostering placements. Feedback to inspectors from children indicated that they would like their social worker to visit or contact them more often so that they could get to know them better.

Inspectors spoke to social workers and team leaders about gaps in statutory visits on children's electronic case records. They confirmed that some of the visits had not taken place. In other cases; inspectors were informed that the visits had taken place, but that they had not yet been written up, or there were delays in uploading records onto NCCIS. These deficits in day-to-day operations carried organisational risks and impacted on the effectiveness of management oversight and scrutiny of practice.

The local audit of children in care practice undertaken between March and July 2020 found significant deficits in statutory visits as required by the regulations; with a compliance rate of 51% in one social work department. Senior managers recognised the need for substantial improvement in the timeliness and quality of statutory visits. This included implementing an agreed naming convention for statutory visits, with management checks of the timeliness and complete-ness of children's records to provide greater assurance of the nature, frequency and quality of statutory visits. The action plan also included a proposal for social care leaders to undertake statutory visits; however this is not in line with regulations which specify that an authorised person should undertake the visits to the child. This was still under consideration at the time of the inspection.

New statutory visiting guidance had been recently implemented across the service. This aimed to strengthen the focus on the child's voice and their experience of foster care and ensure practice consistently met the required standards set out in the regulations. This included developing a checklist for statutory visits. Inspectors identified that tighter management oversight and challenge of statutory visiting/contacts was having a positive impact in raising the quality of practice on more recent children's records sampled.

The service area reported that it had just one social work and one aftercare post still to fill. However, in their respective risk registers, two departments indicated ongoing pressures in meeting demand and managing staff absences. A third department had experienced severe gaps in its capacity over a number of months from October 2019 to April 2020 that resulted in some children in care being unallocated. This area had put in place a case management protocol to ensure team leaders had oversight of unallocated children until such time as team capacity increased to allow children to be re-allocated.

Activity data shared by the service area over the last 18 months is set out in the table below. This shows the impact of Covid-19 on levels of contact and how it has been working to resume its core operations. Managers advised inspectors that they

were aware some social workers had not followed Tusla's guidance for recording statutory visits, using the relevant naming convention. This meant that it was not always clear whether some visits made to see children at home met the criteria for a statutory visit as set out in the Child Care Regulations (1995), or whether a home visit was made for some other reason.

	April 2019	April 2020	August 2020
Home Visits	490	276	401
Access	228	75	157
Statutory visits	41	40	90

Managers of the service told inspectors that they had been actively working to reduce the size of social work caseloads over the past year. Social work caseload sizes varied between 20-25 children per practitioner in each of the four social work departments and most social workers held casework spanning both child protection and welfare concerns as well as statutory work in relation to children in care. Some social workers told inspectors that they thought their caseloads were still too high; with ongoing challenges in workload management, balancing emergency-related child protection activity with other urgent work such as preparing for court hearings for children in care. The impact of this was evidenced on two records sampled by inspectors that led to Court Hearings being adjourned until statutory work was completed. This contributed to delays and uncertainty in permanency planning for these children.

Keeping accurate information about children in care in a service area the size and complexity of Cork required regular and detailed review. The area's business information unit worked closely with departmental managers to keep the child in care register up-to-date. Monthly reporting and review helped ensure records contained relevant legal documents and identified placement changes. Inspectors found copies of appropriate legal documentation on NCCIS - Tusla's national electronic case management system.

Inspectors reviewed 37 records for the timeliness of statutory visits over the last two years. Statutory visits were completed within the minimum required timescales set out in the Child Care Regulations (1995) on twenty of these records (54%). One record exceeded the minimum timeframes and denoted a positive, proactive approach by the social worker in supporting this child as they moved through the different developmental phases of childhood. However a significant number, 17 records (46%) did not comply with the minimum timeframes for visiting.

The gaps and delays in undertaking statutory visits varied significantly. The regulations expect that children are seen within a month of their placement and thereafter on a three monthly basis for their first two years in care. Following this, a minimum of six monthly visits should take place. For one child who had been placed in care in the last year, their first statutory visit only took place nine months after they had been placed in care, following their move to a new foster carer. Other records reviewed by inspectors included two children who had been in continuous care for over four years; where the only record of a statutory visit having been made to them was shortly before this inspection. Inspectors also identified a 15 month gap between statutory visits on a further two case records where six monthy visits would be expected. These four children lived in foster care placements that exceeded the numbers of children placed together, contrary to the standards which specify that no more than two children should be placed at any one time, and any departure from this should be approved by the Foster Care Committee.

The length of time between statutory visits recorded for other children ranged from being slightly outside the six month timeframe for children in long term care at seven months, with delays of over a year in other cases. Whilst a futher record indicated a statutory visit had been made earlier this year, it had been four years since their last one was recorded. This level of statutory visiting to children in care to ensure their safety is of significant concern. It also highlights significant deficits in the governance of the area, that this practice had not been addressed.

The quality of recording of statutory visits was good on 24 records (65%) of the 37 records sampled. Inspectors identified some creative child-centred practice with evidence that children were seen or spoken to privately. Recording of key discussions with children and their foster carers was clear. In these cases, the direct words and feelings of the child were sensitively captured to promote greater understanding of their views and of the things that were important to them.

The standard of recording of statutory visiting practice on five (14%) children's records, however, was poor. These records contained minimal detail to provide assurance of children's safety and wellbeing. It was unclear what was being done or planned to address children's specific needs or concerns. There were delays in statutory visits and relevant case discussions being uploaded onto NCCIS. In one case, records of statutory visits dating back two years had only recently been uploaded onto NCCIS. Another child's record indicated over a year's delay from the visit taking place to it being uploaded onto NCCIS.

Given that much of the workforce had been working remotely over the past seven months, the absence of, or delays in uploading essential care records in a timely

manner in turn impacted on the effectiveness of management oversight and scrutiny of practice. Inspectors brought to the attention of a senior manager one child and their siblings records where there had been a significant deficit in the social worker's case notes, including records of any statutory visits having taken place over a lengthy period of time. Senior managers provided feedback to inspectors that a statutory visit to this child had since taken place and that a child in care review was planned. They also provided assurance that all casenotes for the child and their siblings would be uploaded onto NCCIS, with further management audits of practice planned to check for continuous improvement.

During the earlier period of Covid -19 'lockdown', statutory visits were undertaken on a virtual basis. Innovative practice was seen in the work of one frontline practitioner who provided clear and helpful guidance to colleagues, foster carers and the child's family about ways to engage younger children, providing ongoing support and monitoring of their wellbeing. As the public health restrictions from the point of the first lockdown have eased, there had been a steady return to face-to-face statutory visiting in line with public health advice.

All records reviewed by inspectors contained at least one Covid-19 risk assessment that had been signed off by the relevant team leader. This provided direction about contact arrangements for children with their parents, grandparents and brothers and sisters. Examples reviewed by inspectors also included provisions for meeting siblings placed in care outside the area, and maintaining contact with family who lived outside Ireland. Due care was given to identifying and managing risks to children, their families and foster carers that had underlying health conditions. Positive practice was seen within two supervision records that denoted sensitive exploration of actions to help children and their parents prepare for contact and meeting each other again. Further review of how well the arrangements had worked, and what needed to change to make it a better experience for the child helped in building mutual trust and confidence. Three such records sampled however, required greater clarity about the methods and frequency of contact in line with the overall plan of care for the child.

Data provided by the service area indicated 41 children met with their family members in the foster carer's home. This included two children in private foster care placements. In recent months, the use of the area's designated 'access house' had been actively promoted. This provided a child-centred and comfortable supervised setting for some children to meet their family. Other supervised access continued to take place in suitable outdoor areas or community facilities.

Some children's casenotes indicated that social workers had prioritised visits to children whose foster care placements were at risk of breakdown, including foster carers whose own health was of increasing concern. In these circumstances, social workers provided additional support to take children out on a regular basis, with offers of a respite placement or consideration of assessment of extended family members with whom the child had a relationship. Some records sampled by inspectors also indicated appropriate recognition of children whose behaviours or wellbeing was of increasing concern. Additional support was provided to foster carers to help them to identify strategies for managing children's escalating behaviours. The trauma-informed model of support provided by the Fostering Resource Unit was valued by foster carers in enabling them to support young people through crises.

Inspectors sampled the records of 20 children who had complex needs; including 13 children with a diagnosed health need or disability. Review of these records indicated that children previously known to specialist health or disability services continued to have their needs supported and reviewed, albeit remotely; gradually moving to face-to-face appointments. There was evidence of delays and growing waiting lists in responding to new referrals, either for children recently placed in care, or those who were identified as having increasing needs that required further assessment or specialist intervention. This particularly related to access to child and adolescent mental health services and paediatric assessments.

Inspectors found the level and standard of recording of management oversight and supervision was variable. The frequency of supervision did not consistently meet the timescales set by Tusla within its standard operating procedures. Whilst there were records of bi-monthly or quarterly supervision on 23 care records, seven records contained only one recorded supervision in the last 12 months.

Inspectors rated the content and coverage of supervision records as adequate on 30 records (81%). Better quality records contained clear analysis of risks to children and included routine checks of delivery of statutory visiting, care plans and reviews. Features of these records indicated specific actions and timeframes in response to significant events, complaints or unplanned endings. Two case records positively addressed coaching of frontline social workers to assist them in being more effective in managing their workoad.

Seven (19%) out of the 37 records of management practice were rated as poor by inspectors. These records did not provide effective challenge or set out clear actions to address drift or delay in achieving the standards of practice set out in the

regulations. There was also an absence of discussion about longer-term planning for children; including consideration of enhanced rights or adoption.

Some records denoted a recent leadership drive to improve the quality of case management oversight of children in care. For example, there was an increased focus on the development of absence management plans to improve awareness of risks to children missing from care. However, some records reviewed by inspectors indicated the need for additional guidance for teams to promote the appropriate use and review of absence management plans in line with the age range and analysis of specific risk factors for the child. Principal social workers acknowledged further work was required to consolidate practice in this area.

Service managers had conducted audits of the quality of management supervision in July 2020. Audit findings included the need for team leaders to provide clear case direction and recording of the needs and risks to children and strengthen tracking of progress. Actions to support widespread adoption of the supervision template, use of contracts and frequency levels set out within Tusla's internal guidance were reinforced. The service area intended to undertake a further audit later this year to assess progress made. Social workers reported their team leaders were very supportive, but that they continued to be under a lot of pressure given the wide span of their responsibilities.

