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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of service area:	Dublin North City
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Lead inspector:	Caroline Browne
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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 action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of HIQA's findings.

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

As part of the HIQA 2019 monitoring programme, HIQA is conducting focused inspections across 17 Tusla service areas focusing on **The child and family social worker, Assessment of children and young people, Care planning and review, Matching carers with children and young people, Safeguarding and child protection and Preparation for leaving care and adult life**. These focused inspections will be announced, and will cover six of the national standards.

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

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

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

The key activities of this inspection involved:

- the analysis of data submitted by the area and questionnaires completed by 64 children in care and 11 young people in aftercare
- meeting with or speaking to ten children and young adults availing of the aftercare service
- interviews and meetings with the area manager, two principal social workers for the children in care teams, acting principal social worker for foster care team and the interim aftercare manager
- home visits to four foster care households and meeting with six children in care

- separate focus groups with children in care social workers and child protection social workers, fostering social workers, team leaders for the long-term children in care team, aftercare workers and with foster carers
- review of the relevant sections of 54 files of children in care as they relate to the theme
- phone calls with four parents of children in care, eight foster carers and three children.

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 met with or spoke to inspectors.

2. Profile of the foster care service

2.1 The Child and Family Agency

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

The Child and Family Agency (Tusla) has responsibility for a range of services, including:

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

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

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

2.2 Service Area

According to data published by Tusla in 2018, the Dublin North City service area had a population of children from the ages of 0-17 years of 44,927.*

The area is under the direction of the service director for Tusla, Dublin North East region, and is managed by an area manager who was in this role since 2015. There are two principal social workers who hold responsibility for children in care in the area, one acting principal social worker who has responsibility for the foster care service and an interim aftercare manager responsible for the leaving care and aftercare services.

The long-term children in care team were based in three locations which were Ballymun civic centre, Ballymun, Park House and Park View which were both located on North Circular Road, Dublin 7, and the leaving care and aftercare team were based in Park House. Two child protection teams, who had responsibility for the care of children in care until they were transferred to the long-term children in care team, were located in offices throughout the service area.

At the time of the inspection there were 441 children in foster care in the area. Of these, 154 children were placed with relatives and the remaining 287 children were placed with general foster carers, 72 of whom were placed in private foster care placements.

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

*Annual Review on the Adequacy of Child Care and Family Support Services Available – 2017 (Tusla website, July 2019)

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
- three standards were substantially compliant
- two standards were non-compliant both of which were moderate non-compliant.

Children who met with or spoke to inspectors said they liked living in their foster placements and they felt they were well cared for. The majority of children who responded to questionnaires said that they had an allocated social worker and they were positive about their relationship with their social worker and they felt listened to. There was an emphasis placed on maintaining good links with families and children reported that they see their family and friends regularly. Children also identified that their culture and background was understood and promoted.

The young adults who were in aftercare spoke positively about the support they have received from the aftercare service in order to prepare them for adult life. However, these young adults identified some gaps in the service due to the lack of appropriate housing and mental health services for young people leaving care. The majority of assessments of needs completed for children leaving care were of good quality. There were good systems in place to ensure oversight of assessments of need and aftercare plans were timely. Some children were referred to external providers to receive an aftercare service; however, there was no oversight mechanism in place to ensure that these children received a good quality service that was in line with legislation. Some improvements were required in the area in order to ensure that all children were referred to the aftercare services at an early stage particularly for children with complex needs.

Care planning and child in care reviews were generally of good quality when undertaken and were written in a child friendly manner. There was evidence of

social workers involving children, their parents and foster carers in the process and of care plans being implemented. However, a significant number of children did not have an up-to-date care plan and child in care reviews did not take place within statutory timeframes for 41 children. Placement plans were not consistently used in the area in respect of each placement of a child. A placement plan should outline the specific needs of a child in their current placement and set out how the child's needs would be met by foster carers on a day-to-day basis in line with the child's care plan.

Voluntary consent provided at the time of the child's admission to care had been reviewed in order to assess the continued appropriateness of the child's on-going placement. A recent audit had been completed to ensure parents voluntary consent had been reviewed appropriately and this is now being monitored through the child in care register.

The majority of children in care were allocated a social worker but a small number were unallocated at the time of the inspection. A duty system was in place in order to ensure children were receiving safeguarding visits. However monitoring systems in place to ensure children were visited by a social worker were not always effective as there were a number of children who had not been visited in line with the regulations. The quality of record keeping in the area was mixed and some records were not available on children's files.

Social workers coordinated the care of children and the input of other professionals and children received supports as required. Significant events were appropriately responded to and there were a range of supports made available to children and foster carers when required. There was no mechanism in place to monitor informal or verbal complaints to ensure they were appropriately responded to.

Concerns and allegations were assessed in a timely manner, children were met with and appropriate safety measures were implemented. However, not all allegations and serious concerns were categorised correctly and as a result were not always assessed in line with Children First (2017) or the interim protocol for managing concerns and allegations of abuse or neglect against foster carers and section 36 (relative) foster carers. While there were good governance mechanisms in place to oversee concerns and allegations made against foster carers the same governance mechanisms were not in place for allegations and child protection concerns reported by children in care which did not pertain to foster carers. Safety plans were implemented and monitored when required and the majority of safety plans were of good quality.

There was a process in place in order to match children with foster carers. However formal records of comprehensive matching were not always available. While the social work team sought to match children with foster carers, this was impacted by the limited number of foster carers available in this service area. A large number of children were placed outside this service area. The service area had started to complete long term matches for children who were longer that six months in their placements however approval of long term placements were not always completed in the required timeframes and there remained a backlog of children who were awaiting a long term match.

Assessments of children's needs when they were placed in care were completed by social workers when children were placed in care. Assessments were good quality, comprehensive and included multidisciplinary consultation when required.

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

4. Summary of judgments under each standard and or regulation

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

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

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

What children told us and what inspectors observed

During the inspection, inspectors met with six children in their foster care homes. Inspectors also received 75 completed questionnaires from children and young people living in foster care in the Dublin North City area.

Children told inspectors about the things they liked about living in foster care:

- "Everything - I feel very secure and loved in my foster home"
- "I have freedom. I like that I can hang out with my friends. I play all my sports."
- "I have a normal family life."
- "They (foster carers) are very caring and loving and will support me in any choice I make."
- "I like living with my foster family because they treat me very well and it doesn't feel like I am not one of their birth children or like I don't belong in their house. They give me everything I could ever want in life and they are the best family I could ever ask for and the only family I want to live with."
- "I love my family and am blessed to have the most amazing family. I want to thank my foster carer for all she does for me."
- "I feel very lucky to be part of this family…..I wouldn't change anything in my life"

Children told the inspectors that they liked; living with their siblings, helping on the farm, their pony and dog and being on a farm.
Children said they liked their bedroom, that the food was amazing; they liked their school, their friends and contact with their families. Children also talked about some of the activities they loved doing, such as going on holidays, soccer, GAA and going to adventure playgrounds.

Children also told inspectors some hard things about living in foster care:

- "I am only … years old so this (child in care reviews) is all new to me."
- "I don't like doing forms"
- "I was scared at the start….. but my foster family are good to me"
- "I would like to see my Mam more".

74 of 75 children indicated in the questionnaires that they had an allocated social worker; one child said that they did not have a social worker.

The majority of children were positive about their social workers. Children said:

- "She is really nice. She is the best ever."

- "All I can say is she is very helpful and she is always there when I need her"
- " She is kind and helpful"
- "She is trustworthy"
- "He's nice"
- "My social worker is lovely and is so helpful to me, for me going forward in life and she is the best social worker I will get."

Out of the 75 questionnaire respondents 74 said they had a care plan and one child said they did not have a care plan. 69 out of the 75 children who completed the questionnaire said that they felt listened to by their social worker, while six children said they did not feel listened to.

Out of the 75 children who responded to the questionnaire, 32 children replied that they had attended their child in care review. Some children indicated that they did not like attending meetings where they are talked about.
32 children of the 75 who completed the questionnaire said that someone does talk to them about the decisions, 11 children said they did not know and 19 children said no one talked to them about the decisions made in their child in care review.