The area was also working to strengthen its approach to managing complaints. There were 43 complaints in 2019. Twenty three (53%) of these related to social work service provision.

Complaints were managed at two levels. Efforts were made to try and resolve matters at the first point of contact by the individuals directly reponsible for the delivery of the service. The principal social worker for the respective social work department had oversight of these.

There was also a corporate approach managed by a recently appointed part-time complaints officer linked to the area manager's office. Over the last 12 months the area received 22 complaints through the Tusla *'Tell us'* process or directly through the area manager's office. The standard operational procedure required feedback to be given to the complainant within 30 days; with further updates every 20 days (as required) until such time as the report into the investigation of the complaint was issued and any appeals completed.

Fourteen complaints (64%) had been closed within three months. However, one had remained open for over seven months. The majority of these complaints related to

access to children in care, relationships and communication with the child's social worker. Matters of concern raised through complaints about the performance of social workers were addressed through Tusla's performance management procedures. Of the complaints closed, seven had not been upheld and eight had been partly or fully upheld.

Feedback from young people to inspection questionnaires indicated some had not been given information about making a complaint, and there were mixed views in relation to satisfaction with the outcome. A few children made comments that they had not felt listened to, and that the process had taken too long to get sorted. The level of formal complaints made directly by children living in foster care was relatively low. The service area reported only 12 complaints from children in the past year. It was notable that five of these related to children placed in private foster care placements. Most concerns raised by children were about the level of contact they had with their family, including their brothers and sisters; and of social workers not getting back in touch with them in a timely manner when they wanted to speak to them.

Inspectors found variable practice, with significant gaps and delays in statutory visits made by social workers to children in care in the area. Data provided by the service area indicated over one in five children had not been contacted/visited in line with statutory regulations. Gaps and delays in recording and the backlog of paper-based records not yet scanned up onto NCCIS were areas of significant organisational risk. Children's awareness of and use made of the complaints process was mixed. Significant gaps in organisational performance had been recently recognised through internal audit; with actions in progress to raise standards and improve the quality of practice. This will take time to fully embed and required stronger management oversight and challenge to achieve full compliance. For these reasons we have judged this standard to be Non-Compliant Major.

Judgment: Non-compliant major

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.

Summary of inspection findings
The quality of assessments of children's needs carried out by social workers overall was adequate. Assessments of children's needs were found within various documents on children's care records. Child protection and court reports generally provided a full picture of children's needs, including an overview of their experiences prior to and following their placement in care. Care plans mostly provided a clear overview of the child's needs and how they would be met. Taken together, these approaches helped inform children's future plans including assessment of their best interests.

The care records of white Irish children generally reflected their culture and faith well; indicating that important church, cultural and sports activities were appropriately considered and planned for with the young person, their family and foster carers. Children's assessments however, did not sufficiently explore the identity and care needs of children from diverse racial or cultural backgrounds. A total of 91 (13%) children in Cork were identified as having a different cultural or ethnic heritage. Recognition of diversity/cultural competencies had been identified as a learning and development priority for the workforce, but training data submitted by the service area indicated that this had not yet been delivered to all staff who required this.

The care records of children with diagnosed disabilities or complex health needs (8% of all children in care) generally included key assessments made by relevant health professionals. These records provided good levels of additional information about children's development or their individual support needs.

A total of 115 children had been placed in foster care in the service area over the past 24 months, five of whom were placed in private foster care. Inspectors reviewed 22 care records to assess the quality of assessment practice including for emergency placements. Seventeen of these records (77%) evidenced the assessment was well-completed at the point of placement or within six weeks following an emergency placement. Four assessments of needs were ongoing at the time of this inspection.

Assessment records evidenced that feedback had been sought from children, their families and wider professionals/agencies to create a holistic picture of their needs and of the things that mattered most to them. For one child, their admission to care had provided an important opportunity for further assessment and support in meeting their complex needs. However, the six-week assessment timeframe for completion of a comprehensive assessment of children placed in foster care in an emergency had not been consistently met. One such record sampled by inspectors had only been completed eight months after the child had been admitted to care.

A total of 112 children (16%) experienced a placement change in the last 24 months; 17 of these were children placed in private fostering placements. On two children's records where there had been an unplanned ending; there had not been a timely follow up by the social worker to assess for changes in levels of risk to the child, including any impact on their emotional or mental wellbeing. This was an area of social work practice that required strengthening to ensure close monitoring of the impact for children who had experienced sudden or unplanned changes of their foster care or school settings.

The service area had given priority to identifying and supporting foster carers to be better equipped in recognising and responding to the emotional and behavioural needs of children. Approximately 50% of its foster carers had received additional trauma-informed training. Foster carers told inspectors this enabled them to better understand and contribute to the ongoing assessment and review of the needs of the children they cared for.

Social workers recognised the risks to and impacts for children who had previously experienced abuse and neglect. They sought additional support from play therapists and social care leaders to undertake individual work with children. This included helping them understand why they were in care and to safely explore their wishes and feelings about changes in their family relationships and personal circumstances. Care records seen by inspectors included positive examples of direct work with children to help them work through points of anxiety and crises in their young lives. The service area had recently recruited a child psychologist for children in care to help improve identification of risk and target additional support to those adversely affected by their earlier exposure to abuse and neglect.

One social work department had identified growing concerns in securing timely medical examination of children and young people entering care. This was clearly highlighted as an area of increased risk in a recent 'Need to Know'* report which

* Tusla's internal national incident management system for escalating serious concerns and flagging organisational risk

indicated significant delay in assessment for a child with complex needs who had been taken into care in an emergency. It also flagged wider organisational gaps including the lack of a proper process for ensuring full health screening and assessments of children entering care in compliance with Child Care Regulations. The department's risk register highlighted the lack of a clear and agreed emergency care pathway, with some children being seen by the out-of-hours GP service or Accident and Emergency Department in circumstances where a medical examination was deemed necessary. In other situations, foster carers were requested to take the child to be medically examined by their family GP as soon as practicable. The service area had escalated these concerns to the Department of Children, Equality, Disabilities, Integration and Youth for onward discussion with the Department of Health.

One record sampled by inspectors indicated that a child had been initially prevented from receiving a full medical at the point of their admission to care given they did not have a medical card. A foster carer also raised concerns with inspectors about the absence of and delays in securing relevant health information about the status of a child's immunisations. The lack of an effective integrated system of holistic health screening and assessments risked health inequalities (a common feature of children who have experienced neglect) not being promptly identified and addressed. The service area aimed to address this area of risk through developing a protocol with the HSE to ensure social workers have an identified process for accessing medicals for children being placed in care in a timely way.

Access to specific therapies, counselling and psychological support had been slow or difficult for some children following their placement in foster care; with delays in response to social work referrals due to gaps in the capacity of the local health or voluntary sector agencies combined with the impact of Covid-19 on wider demand for such services. Foster carers commended the additional support they had received for younger children from the Early Intervention team; but raised concerns about the availability of additional assessments and support for children with disabilities or complex health needs over six years of age.

Tusla and Health Services Executive (HSE) senior managers participated in 'Joint Protocol' meetings to discuss children in care with diagnosed disabilities or complex health needs to help strenthen joint approaches to the delivery of their care. Managers reported good relationships between frontline social work and health practitioners; but that the forum had yet to be fully established and that there remained ongoing issues in relation to jointly resourcing some packages of care. Senior managers engaged in the inter-agency group meetings checked local progress against action plans put in place following the Ombudsman for Children's

'Molly' investigation. This was helping to provide a strengthened focus on the support needs of children with disabilities or complex health needs in foster care.

Inspectors were advised of the service area's management approval process to address gaps in the assessment or support for children with specific health or disability-related needs. This included examples of bespoke commissioning of therapies from private agencies, or in some instances, by foster carers themselves. Whilst this provided additional assessment or support for some children, it did not support an equitable evidence-based approach to assessing children's needs and monitoring their outcomes.

The quality of social work assessments of children's needs overall was adequate, with some examples of good practice. However, assessments following the placement of children in care in an emergency were not consistently undertaken in a timely manner, with evidence of delays in health assessments being completed. The focus on children's ethnicity and further assessment and review of children's wellbeing following an unplanned ending of their placement was not sufficiently robust. For these reasons the area was judged to be substantially compliant.

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 review processes to enable the care and developmental needs of children to be actively planned for, managed and monitored were not effectively or consistently delivered across the service area. Some children did not have a written up-to-date care plan or a review of their needs for a lengthy period of time. There were marked inequities in the experiences of children and the capacity of local social work departments to prioritise this work. Records reviewed by inspectors denoted significant breaches in the expected standards of practice and frequency of reviews set out in the Child Care regulations. Local arrangements did not ensure children's needs, as well as their wishes, hopes and aspirations, including in relation to permanency planning were realised in a timely manner. Differing practices and levels of management oversight were evident in the approaches taken by each social work department.

One social work department had a lengthy 'overdue' waiting list for child in care reviews dating back to 2016. In October 2019, this department highlighted on its risk register 'a serious inadequacy of resources to meet regulatory requirements in relation to reviews of children in care.' The impact of not having sufficient organisational capacity to address this over a number of years was clearly identified. The department acknowledged it had 'failed to meet 50% of its care review activity in line with child care regulations in previous years, and that this had fallen to 30% compliance' mid-year 2019. The risk register also highlighted 'only 23% of the initial reviews were completed on time'.

The audit of children in care undertaken by principal social workers between June and July 2020 identified practice improvements were needed in local arrangements for child in care reviews. This included ensuring relevant documentation was uploaded onto NCCIS and the use of a specified naming convention to support efficient identification of relevant records. The action plan envisaged that the review backlog would be addressed in part by the development of an independent review service, 'subject to adequate resource allocation'.

Over the past year, the service area had undertaken a scoping exercise to quantify the levels of additional resources needed to progress the development of an independent review service. This new team was in the process of being established at the time of this inspection. Senior managers, in further discussion with inspectors, acknowledged the new team would initially provide approximately 50% of the

additional capacity needed. They reported further work was required over the next 2-3 years to reconfigure service capacity to fully address the backlog and sustain the required levels of organisational performance moving forward. The sufficiency of the proposed plan, including the estimated length of time to achieve the required standards of practice, remained of concern to HIQA inspectors.

Recent data provided by the service area indicated that 66 children in foster care did not have an up-to date-care plan (9%). This had previously been reported to Tusla's national office as affecting 71 children in June 2020. Data submitted to inspectors highlighted that there was an additional 248 children whose care plan reviews were overdue (35%). This suggests significant under-reporting by the service area of the numbers of children whose care plans were out-of-date. Foster carers also raised concerns with inspectors that care plans were out of date, and the impact this had on providing permanency for children.