56 children who replied on the questionnaire indicated that they had enough contact with their birth family while nine children said they did not and 11 children were not sure.

11 young people over the age of 16 responded to the questionnaire. Four of these indicated that they had an aftercare plan and two responded that they did not have an after care plan. Three of the respondents who had an aftercare plan said that their aftercare worker listened to them, while one young person responded that they did not feel listened to. All four respondents who had an aftercare plan said they had a say in it. Seven (of 11) young people said they knew what money they were entitled to. Three said they were not sure and one young person said they did not know what their financial entitlements were.

Inspectors also met with or spoke to 10 young people in aftercare as part of this inspection. Young people said many positive things about the aftercare service:
"The opportunity aftercare gives you in terms of funding, housing and most of all education is what I like most"
"I always feel like I have someone to turn to with issues or problems I face in life, aftercare have provided [me] with the supports I need"
"More listened to, more personal, treated like an adult"
"As I fell on hard times [aftercare worker's name] have given me an amazing opportunity and has changed my life in more ways [than] she could imagine"

"Had a great aftercare experience and a great aftercare worker"
"Made a huge difference in my life… taught me independent living skills".

Young people also spoke about the challenges they face in using the aftercare service:
"[If] you don't get education, you're pretty much homeless"
"Mental health is not getting the attention it needs"
"Need more mental health schemes for 18+, supports in life during or without college placements"
"Fear of homelessness"
"Many young people in care were too traumatised in their childhood and do not finish school or make it to third level education."

Aftercare was described as "always there if you need anything"
"Who else do you have left to turn to"
"Aftercare treats you like an adult… you have to put the work in"
"If you want it for yourself, you have to do it".

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.

Summary of inspection findings under Standard 5

Data provided to inspectors prior to the inspection showed that 413 children in care had an allocated social worker; however, 28 children in care did not have an allocated social worker. At the time of inspection, there were two social work vacancies and two social work team leader vacancies. There were no children in care who were dual unallocated. A duty system was established in this service area for children who were unallocated a social worker in order to ensure children were visited and that they had their statutory child in care review in line with statutory requirements.

There was a guidance document for managing unallocated cases which was devised in August 2018 and was revised in July 2019. The revised guidance outlined that no children should be dual unallocated which meant that all foster care households should either have a fostering link worker allocated to the foster carers or a child in care social worker allocated to the child. In addition, cases which were prioritised as high needs should not be unallocated to a social worker. This guidance document also outlined that all unallocated cases would be reviewed by the principal social worker on a monthly basis. While the August 2018 guidance document provided some guidance in relation to the type of case that should not be unallocated, inspectors found that the revised guidance document required further review as it did not adequately provide guidance in relation to how the case should be

prioritised. While the policy indicated that cases should be prioritised for allocation based on Tusla's Measuring the Pressure policy, the revised policy was not effective in ensuring that high priority cases were allocated. For example, inspectors found that a baby did not have an allocated social worker and two children who were identified as having a mild disability were unallocated at the time of the inspection.

The principal social worker took responsibility for unallocated cases and a duty system was in place on the children in care team whereby all children in care social workers alternated on a weekly basis to cover calls relating to unallocated cases. This member of staff was available to complete tasks identified as a priority such as a statutory home visit by the principal social worker on the unallocated lists. This dedicated member of staff was also available to receive calls from those who were unallocated and respond to any emergencies or issues raised for these children. The principal social worker told inspectors that some unallocated cases were also assigned to a social care worker when a specific piece of work or support was required for these children and there were also joint visits conducted by the social care worker and the allocated fostering social worker to these children in an effort to ensure children were appropriately safeguarded.

The unallocated children in care were also tracked through the child in care register which was monitored by the principal social worker. The principal social worker reviewed unallocated cases through monitoring this register and prioritised what was required on these cases and arranged for statutory visits and child in care reviews to be convened by the duty social worker. This register was updated with the case categorisation which identified if the needs of the child were deemed to be high, medium or low and the date of last visit to the child. The team leaders told inspectors that all unallocated cases were reviewed at supervision and risk assessed and that these risk assessments were placed on the child's file outlining if they were categorised as high, medium or low cases. Inspectors also found that unallocated cases were also discussed and reviewed at team meetings.