Child Care Regulations require that the initial review takes place within two months of placement, and thereafter at six monthly intervals for the first two years of their time in care. Following this, it is expected that there is an annual review of children's care plans. Inspectors reviewed a total of 40 children's records for care planning and reviews. Only 14 (35%) of these had been undertaken in line with the frequency timescales set out in the regulations. Three reviews were slightly outside the required timescales. In these cases, there was evidence of a two to three month delay as the reviews were re-scheduled due to Covid-19.

Twenty three (58%) care records indicated lengthy delays between reviews, and reviews were increasingly overdue. Inspectors sampled four children's records who had been taken into care since January 2019. Three out of four records only contained the initial statutory review. Two of these children had additionally experienced unplanned endings since they were brought into care. No review had subsequently taken place to check their safety and wellbeing; how they were settling into their new placement, or what learning could be gained from the unplanned ending. One of these four children was still due to have their initial statutory review almost a year after they came into care. Inspectors brought this significant deficit in practice to the attention of senior managers following the inspection, and were advised a review was being scheduled for this child.

In two other children's case records sampled by inspectors, the implications of not having a recent review and up-to-date care plan were significant; and negatively impacted on the timeliness of decision-making by the courts in relation to the future care arrangements of children. In these examples, the child's Hearing was adjourned to allow the social worker further time to schedule the child's review and update

their care plan. Such organisational capacity challenges risked further delay and uncertainty for children, their family and foster carers.

Other examples from case records sampled by inspectors included children being reviewed every two years instead of annually. One record indicated that there had been a five year lapse prior to their last review taking place two years ago, which was now well overdue. Two other children's records indicated a four year lapse between reviews; with their reviews now overdue by nine months. These records indicated that a request for review had been made by the child's social worker, but that no date had been agreed due to local capacity challenges.

The impact of these delays and gaps in the expected standards of care planning and review practice, combined with deficits in statutory visits referred to earlier in this report, meant that some children in the Cork service area were being left without the required safeguards to provide assurance of their ongoing safety and wellbeing. Given that the area also had relatively high numbers of children placed in homes outside the approval levels and recommendations made by the Foster Care Committee, (discussed further in the next section of this report); this was of significant concern.

Overall inspectors rated the quality of the care planning and review records for 14 children as poor (35%), for 13 children as good (33%), and 13 records indicated a mixed picture of practice. The levels of management oversight and scrutiny of review practice varied significantly. The area's risk register highlighted serious concerns about organisational capacity to provide sufficient governance and assurance of social work practice given the high level of cases team leaders had oversight of.

When reviews of children's care plans did take place they provided an important check of the needs and the direction of care for the child, their foster carers, wider family members and partner agencies. The child in care review and care plan template provided clear guidance to social workers and others to promote holistic review of the needs of children to inform future care planning.

Inspectors found that care plans overall were comprehensive in 33 (83%) out of the 40 records. These provided a clear picture of children's needs; with better quality records providing important child-centred detail about their interests, needs and what family life was like for them. However, there were gaps in the required detail of care plan actions including timescales and accountabilities for meeting children's needs on six records (15%) sampled. For example, agreed timeframes for progressing enhanced rights applications or actions outlining the additional supports

a child required were not specific enough to enable effective tracking of progress. This risked leading to drift in care planning for the child.

The management of reviews and standard operating procedures were delivered differently in each social work department. In two departments, there was an established independent chairperson for reviews who together with administration staff managed the end-to-end process with social workers 'booking' their review meeting slot. One social work department required a 3-4 week notice-period. This area's process did not allow for urgent review of children's needs. Arrangements for 'booking' a review with the independent review chair in the other department were intended to address critical priorities such as children newly received in to care; unplanned placement breakdowns or length of time since the last review. However, these were not effective. Ongoing pressure on the reviewer's capacity was having an increased impact on the responsiveness of social workers in promoting long term plans for children.

In the other two departments, team leaders or social workers chaired the child's reviews. In one care record sampled, the review was chaired by the child's own social worker. The reason inspectors were given for this was one of timing prior to transferring the case to a new worker. However, such inconsistencies in practice, including levels of team leader oversight, do not provide the level of scrutiny, challenge and support that is expected within Tusla's guidance.

Children's records also denoted delays in the care plan being signed off by team managers, with a delay of over a year in one care record seen. In one department, the review chair routinely signed the care plan and review templates as both social worker and team leader.

One social work department produced separate minutes of the child's review meeting, other departments generally incorporated the discussion into the review template. In one area, however, there were instances where only the care plan was completed; with the review form directing the reader to the care plan for relevant details. This meant the record of discussions about progress and tracking of changes for children since the previous review was not sufficiently robust. Such practice did not comply with Tusla's own processes for reviews or promotion of best practice. The recent appointment of a team leader to the new independent review team aimed to strengthen co-ordination and monitoring of review practice.

Other areas for improvement identified by inspectors included the need for consistent recording of reviews and care plans on NCCIS. Inspectors found many incomplete templates within documents on the child's care record that indicated a

proposed care plan or review date; but these had not been progressed months or indeed over a year later. In other records, it was difficult to find the previous review or assess the currency of the child's care plan.

Following the inspection, HIQA escalated concerns about systemic weaknesses in the child in care review processes in the area, specifically:

- the backlog of reviews with 248 overdue
- inconsistency in review practice and
- sufficiency of the child in care audits and action plans recently put in place.

The service area's response did not provide adequate assurance that these concerns would be addressed with the urgency that was required. As a result, a meeting was held with the Service Director for the Region to highlight these concerns. He acknowledged that further action was required in order to address these deficits in a more timely and urgent way. He planned to meet with the area manager and with Tusla's Director of Services and Integration in the near future to consider further approaches to achieve a sustainable approach and address the legacy challenges in the area. The Service Director indicated that he had been restricted by his resource allocation to create the additional capacity that was required.

The service area did not use placement plans for children in foster care. Tusla's Alternative Care Handbook (2014) requires every child in care to have a placement plan in addition to their care plan (in line with child care regulations). Tusla expects the child's social worker to draw up a new placement plan when the child's placement changes, and for it to be subject to regular review. The area was not compliant with nationally expected standards of practice in this regard. Senior managers told inspectors that they thought their local approach was sufficient to capture the aims and objectives of the placement and the levels of support the child, their families and foster carers required. Inspectors considered the service area would benefit from further review of practice to provide assurance of the 'best fit' between the child's needs and the capacity of foster carers to achieve the desired placement goals for the child over time.

Inspectors identified mixed levels of attendance of fostering link workers at child in care reviews. This was recognised as an area for improvement by the service area's Alternative Care Governance Group. Their absence detracted from a holistic appraisal of how well children's needs were supported by the capacity of foster carers, including for those who had recently moved placements. Whilst most foster carers told inspectors they valued the involvement of their link worker, a few raised concerns about recent turnover or gaps in their availability.

Good attention was paid to encouraging children to participate in their reviews, with evidence that most children (over the age of six years) were supported to complete their pre-review form. A total of 29 out of the 40 records (73%) evidenced active involvement of the child whether through completing their review form and/or attendance at their review. Social workers encouraged children to be involved in their meeting whether face-to-face, or more recently, virtually. They also ensured appropriate arrangements were in place for the inclusion of the child's birth family and foster families. Feedback from children and young people to the questionnaires indicated some gaps in children's understanding of what a care plan was; the availability of support from social workers to help them prepare for their care reviews, and ensure they were consistently informed of the decisions made at their care review.

Records evidenced appropriate challenge from review chairpersons in ensuring children were supported to have their say. When children attended in person, their wishes and views were valued and clearly noted. Positive practice to engage children included the use of pictures to help younger children talk about their relationships with their different families and express their wishes and feelings.

The independent review chairpersons reported generally good engagement by schools in the child's review through attendance or submission of the child's school report. Health professionals or therapists involved in the delivery of care to children with disabilities generally attended or submitted reports of the child's needs and progress. GP involvement, including provision of reports was less regular; but they were seen to offer additional support outside the meeting, for example, in following up delays in access to specialist services.

The quality of discussion at reviews about the specific risks to and individual needs of children with disabilities or complex health needs was generally good. This helped build a shared focus on everyone working together, whilst recognising children's vulnerability and their need for ongoing support combined with promotion of their independence. Reviews helped flag early recognition of young people who required additional or specialist support as they moved into aftercare services.

Recent child in care reviews have largely taken place by teleconference. Inspectors observed a review that was conducted this way. The meeting was chaired by the independent chair in a sensitive and respectful manner. The approach was very inclusive of the foster parent; with relevant reports about the child's presentation and needs provided by health and education agencies, the child's social worker and the fostering link social worker.

The service area reported 25 unplanned endings of foster care placements over the last 12 months, five related to children in private foster care placements. The area's risk register identified concerns about the short notice period given by private providers before ending the placement. Data provided by the service area indicated 19 reviews were held following an unplanned ending; four with respect to private placements. For six children, reviews of unplanned endings had not yet taken place. In these cases, there were missed opportunities for learning and further assessment of children's needs and of the circumstances that led to the placement ending. This issue had also been highlighted as an area for improvement by senior managers in the recent child in care audit.

There was evidence of case prioritisation and strengthened activity to try and reduce the numbers of unplanned endings in recent months. Data provided by the service area indicated 33 reviews of placements at risk of ending had also been undertaken in the past year; with additional support provided to help maintain the placement. One child's record reviewed by inspectors indicated a range of child-centred social work interventions to achieve a smooth transition to a new placement.

Only two foster carers had been granted enhanced rights in the past 24 months. This was significantly less than the numbers of care placements that may be eligible, and did not take sufficient account of the wishes of some children and foster carers given the strong emotional attachments they had formed with each other. Many of these children had lived in stable, secure placements from a young age.

A total of four children had been adopted over the last 24 months. Again, feedback from young people and foster carers evidenced their wishes to progress to adoption as a permanence option, including for older children; but that the process was too slow and protracted.

A total of 39 children were listed as being in voluntary care in Cork. Tusla national office recently audited consent arrangements in Cork and found 100% compliance in ensuring an agreed end date, including timescales for further review of the child's care arrangements. The service area had a well-established process for reviewing voluntary consent. Inspectors reviewed four records for voluntary consent and found there had been appropriate review of the child's care status and involvement of birth parents.

Records reviewed by inspectors denoted significant breaches in the expected standards of practice and frequency of reviews set out in the Child Care regulations. The sizeable backlog of overdue reviews (affecting over one in three children), some dating back years; combined with high numbers of children not having an up-to-date

care plan, provided limited assurance that children's care needs were being effectively met. Over-stretched organisational capacity to provide timely review of children newly admitted to care and of unplanned endings was leading to drift and delay in making important decisions about children's future care arrangements. The inconsistencies in planning, recording and management oversight of care plan and review arrangements were contributing to inequitable experiences for children. Although the service area had recently started to plan to reduce these risks, there remained significant uncertainty about resources and capacity to deliver the level of performance improvement urgently required. For these reasons we have judged the performance of the service area as non-complaint major against this standard.

Judgment: **Non-compliant major**

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.

Summary of inspection findings under Standard 8

Feedback from children and young people via questionnaires and telephone contact indicated that many children were happy and thriving in their foster care placement and had a strong attachment to and sense of identity with their foster carers and other children living in their household. They had stable placements and felt well-cared for by loving and skilled foster carers.

Inspectors identified serious and growing concerns about the capacity and sustainability of fostering arrangements in the Cork service area and the impact this was having on children who needed to be brought into care over the last couple of years. Records sampled by inspectors indicated a poor experience for some children who had been taken into care in an emergency or whose foster care placement had broken down. The impact on children who had been moved from their previous care arrangement or who were no longer able to live with their siblings was strongly felt by a small number of children who responded to the questionnaires and by foster carers raising concerns with inspectors on behalf of children they cared for. Inspectors found that the service area's capacity to match children to foster carers best placed to meet their individual needs was severely compromised. Social workers told inspectors the service was 'in crisis'. At the time of the inspection, there was not a robust strategy or improvement plan in place to address this area of significant and escalating concern despite this having been recognised by service area managers for a considerable period of time.

Review of records and discussions with social workers indicated some worrying trends over the past couple of years. In one case, the Court Hearing had to be adjourned for a month with the child remaining at home on a Supervision Order until a placement was found. Another child had to remain in hospital for an additional week as a 'social admission' as a foster care placement was not available. Concerns were also raised about another child spending six hours in a Garda station as there was no placement for them. Seven of the service area's 'Need to Know' escalations in relation to children in foster care over the last two years were due to there being no placement available at a time of urgent need for the child. One social work department had recorded 15 instances where there was no foster care placement when needed in 2019.

In recent months, there was increased reliance on Tusla's national emergency out-of-hours service. This initiative had been put in place earlier this year to provide placements for children in recognition of the additional risks children and foster carers faced resulting from the Covid-19 pandemic. Social workers told inspectors of their growing concerns for children and that the current severe shortage of foster carers in Cork did not make matching a meaningful process. They reported having to drive around with the child in their car until such time as the out-of-hours service was available. In these circumstances, children were at risk of being placed some distance from their family and community.

Inspectors brought to the attention of senior managers specific ongoing concerns that were highlighted in a 'Need to Know' notification where children continued to remain living at home despite their having met the legal threshold for being taken into care over six months previously. The area provided an outline of the work it had undertaken to try and source suitable foster care arrangements and the significant challenges it had faced in finding an appropriate placement either internally or in private foster care. Inspectors were advised that in the interim there were regular social work visits to the family home to monitor child protection risks, with additional family support provided. However, there had been substantial delay in finding the right placement for these children; and an appropriate plan, in their best interests, had yet to be agreed. This case had been previously escalated by HIQA following a previous inspection in January 2020.

Data provided by the service area indicated that 35 children were awaiting a foster care placement. There were only six foster carers identified with existing capacity; but these were all subject to restrictions. Although there had been an additional 25 private foster care placements approved by the Foster Care Committee; again these were subject to restrictions including being able to be accessed by other service areas which impacted on placement availability. Five children were awaiting a private foster care placement, and one child was awaiting an out of area placement. There were no children awaiting transfer into the Cork service area.

Good attention was paid by social workers to enabling children to maintain contact with their families and local community. A total of 691 Cork children (97%) were placed within the Cork service area where they were able to maintain their local ties and connections. This is a significant achievement, but it is dependent on some children having been placed with foster carers in households that exceeded the numbers of children they were approved to care for. There were 40 such foster care households in the Cork service area; comprising 137 children (19% of all children in foster care); who were placed with more than two other children they were not related to. When the foster carer's own children were considered, the numbers of

children being cared for in some of these settings was large. Inspectors' review of children's records indicated that placing additional children in households where there were already two other foster children or more was an area of practice for wider discussion within matching and care review processes.

Social workers told inspectors that when foster placements were required for children; they considered the suitability of the child's wider family members in the first instance. A total of 217 children (30%) were supported in relative foster care settings in Cork. Children and young people reported positively on being able to be cared for by members of their own family network.

Records overall provided inadequate consideration of the 'best fit' of a child and their siblings' needs to the skill and experience of foster carers. Consideration of children's ethnicity, faith or racial heritage with foster carers from a similar background or with prior relevant experience was weak. Foster carers told inspectors they were not aware of any matching process that focused on the diversity of children placed with them. Given the steady increase in children coming into care from wider ethnic or cultural backgrounds, this was an area of matching practice which required strengthening.

Inspectors reviewed 17 children's records for matching. This included children who had been placed in care in an emergency. Inspectors were advised the service area did not use a matching template, but conducted matching discussions/meetings in searching for an appropriate placement. Only eight children's care records (47%) reviewed by inspectors contained any reference to the matching process. Most information related to email exchange between departments focusing on the availability of placements. The Fostering Resource Unit (and private providers) completed a template that included brief details about children's specific needs; but this did not provide an effective system for scoring or matching the experience and competencies of foster carers to the priorities for specific children or sibling groups.

Better practice was seen in one case record where following a placement breakdown, a professionals meeting was held to agree the foster carer competencies required. In this case, the child was able to visit prospective foster carers prior to moving to live there in line with best practice. Other records indicated that whilst there had not been a formal matching discussion or record made; the child had been placed with a foster carer with the relevant knowledge and skills to meet their specific needs. There was also some evidence that priority was given to promoting continuity for children. In one case the child was subsequently placed with a foster carer who was caring for their sibling; and another child was returned back to the

care of their previous foster carer when their reunification plan had not been successful.

The service area advised that it had just 15 children who were waiting approval of long term placements; and that there had been 30 approvals in the last 12 months. Discussions with social workers highlighted gaps in their awareness of the long-term matching process and options for permanency planning. Care records indicated gaps and inconsistencies in the levels of consideration given to long term planning for children who had been in care for some time and subject to Full Care Orders. In a recent review of foster carers by the Foster Care Committee, two children were noted as having been in the same placement for the past seven years. However, their long term-placement status had not been confirmed. It was therefore unclear to inspectors whether the data provided by the service area in respect of long term matching was accurate. Good practice indicates that decisions for permanency should be considered within six months of the child's placement in care and be regularly reviewed.

The area did not have a formal 'special foster care' category of provision. In certain circumstances, enhanced payments were made to foster carers supporting children with high or complex needs with approval by principal social workers. Foster carers told inspectors they felt there was a need for greater transparency in management decision-making linked to children's assessed and changing needs and levels of support provided.

Inspectors found that the service area's senior managers were acutely aware of the organisational challenges and barriers frontline teams faced in matching children to foster carers who had sufficient capacity and were suitably skilled to meet their individual needs or as part of a wider sibling group. The service area reported a number of actions in progress but evidence of organisational impact in delivering service improvement was limited. The significant shortfalls in foster care capacity had been flagged as a major concern on the area's risk registers since 2018. Placements were then, and have continued to be, allocated to children based on availability rather than suitability; with teenagers recorded as being dis-proportionately affected. The critical shortage of foster carers in the area was noted again in the 2019 risk register. A further update to the risk register in February 2020 highlighted the enormous pressure this was placing on frontline social workers to find a placement, sometimes out of hours. Specific gaps in provision included placements for young people with mental health needs or diagnosed disabilities.

The service area prepared a report for the national Tusla office in April 2020 which further outlined these serious and ongoing concerns. It highlighted that the

Fostering Resource Unit was often unable to identify a placement; with limited capacity within the private sector. The risks to and impact for children was clearly outlined in a range of ways including:

- delays in the timeliness of applications for Care Orders when a placement could not be identified resulting in children having to remain in what had been previously assessed as an unsafe or harmful home environment
- children remaining in residential care when their care needs and best interests would be better met in a foster care setting
- inadequate matching based on placement availability resulting in poorer outcomes for children, including heightened risk of placement breakdown, with children experiencing multiple emergency care placements
- children returned home on a Care Order as no other suitable placement could be found following a placement breakdown.
- increased risk of children being placed out of area.

Following the inspection HIQA escalated these matters further with Tusla senior managers given that management actions to date had not addressed these organisational risks in a timely way. HIQA was not assured that the service area had the capacity to address this longstanding issue with the urgency required. HIQA met with the Service Director following the inspection to highlight this concern and the need for a concrete plan for addressing these areas of escalating risks to children and the organisation. The Service Director considered that this was a wider challenge and that it needed further discussion nationally in seeking alternative approaches to address these known gaps in foster care provision.

Inspectors identified serious and growing concerns about the capacity and sustainability of fostering arrangements in the Cork service area and the impact this was having for children. This included children remaining at risk at home given that no other option could be found, or experiencing a number of placement moves given the lack of available or suitably experienced foster carers. Particular pressures were identified in securing suitable foster carers in a timely manner in response to an emergency care placement and following a placement breakdown. Social work practice in matching children with appropriately skilled and experienced foster carers, including long-term matching was under-developed. Whilst these organisational risks were clearly recognised through risk registers since 2018, and the impact for children was clearly flagged within 'Need to Know' reports; strategies to effect change and improvement were largely ineffective in preventing delays and tackling poor experiences for children at a significant point of crisis in their lives. For these reasons we have rated the area's performance as Non-Compliant Major against this standard.

Judgment: **Non-Compliant Major**

Standard 10: Safeguarding and child protection
Children and young people in foster care are protected from abuse and neglect.

Summary of inspection findings under Standard 10
The service area had appropriate guidance and systems in place for identifying and addressing serious concerns, allegations and complaints made by children in foster care. Service managers were working to continuously promote stronger safeguarding practice and embed organisational learning from significant events. The vast majority of children and young people who responded to the inspection questionnaire were aware of what they needed to do to keep themselves safe. They said that their social worker had discussed this important aspect of personal safety with them.

Data provided by the service area indicated that there were 13 allegations against foster carers over the last 12 months. Eight of these remained open at the time of the inspection. In addition, 18 serious concerns had been made against foster carers. Seven of these were open at the time of the inspection. Eleven allegations or concerns had been upheld. Four children had been removed from their foster care placements.

Social workers told inspectors they were familiar with Tusla's Interim Protocol for managing allegations of abuse and neglect against foster carers. They highlighted examples of joint work with fostering link social workers under the direction of a team leader. They recognised their accountabilities as the child's social worker to assess for child protection risks through use of intake records and initial assessments in line with *Children First* and standard business processes.

Inspectors sampled seven records where there were allegations against foster carers, and also reviewed an additional two records relating to allegations against others. All were classified appropriately; with records indicating whether the threshold for significant harm had been met. These records reflected safeguarding practice at different stages of the investigation process. All records indicated appropriate action had been taken to ensure the children were safe. A high standard of child-centred practice was seen on three records which clearly captured children's concerns and what they wanted to see happen to help them feel safe. This included a personalised letter to a child telling them of the outcome of the allegation, how risks to them were being managed, and that the social worker was happy for the child to remain living with their foster carer.

Casework reflected the complexity of risk in circumstances for example where household relationships had become severely strained. Risks to the welfare of

children, the viability of the placement and foster carers' capacity to keep children safe were considered. Additional supports and specialist advice was sought as required. Wider family support was encouraged to assist in working through concerns including making effective use of family network meetings to support relative carers.

Social work practice in managing the allegations did not consistently follow process and timeliness requirements for preliminary enquiries and initial assessments as set out in Tusla's standard business processes at all stages of the investigation process. Practice did not comply with Tusla's standard operating procedures on four of the eight records sampled. One record indicated that appropriate action had been taken to safeguard the child and investigate wider concerns, but the relevant intake record and initial assessment documentation was not available on NCCIS. Inspectors brought this to the attention of the team leader and were assured that the work had been undertaken but had not yet been written up. On another case record, although the issues of concern had been immediately addressed with a referral made to the duty team and an intake record completed on the same day as the referral; the initial assessment had not commenced until six weeks later. In another child's case there had been a three month delay from the referral to an intake record being developed, with a further two month delay before this was signed off by the team leader. Both these initial assessments were not completed within the required target 40 day timeframes. Another record indicated a lengthy timescale of more than eight months from the start date of the initial assessment through to it being concluded.

All eight records contained safety plans which were appropriately detailed and signed by relevant people. They provided clear direction for foster carers and for the children and young people to help manage and reduce risks. They included for example stay safe work with children, clear boundaries about activities and time of greatest risk, with enhanced supervision and ongoing contact and review by the child's social worker and the fostering link worker.

Inspectors also sampled one complaint and one serious concern. The complaint could not be substantiated and did not met the threshold for preliminary enquiry through the department's duty team. The record indicates further action was appropriately undertaken to gain more information about the complaint. In relation to the serious concern, the issues were immediately explored with the foster carer who was helped to understand the underlying causes of the child's additional needs and concerns. This practice indicated a thoughtful response in exploring risk that resulted in a referral for specialist help for the child and strengthening of strategies for foster carers in responding to their needs.

The chairpersons of the service area's Foster Care Committees were informed about any allegations against foster carers within five days in line with Tusla's Interim Protocol. There was a clear pathway for the management of appeals with appropriate follow up review of foster carers' suitability and approval status having been informed of the outcome of the allegation. Minutes of foster carer reviews documented ongoing risks to the safety of children and quality of care provided, including checks for provision of safety plans. Appropriate attention was paid to addressing any additional training or support required by foster carers.

Following the last HIQA inspection of fostering services in 2017, the service area had implemented 'safeguarding oversight plans' for circumstances where children were placed with relative carers, often in an emergency; but where the relevant assessments and checks of their suitability had not been completed. Children in these situations were subject to quarterly review by the Safeguarding Oversight Group which included senior managers. All outstanding actions in relation to the 73 unapproved relative foster carers highlighted in the previous inspection had been addressed. The service area reported it had six households under consideration where assessment or approval decisions had yet to be completed. Frontline practitioners provided updates of children's safety plans to the Group to enable review of the continued safety and welfare of these children. This denotes enhanced safeguards for children pending the approval of relative foster carers.

There had been a total of five notifications of children missing from foster care over the past 12 months. Senior managers reported that they were routinely advised about such incidents, and that in these cases children were generally absent for a few hours duration. Records of joint liaison meetings with An Garda Síochána indicated that there had been further discussions about the joint protocol, local practice and oversight and review of the data. The recent focus on the development of absent management plans for all young people over the age of 14 years indicated a strengthened management focus on this area of risk.

Social workers were alert to harm to children from bullying and its impact on them, including when they transitioned from primary to secondary school. Risks of exploitation of children from social media was also highlighted within safeguarding arrangements on a few case records sampled.

Inspectors reviewed two records of children in care who were also still listed on the CPNS. Data indicated that there were five children in care in the area who were also listed on the CPNS. Managers provided assurance of actions being taken to progress planning for these children in line with court legal processes.

HIQA's risk-based inspection of service arrangements for managing risks to children on the child protection notification system (CPNS) in January 2020 identified the need for a clear process for conducting and disseminating learning from serious incidents including National Review Panel reports. Tusla's new Rapid Review Process was recently piloted in relation to the unexpected death of a young person who had left care. The approach taken in exploring the incident was effective and provided some important learning about good practice; including the importance of persistence in engaging young people and working through their network of support in line with their wishes and openness to receiving help. A further review by the National Review Panel was pending.

Senior managers confirmed that all social workers had been trained in Tusla's national approach for safeguarding children. Learning and development groups had been established to promote sharing of knowledge and reflections on practice. Social workers had adopted the nationally approved child safeguarding approach in exploring the potential for reunification of children back to their families. Regular family welfare or network meetings were held to map progress. This approach was also seen by inspectors to have been effectively used to resolve conflict in relationships between children, their families and foster carers, including concerns over the safety of children during access arrangements.

Most foster carers reported they had attended Children First training and were aware of their responsibilities for reporting child protection concerns under the Children First Act (2015).

The service area had taken action to strengthen its safeguarding practice and oversight of children in foster care; with evidence of wider promotion of learning and use of appropriate tools for the assessment and management of risk. Some records indicated a strong standard of child-centred practice; with appropriate actions taken to understand children's experiences and help them to feel safe. However, relevant case records to inform analysis of the nature and level of risk were not consistently undertaken or recorded in a timely way at all stages of the investigation process. This risked leading to delays in reaching decisions about the safety and suitability of placements and the provision of any additional support provided to the child or foster carers. For these reasons inspectors have rated the service area's performance as substantially compliant against this standard.

Judgment: **Substantially compliant.**

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.

Summary of inspection findings under Standard 13
The responsiveness and quality of work undertaken by the aftercare service in the Cork service area was widely commended by young people, foster carers and others inspectors spoke to as part of this inspection. Young people using the service reported they felt valued, listened to and were well-supported as they moved to greater independence and fulfillment of their needs and aspirations. The aftercare service was effectively managed and proactively met the challenges of operating in a large area with high levels of activity.

Data submitted by the area indicated there were 100 children aged between 16 and 18 years in foster care in the Cork service area who were eligible for the aftercare service. Ninety-four children had been referred to the aftercare service.
A total of 59 assessments of need had been carried out and 17 children had been provided with an aftercare plan.

A total of 43 young people over the age of 16 years gave feedback on their experience of the aftercare service through inspection questionnaires. A total of 27 young people said they had an after care worker who listened to them and helped them prepare for the future. Altogether 24 young people reported they had an aftercare plan, and indicated that they had been involved in developing the plan. Thirty four young people said they had been helped to develop independent living skills.

The aftercare team consisted of nine aftercare worker positions and two aftercare managers. Their work was overseen by a principal social worker. The work of the team was informed by the Tusla national aftercare policy which was implemented in full in the area. The aftercare team was stable, with suitably experienced aftercare workers. They were aware of their accountabilities for the provision of support and were invited to attend child-in-care statutory reviews.

There was no national caseload weighting system to gauge how many cases should be carried by an aftercare worker. Inspectors were told that the average caseload of an aftercare worker in the service area was 40 cases. The aftercare managers told inspectors that a national weighting system was due to be rolled out nationally and a

new standard operation procedure for aftercare services had recently been approved.

Aftercare workers sent out information leaflets to young people and their foster carers, held meetings with them to introduce themselves and provide information about the aftercare service. The level of information provided was good. Records of contact with young people indicated open and supportive conversations with them and their foster carers about their entitlements, future life choices and opportunities. The support provided was person-centred and at a pace that worked for them. Assessment practice enabled a 'fresh pair of eyes' to improve recognition of young people needs and areas where they would benefit from additional support to improve their education, employment and health outcomes. The aftercare team had provided information and briefings to their social work colleagues in the child in care and foster care teams.

The aftercare service hosted a weekly drop-in service for young people which provided advice and guidance for those leaving or who had left care. This offered dedicated time and space for young people to make contact by phone or arrange a face-to-face meeting with aftercare workers. Aftercare workers reported good engagement with young people, with very few refusing or dropping out of the service. The drop-in clinic recorded 382 contacts in 2019 and included a monthly EPIC advocacy appointment service. The service kept a record of the date, type of contact made and the purpose of the contact with young people.

Inspectors reviewed the files of 14 young people over the age of 16 years who had been referred by their social workers to the aftercare service, the majority shortly after their 16th birthday. The aftercare team had started a system to prompt social workers to make timely referrals on the child's 16th birthday. The aftercare managers told inspectors that this had improved timeliness of referrals to the aftercare service. Once referred, young people were supported by the aftercare service in one of two ways depending on the level of support that they required. Some (100 young people) attended the aftercare clinic for support provided by two aftercare workers and others (225 young people) were allocated an aftercare worker who would meet with young people outside of the clinic.

An inspector observed an aftercare clinic appointment which provided clear guidance to the young person about what the aftercare service had to offer. Future steps in getting to know each other and planning actions to progress what the young person saw as important to them were effectively covered. Foster carers told inspectors they rated highly the quality of service provided.

The aftercare service sent feedback forms to 40 young people availing of the service in 2020. Twenty-three forms were returned and the average rating for the service was 8.8 out of 10. The service planned to build on this feedback to see how they can further improve their service to meet the needs of young people.

Assessments of need were carried out for all young people leaving care and each young person was allocated an aftercare worker in order of priority and before they reached the age of 17 years. Of the 14 care records reviewed by inspectors, ten contained an assessment of need. All assessments sampled were comprehensive and of good quality in recording the needs and aspirations of young people. The service used a standardized template to provide a detailed picture of children's strengths and needs. Young people signed their assessments to indicate they agreed the contents and this was evident on records seen. The remaining four were awaiting their assessment of need but were still 16 years of age.

Inspectors were told and found in care records that aftercare workers were allocated when a young person reached their 17th birthday to complete their assessment of need. Inspectors found that when young people were referred to the aftercare service close to their 17th birthday, they were promptly allocated for the assessment of need to be completed in a timely manner.

Aftercare plans were completed in line with Tusla's guidance. The guidance required the aftercare plan to be prepared six months prior to their 18th birthday or within four months of the child becoming eligible. Of the 14 aftercare records reviewed by inspectors, six contained completed aftercare plans. All had been appropriately signed off by the young person, their aftercare worker and team manager. Aftercare plans were based on young people's assessment of need, they were comprehensive and clearly set out what supports would be available for young people and how goals would be achieved. Plans included areas such as budgeting skills, funding for further education and for completing housing applications.

Good practice in the area involved the aftercare service taking part in an executive leadership programme to explore the limitations of using the housing capital assistance scheme (CAS) to help prevent young people becoming homeless. The team hoped to involve external agencies in this programme to explore solutions to assist in meeting the housing needs of young people as this was recognised as a significant gap in provision in the service area.

The aftercare managers produced an annual report of the adequacy of the service in line with national policy. They maintained records and statistics on young people who had left care and were provided with an aftercare service. They also submitted

quarterly returns to the Tusla national office on referrals, assessments undertaken, and aftercare plans completed and the timeframes involved. In 2019, the living arrangements for young people aged 18-23 availing of the service were as follows:

- 46% in foster care
- 31% in independent living
- 11% returned home/ extended family
- 5% in residential care
- 5% other
- 2% supported lodgings.

In 2019, the training and educational achievements of young people availing of the aftercare service was as follows:

- 29% 3rd level
- 26% PLC (post-Leaving Certificate)
- 22% Accredited training
- 17% 2nd level
- 6% vocational training.

The service had an aftercare steering committee. It comprised a wide range of services, including the local authorities, voluntary services and the Health Service Executive. The steering committee met on seven occasions approximately every 7 – 8 weeks throughout 2019. Twenty-one young people had their case presented to the steering committee in 2019, six of whom were residing in foster care.

Ongoing engagement with young people using the aftercare service was good; with appropriate systems in place to effectively equip them for managing their own homes, education and work lives. 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 had good practice in relation to the aftercare provision following the receipt of a referral for a young person. The area recently implemented an alert system to assist with timely referrals. Assessments of need and aftercare plans were timely, and good quality, and were drawn up with the young people who co-signed these documents with the aftercare worker. Allocated aftercare workers were invited to the young people's child in care reviews. The service area implemented the legislation and standards and provided a good quality aftercare service to young people. For these reasons we have rated the performance of the service area as compliant against this standard.

Judgment: Compliant

Appendix 1 — Standards and regulations for statutory foster care services

***National Standards for Foster Care* (April 2003)**
Theme 1: Child-centred Services
Standard 1: Positive sense of identity Children and young people are provided with foster care services that promote a positive sense of identity for them.
Standard 2: Family and friends Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.
Standard 3: Children's Rights 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.
Standard 4: Valuing diversity 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. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III Article 8 Religion*
Standard 25: Representations and complaints Health boards* have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.

* 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*
Standard 9: A safe and positive environment

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

* 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)**
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*** *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.

* 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).

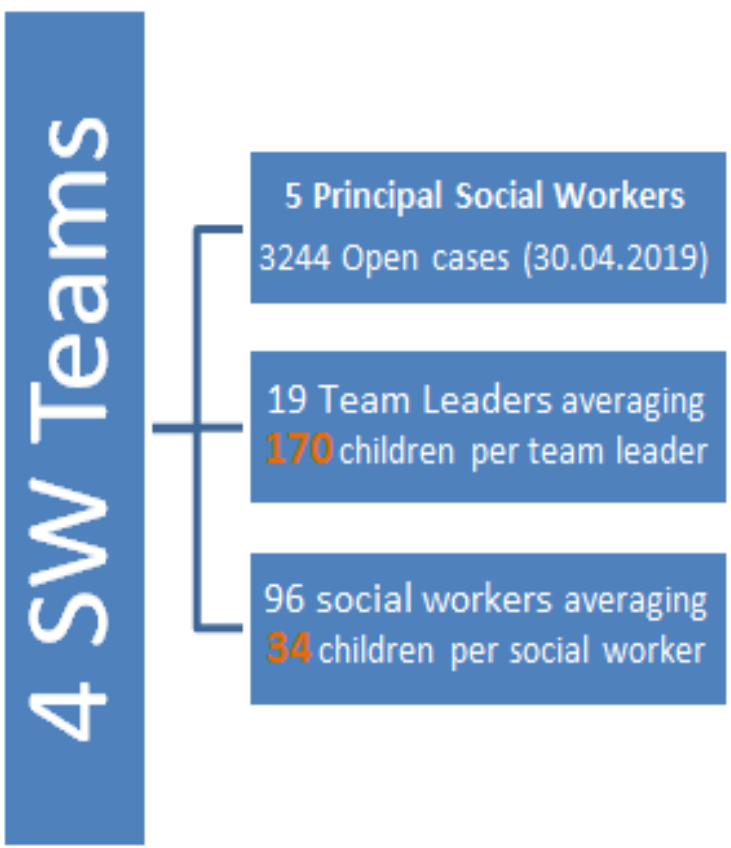
Child Care (Placement of Children in Foster Care) Regulations, 1995 *Part III, Article 6 Assessment of circumstances of child* *Part IV, Article 16 (2)(d) Duties of foster parents*
Standard 12: Education The educational needs of children and young people in foster care are given high priority and they 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* *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

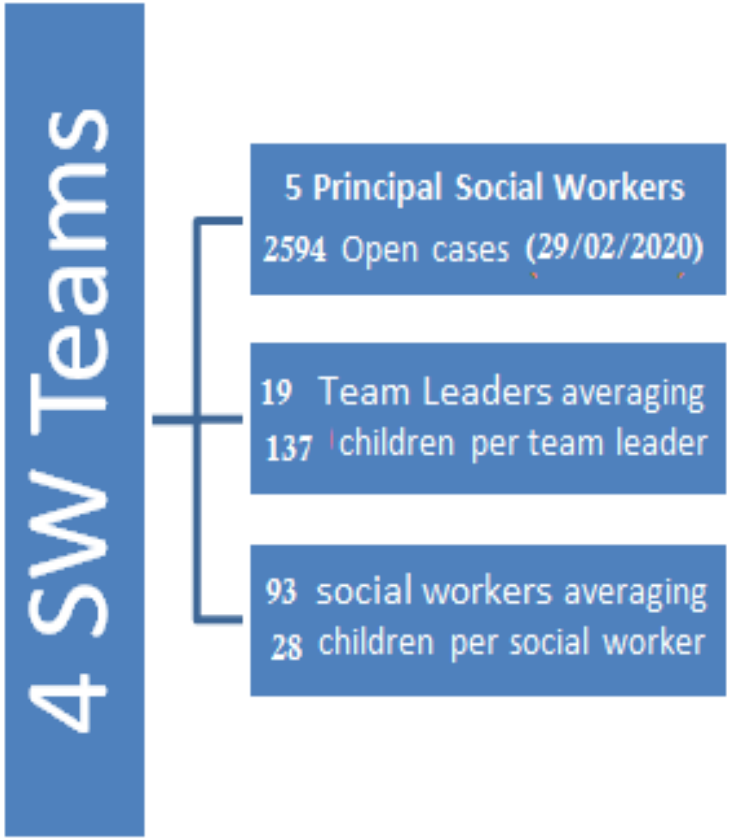
* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

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 Cork Service Area*





* Source: The Child and Family Agency

Compliance Plan

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

Provider's response to Report Fieldwork ID:	MON 0030130
Name of Service Area:	Cork
Date of inspection:	28th September to 1st October 2020 inclusive
Date of response:	15/01/21

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 Major

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

1. Not all children were visited in line with the frequency set out in regulations, and the frequency and quality of statutory visits required improvement.

2. Social workers did not ensure that complete and up-to-date electronic records of children in care were maintained.

3. Management oversight did not ensure that the required standards of practice as outlined within regulations and guidance were consistently met.

4. Supervision was not undertaken with the frequency and in line with the expected standards of practice.

5. Not all children were aware of or had their complaints investigated promptly.

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.

Please state the actions you have taken or are planning to take:

The TUSLA Corporate Pan 2021-2023 commits a joint initiative between TUSLA HR & Operations to develop multi-annual Workforce Plans, focusing on supply, recruitment, retention and talent management to ensure we have the workforce required to deliver high quality integrated services.

The Cork Area has a Three Year plan to ensure full compliance with its statutory commitments as follows:

1. The reassignment of a Team Leader to manage an Area-wide Child in Care Review Team to facilitate and quality assure a co-ordinated and standardised approach across the four child protection teams in respect of children in care statutory reviews. **Implemented November 2020**
2. The reconfiguration of an existing post to put in place an additional dedicated social worker (this is in addition to the 2.0 WTE currently in situ). **Implemented December 2020**
3. The recruitment of two additional social work posts for an initial period of six months to address the backlog of Child in Care Reviews. **In progress December 2020**
4. The two posts referenced have been approved for regularisation to permanent posts in the 2021 new service developments allocated to the Area. An additional Administrative post has also been approved for the Child in Care Review team. **2021.**

5. The establishment of a schedule of Child in Care Reviews for 2021 with monthly review of progress by the Area Management Team. **Q1 2021**
6. A business plan to increase the number of team leaders to reduce the ratio of social workers to team leaders has been submitted for consideration in any staffing increases that may arise in 2021 – one SWTL has been approved for 2021. The Area is looking to move from a 1-6 ratio currently in place to 1-4 ratio by 2022. This would increase considerably the capacity of the teams to manage the increasing volume of work devolving upon this grade and will improve considerably the governance and oversight of front line operation and service delivery expectations. **2021-2023**
7. A key objective for National Operations is to strengthen national and regional structures and culture for the governance of risk and incident management in the operational system. To support this, the National Operations Risk Management and Service Improvement Committee (NORMSIC) is being re-established in February 2021 with revised Terms of Reference and Membership. A standardised Regional Risk Management and Service Improvement Committee will be established in each of the 4 Regions in March 2021 and will report to the National Group. **Q1 2021**

Statutory Visits and Supervision

8. A Guidance note to address the frequency and quality of statutory visits was **implemented in Q3 2020** as part of the Action Plan following audits of Children in Care files. This guidance includes the following: exploration of family and friends, cultural religious and social needs, health and educational needs and children's rights including complaints.
9. Children admitted to care in a planned manner will be discussed at the first supervision session post admission but no longer than 6 weeks. The statutory requirements of statutory visits, CIC Review and assessment of need will be discussed and planned. The timeframes for these will be recorded in the supervision record. **Immediate implementation**
10. The quality of statutory visits will be embedded in practice by using the statutory visits guidance document as a pro-forma and the recording will be completed in accordance with the naming convention on NCCIS. **Immediate implementation**
11. Audits of new admissions to care will be undertaken on a quarterly basis for 2021 to assess compliance with statutory visits, care planning, assessment of need and supervision. **Q1 2021**
12. A Supervision pro forma tracking tool piloted in one area will be implemented across the Cork area. Supervision of Children in Care will include discussion of the minimum regulatory requirements regarding review, statutory visits and consideration of permanency planning/re-unification. The pro forma Supervision record will be copied onto the individual child's file on NCCIS. **Quarterly Review 2021**
13. The Area will establish an action plan to in relation to the recommendations arising from the report of the Quality Assurance Supervision Audit undertaken in Q4 2020. **Pending QA Report being received in Q1 2021**
14. Team briefings will take place regarding statutory visits, how to conduct them, follow the guidance and recording of same on the NCCIS. A Principal Social Worker, along with a Team Leader representative from each team will form a working group to devise and roll out these sessions to ensure a standardised approach across the Area. **End Q1 2021**

Record Management/NCCIS

15. The Business Information Unit will develop an Advanced Find on NCCIS that will highlight new placements including admissions for all children in care. This will be made available to all Principal Social Workers and Social Work Team Leaders and will assist in ensuring compliance with statutory visits. Compliance with the NCCIS naming convention for statutory visits will also be audited. **Quarterly basis throughout 2021**
16. These audits will involve the Child Protection Teams reviewing 10% of children in care records to assure themselves of the quality and consistency of the visits and that the records of same are on the NCCIS. **End Q2 2021.**
17. The Child Protection Principal Social Work group will take the learning from the audits and devise a learning Action Plan based on the findings of same. Consultation with the Working Group on Dissemination of Learning will ensure an integrated approach to implementation. **End Q3 2021.**

18. The implementation and outcomes of this plan will be reviewed by the Area Management team. **End Q3 or beginning Q4 2021.**

19. The Area will request a report from NCCIS to highlight and flag shortfalls and deficits in the recording on the system. This would allow supervisory grades to run a report highlighting such deficits and allow questions to be asked as to the explanation for same. **Review Q2 2021**

20. As an interim measure the Business Information Unit will work with NCCIS national on a solution that will provide Area/ Department management oversight on children who have not had a case note within a defined time period. Immediately the Business Information Unit (BIU) will work to provide periodic numeric oversight. Once the case note deficit is identified, files will be audited and an Action Plan will be implemented at supervision to ensure compliance is achieved. **Q1 2021**

Complaints

21. The complaints process is on the Agenda for each Statutory review. As already set out earlier, the number of Statutory Reviews will increase due to the establishment of the Children in Care Statutory Review Team. The Children in Care Review application form, which is completed by the Social Worker, asks if the Child has been made aware of the Complaints process. The Children forms (Tactic Forms) also afford a child the opportunity to identify who they would tell if anything was worrying them. The complaints leaflet will be made available to all children at review or at first statutory visit. All current outstanding complaints will be addressed and concluded. **End Q4 2021.**

22. The Child in Care Review Group are looking at a range of issues with Empowering People in Care (EPIC) and young people including their knowledge of and experience of management of complaints. **Commencing Q2 2021.**

23. The Area Complaint's Officer will conduct an exercise examining the experiences and knowledge of children in care in relation to the complaints process, 10% of children in care within the area will be contacted directly. **Commencing Q1 2021.**

24. The Complaints officer will compile a report in relation to this matter with a view to developing an action plan. This action plan will be signed off by the area management team and in consultation with the dissemination of learning group implemented within the area. **End Q3 2021.**

Proposed timescale:	**Person responsible:**
Immediate implementation to end of Q4 2021	**Area Manager, Principal Social Workers.**

Standard 6 – Assessment of children and young people

Substantially compliant

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

- The assessments of all children placed in care as an emergency required improvement to ensure their needs were identified within the required timescales.
- The focus on the identity and care needs of children from diverse racial or cultural backgrounds required improvement to enhance recognition of their individuality.
- Health screening and assessments of children with complex needs or disabilities entering care required improvement to ensure their specific additional needs were recognised.

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.

Please state the actions you have taken or are planning to take:

As the Children in Care Review team takes on new staff as outlined earlier, then the move towards full compliance with statutory care reviews will begin to have the intended effect with the intention of moving to a prioritisation of children being admitted to care with the first review taking place within 8 weeks of the admission to care.

1. The assessment of need will be discussed at the first supervision post admission to care which will take place no longer than 6 weeks later. Any outstanding aspects of the assessment of need will be discussed with a view to implementation and any reasons why there may be a delay in completion will be recorded. **immediate implementation**
2. An Advanced Find on NCCIS was set up to identify all placement moves including admissions to care. The CIC Review TL will check this weekly to identify what CIC Reviews need to be scheduled. **Q4 2020**
   The Business Information Unit (BIU) will provide guidance on how the Review team can extract their own data from NCCIS **Immediate Implementation** The Business Information Unit will work with the new Children in Care Review team to develop a management information template and then request the development of this by National NCCIS **Q3 2021**
3. The Children in Care Review Team Leader will provide a quarterly report in relation to compliance with this action. **Q1 2021.**
4. A number of staff will be attending a three-day course in December 2020 entitled Cultural Diversity and Inclusion Training. Following feedback on the course it is intended, if suitable, to roll it out to the wider staff group in 2021. **Q2 2021**
5. Tusla Cork has an ongoing Children in Care Steering Group with EPIC and it is intended to develop an initiative with the children in care group to look at their experience of the services awareness and engagement with children in care from diverse ethnic backgrounds. These collaborative initiatives with EPIC have proven to be very informative and practice-influencing in the past. **Q1 2021**
6. In addition, any issues relating to the cultural racial or religious needs of the child will be addressed with the foster carers at the commencement of the placement and that this is recorded. **Q2 2021**

7. With regard to health screening and assessments the Joint Protocol between the HSE and Tusla provides the frame work for such discussions and the respective levels within each Agency meet to discuss complex cases which ultimately can be escalated to CHO and Area Manager level for final sign off. A revised Joint Protocol has been issued (December 2020) and will be implemented. **Q1 2021** **8.** The issue of medical assessments of children coming into care is an issue and engagement on trying to resolve this problem commenced with the plan to devise an agreed protocol to implement. **End Q1 2021**	
Proposed timescale: **Immediate implementation to end of Q3 2021**	**Person responsible:** **Area Manager and Principal Social Workers.**

Standard 7 – Care planning and review

Non-compliant Major

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

1. The area was not adequately resourced to meet the care planning and review requirements for children in care in the area.

2. Not all children had an up-to-date care plan.

3. Not all children understood the purpose of their care plan and were supported to prepare for their care plan review.

4. Placement planning for children in foster care required development to ensure practice complied with the expected standards in the provision of foster care.

5. A significant number of children did not have their care plan reviewed in line with the frequency timescales set out in regulations.

6. Arrangements for organising and managing care plan reviews required improvement to ensure a consistent standard of practice and management sign-off of care plans.

7. The coverage and quality of child care reviews did not adequately address the range of issues relevant to the safety and wellbeing of children including:

    a. unplanned endings
    b. long-term planning
    c. specific cultural and ethnic needs
    d. enhanced rights.

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.

Please state the actions you have taken or are planning to take:

A business plan outlining a three-year plan to develop a dedicated Children in Care Review team has been developed. Incremental progress is aligned to internal reconfiguration and new resource allocation. Progress to date and future plans are outlined as follows:

1. Reassignment of a Team Leader to manage the Children in Care Statutory Review process. This will provide greater quality assurance, consistency and oversight of the organisation and delivery of the Statutory Review Process. **Implemented**

2. An existing post has been reconfigured to provide an additional full time Chairperson for statutory reviews. Subject to the full availability of the person, this will improve condiderably the number of reviews that can be conducted in a year. **Implemented**
3. Two additional social workers are being recruited for an initial six months. The objectives for the team to the end of Q2 2021 will be to meet the obligations for all first reviews and to address the backlog. This will be contingent upon many factors including consistent staffing, the pandemic and the demands of Cork District Court. An additional Administrative post has also been approved for the Child in Care Review team. **End Q1 2021**
4. Submissions to make those two workers permanent have been approved as part of the Area's 3-year plan. **Implemented**
5. Similar submissions will be submitted for 2022 and 2023 until such time as the proposed full team complement is reached, ie 8 social workers and a Team Leader. **2022/2023**
6. The Area will request National NCCIS to develop a report to allow oversight of reviews completed for each child – in the interim the Business Information Unit will pull data and incorporate it into an Area local management information report. **Ongoing**
7. The Area has requested national NCCIS team to amend the current national report to reflect accurately the Care plan status. **Ongoing**
8. A key objective for National Operations is to strengthen national and regional structures and culture for the governance of risk and incident management in the operational system. To support this, the National Operations Risk Management and Service Improvement Committee (NORMSIC) is being re-established in February 2021 with revised Terms of Reference and Membership. A standardised Regional Risk Management and Service Improvement Committee will be established in each of the 4 Regions in March 2021 and will report to the National Group. **Q1 2021**

The development of the independent CIC review team will ensure consistency in the planning & delivery of the Child in care reviews and ultimately the delivery of timely and comprehensive Care Plans. The key issues relating to permanency planning, children's needs, and unplanned endings will become integral to the Care planning process and will be evidenced in the Care plans.

9. All those in attendance at the CIC Review sign the Participation and Attendance Sheet which signals their agreement to the Care Plan being developed for the child. This is scanned to the child's records on NCCIS. **Implemented**
10. The CIC Review Team Leader will liaise directly with the TL for the child if there are any issues arising from the Review that require further consideration and decision making. **Implemented**
11. The Chairperson compiles the Care Plan and the CIC Review Team Leader reviews same and sends the TL and SW the record of decisions and actions agreed at the Review for final approval. There will be a five-day turnaround period for this approval to ensure Care Plans are completed and sent to participants in a timely manner. **Immediate implementation**
12. Once approval has been received this will be noted in the Care Plan and it will be closed on NCCIS with the SW signature and CIC Review Team Leader approval. **Immediate implementation**
13. The responsibility for the implementation of the Care Plan remains with the child's SW with appropriate governance and oversight by the case management Team leader. The next supervision session after the CIC Review will focus on giving effect to the implementation of the Care Plan decisions, and this will be tracked in subsequent supervision sessions. **Immediate implementation**
14. The Team leader for the Child in Care Review unit will meet with the PSW's on a quarterly basis and will provide a report on trends and themes arising at reviews. This will contribute to further assurance and standardisation of the process across the Area. **Q1 2021.**
15. The CIC Review Team will keep 6 days per month available to schedule CIC Reviews for new admissions to care and new placements. **Implemented**
16. Where placements are at risk of disruption a Professional Meeting will be scheduled to review and plan accordingly. The next review will be prioritised to meet the 2-month regulatory requirement. **Implemented**

17. The issue of long term/permanency planning was being addressed by way of nationally driven workshops. However shortly after these commenced they were stopped due to Covid 19 restrictions. As soon as it is possible to resume the workshops staff will be freed up to attend. In the interim, the increase in the frequency and timeliness of the statutory reviews, and the consistency of same arising from the new arrangements, will ensure the permanency planning is to the fore as per section 5 of the Care Plan The governance and oversight of the care planning process including manager approval of care plans will be ensured by the Team Leader for the CIC Review Team. **To be reviewed in Q1 2021**

18. The Child in Care Review Team is developing feedback forms for participants attending Child in Care Reviews with initial focus on Children's views. **Q3 2021**

19. The National Placement Plan sets out the access arrangements for children in care and any additional actions required to meet children's needs. This information will be captured in the Care Plan. Section 12 (Family and Social Relationships) will incorporate all access arrangements, Section 9 (Education) will incorporate any educational assessments/interventions identified and Section 10 (Emotional and Behavioural Development) will incorporate any therapeutic needs of children identified. The Actions of the Care Plan will outline those responsible for implementation and the time lines for completion.

Care Reviews will have actionable recommendations relating to racial, cultural and religious identified need, which will be included in the Care plan.

20. During the assessment of need period where a determination that care is required for a child, racial, cultural and religious needs will be subject to assessment and the care planning stage will reflect how these needs will be met. In circumstances where a child enters into care in an emergency or unplanned manner, these cases will be prioritised for follow up to establish their specific needs. **Immediate implementation**

21. Where a child enters into care with a non-Irish or dual citizenship status, the Team Leader will ensure that written contact is made with relevant Embassy or Consulate to advise of the care status of the child, subject to appropriate consent (parent/court). Any other cultural/ethnic supports that may have been identified in the assessment process can also be brought to the attention of the Embassy/consulate staff as deemed appropriate. **Immediate implementation**

22. All staff in the Children in Care Review team will undergo Cultural Diversity and Inclusion Training and will address these issues as per section 11 of the care plan. **Q2 2021.**

23. The Children in Care Steering Committee (into the voice of the child) will seek the views of children from different cultural backgrounds into their experiences of care. **Q2 2021**

24. The manager of the Fostering Resource Unit will conduct a training needs analysis of foster carers relating to raising awareness and identifying training needs in regard to racial, cultural and religious issues. The results of this exercise will be forwarded for consideration to the Area Management team for review and action as appropriate. **Q2 2021.**

Enhanced Rights

25. A detailed summary explaining Enhanced Rights will be developed and sent to all relevant front line staff, managers and foster carers. **Q1 2021.**

26. Over 380 children have been in their care placement for five years and the foster carers are therefore eligible to apply for enhanced rights having met that criteria. All these families, as well as those where the child has been in the placement for four years will be sent the relevant information and advised to discuss it with their social worker and link worker. If an application is approved by the Social Worker, then it can be discussed at the Child in Care Review. The matter will also be discussed at the Foster Carer's Review. **Q1 2021**

Proposed timescale:	**Person responsible:**
Immediate implementation to 2022/2023	**Area Manager and**

	Principal Social Workers

Standard 8 – Matching carers with children and young people

Non-compliant Major

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

- There were insufficient foster care placements available to ensure that children could be matched in a timely manner to foster carers with capacity and skills best placed to meet their needs.
- There was a significant shortfall in the availability of suitable emergency foster carers within the service area to ensure children did not experience multiple placement moves or be left in potentially at risk situations.
- A significant number of children were placed within foster care households with two or more other children in care.
- The process for matching individual children and sibling groups required improvement to provide assurance of the 'best possible fit' of children to foster carers.

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.

Please state the actions you have taken or are planning to take:

A national fostering recruitment group was established in 2018 with reps from each region and the following actions have taken place.

A needs analysis report was completed by an independent researcher which formed an evidence based approach to 2 national fostering campaigns in 2019 and 2020. These campaigns had specialist communications and PR inputs to ensure correct targeting of media outlets and demographics who may be interested in fostering. Fostering reps nationally identified successful recruitment activities for further development. Fostering recruitment champions were identified in each Tusla area who were key leaders and drivers in recent national fostering campaign in terms of local activities/media/identifying spokespeople etc. Engagement between SD for fostering and Director of Service and Integration was held with Tusla funded agencies to garner their support with the most recent fostering campaign through social media/media interviews.
A dedicated national fostering enquiry line was established to ensure a quick and speedy response to any calls from people interested in fostering with the aim that all enquiries are responded to in 3 days.
Out of hours' support is available to foster carers.
A national bespoke information leaflet was published at the end of 2020 for members of the travelling community who may be interested in fostering. Dedicated posts on social media were circulated by Pavee Point also relating to recruitment of carers from travelling community.
What Works funding has been awarded to support recruitment of foster carers from the Traveller/Roma communities. Recruitment is taking place for the appointment of 2 members from these communities to work with Tusla on this initiative.

Engagements and information sessions have been held with the Muslim/Islamic community in the Dublin area and we will be replicating this in the Cork area. **Q2 2021**

The National Emergency Foster Care Committee will be extended to end of **Q 1 2021**

A National Strategic Review of our approach to Fostering will be facilitated to identify opportunities to strengthen our services. **Q1 & Q2 2021**

Local Cork Fostering Resource Unit Strategic Development Plan for 2021
Subset to the National Plan:

Fostering Connections/Trauma Informed Care PHD Research completed in March 2020 (Tusla Copyright) which has been continuously rolled out to Cork Tusla Foster Carers and will continue in 2021 until all Carers are trained. This also helps with retention of foster carers in the Cork area. **Implemented and Ongoing**.

Recruitment Committee set up in 2018 to explore the needs of the service and active in promoting and exploring new ways to recruit carers in line with the National Recruitment Strategy. Principal Social Worker also part of the National Fostering Week committee. **Implemented and Ongoing**

Register kept of all interested parties to fostering locally from the Nationally email and also local phone in and returned on a quarterly basis to the National Office of where each interested party is in the fostering process. **Implemented and Ongoing**

The National Action Plan includes the following:

- Cork FRU attended the feedback session on the Fostering Week, as the view from the local Cork FRU team is these events need to occur Nationally more than once annually but possibly twice if not quarterly through National.

- Fostering Champions have been identified as several members of staff who attend the National meeting are also part of the local Recruitment team and were instrumental in the advertising and promoting of fostering local in the Cork City and County.

- Fostering Staff and Champions used their own personal connections with radio to promote Cork Fostering during the Fostering Week and Care Day and we continue to advertise in these newspaper publications as well on a monthly basis.

The National Enquiry line - our own local telephone number is responded to by a dedicated social worker in the department within the time frame given by the National Office. **Implemented**.

Retention of foster carers is the main issue that we are attempting to address in Cork, support through continued support groups six currently with the pandemic done remotely, continued training through the TIC for carers, support groups for birth children of foster carers also continue. Training schedule for 2021 will be sent out with the Fostering Newsletter in February 2021. **Implemented**

Cork FRU staff Champion will be given an opportunity to recruit go out to community services to make connections with local minority communities along with the general public. The purpose of the role is to explore other avenues of recruitment for the Cork area in order in increase our capacity this does not replace the existing recruitment strategic plan for Cork but runs parallel to it. **Q2 2021**

1. Two extra staff to be assigned to the Fostering Resource Unit to address the assessment and capacity issues regarding placements. The recruitment process has commenced. One will focus on Relative Assessments and the other on General Foster Carers (Given the time frames for assessment this should allow the current backlog of 17 Relative Foster Assessments and 19 General Applications to be completed in six months). **Q1 2021**
2. A Standard Operating Procedure, Guidance note and template is currently being developed to progress the matching process. **Implementation Q1 2021**

3. Arising from the National Foster Care Campaign the Area received a significant number of enquiries from prospective foster carers – these will be screened and training and assessment planned. **Q1 2021** 4. The Area will establish for 2021 a recruitment campaign and schedule of events to promote foster care **Q1 2021**	
Proposed timescale: **Immediate implementation to end of Q2 2021**	**Person responsible:** **PSW FRU**

Standard 10 – Safeguarding and Child Protection

Substantially compliant

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

- Social work practice in managing the allegations did not consistently follow process and timeliness requirements for preliminary enquiries and initial assessments as set out in Tusla's standard business processes.

Action required:

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

Please state the actions you have taken or are planning to take:

1. The timelines for the eight identified cases will be examined to ascertain/determine the issues which led to the delay. An audit of these cases plus 25% of IP cases across the teams to examine the timelines for themes, reasons for delays and to ensure implementation plan is put in place to address the delay in timelines. **Q1 2021**
2. A half day per month will be set aside to hold urgent CIC reviews for Children including those involved in an IP process, this will also help to address the assessment timelines. **Q1 2021.**
3. The Interim Protocol process does not align with the Initial assessment under the SBP, this can cause delays in practice and outcomes. Due to the non-alignment of these policies, we will also issue a Practice Directive to ensure that forms re IA are launched**. Q1 2021**
4. The tracking of cases arising will be tracked for compliance with business process timelines.

Proposed timescale: Q1 2021	**Person responsible: PSW FRU**