Inspectors reviewed eight files of children who were unallocated at the time of the inspection. On review of the unallocated case lists inspectors found that the longest period of time a child was unallocated for was 10 months. Inspectors found that all of the children who had been unallocated had a visit from a social worker or social care worker in the last six months. However; inspectors found that four of those eight children did not receive statutory visits in the last two years in line with regulations. Two of the unallocated cases had a risk rating tool which identified that the case was reviewed and risk rated. However, this review of unallocated cases was not evident on all unallocated cases reviewed. There was evidence in two

unallocated cases reviewed that a social care worker was completing specific pieces of work with children where this was required to meet the child's needs.

When children in care were allocated a social worker, they were not always visited in line with timelines prescribed by regulations. Data provided by inspectors showed that 21 children had not been visited in line with regulations. However, the principal social worker acknowledged that this figure related to the children's most recent visits and there was no mechanism in place to track whether statutory visits were carried out in line with regulations over a two year period. During the inspection fieldwork, the principal social worker identified that seven of these children had been visited since the data had been submitted and there remained 11 children who had not been visited in line with regulations. Inspectors requested and received assurances from the principal social worker that these children would be visited by a social worker without delay.

Inspectors reviewed 22 files of children who were allocated a social worker for the purpose of reviewing the timeframes of statutory visits over a two year period prior to the inspection and found that 12 of the 22 children in care had received statutory visits from their allocated social worker in line with regulations. However, 10 children in care had not received statutory visits in line with regulations. While seven of these children had been visited recently, there remained three children for whom a statutory visit was outstanding. Assurances were sought and received that those who required a statutory visit would be visited by a social worker without delay. Further to this, inspectors found that there were also significant gaps in visits for these children over a two year period. For example, inspectors found that two children had not been visited in eight months, one child had not been visited in ten months, one of those children required a statutory visit every three months as they had been placed in care in the past two years. One child had received only one statutory visit by their social worker in one year.

While there were systems in place in order to monitor and oversee statutory visits to children, this system was not always effective. Team leaders told inspectors that they monitored visits to children by recording the last visits on the child in care register and during supervision where they also reviewed the last visit to the child. Inspectors found that while these mechanisms were in place to monitor visits to children, there remained children who had not received visits in line with regulations. Inspectors found that while the child in care register provided the date of the last visit to the child, it did not include a record of previous visits, therefore could not provide assurances that visits were completed in line with regulations over a two year period. On review of files, inspectors found that case management was also used as a mechanism of monitoring visits to children in care but this was not evident

on all files reviewed. Inspectors found that case management was judged to be of good quality in 19 of 25 files reviewed. However, in six files reviewed there were limited records of case management and as a result they were judged to be of poor quality. For example, two files had no records of case management, two files had one record of case management occurring in a two year period, one file had one case management records in a one year period and one file had no case management records.

The quality of visits to children in care was mixed. In 30 files reviewed, inspectors found that 17 were deemed to be of good quality as the child was seen in private and visited in the foster carer's home in line with regulations and there were records of the visit. A comprehensive support and supervision template was used by social workers which provided a detailed record of the visit to the child and reviewed areas such as the child's health, education, emotional needs and behaviours, family relationships and any issues arising for the child. However, in thirteen files reviewed the quality of the home visits were deemed to be of poor quality due to the visits not being completed in line with timelines prescribed by regulations, lack of records available on the child's files, and where the child had not been seen in private.

Social workers maintained good links with families and they encouraged and facilitated contact between children and their families when appropriate. Inspectors found that 25 of 30 files reviewed for the role of the social worker; there was evidence that social workers had maintained contact and links with children's families while children were in care. Data submitted showed that 100 children had access with family members in the foster carer's home. Inspectors found examples of good practice and social workers ensured that children kept in contact with birth families and siblings and attended family occasions and events. Of the 75 children and young people who responded to questionnaires 61 children (81%) said that see their family and friends regularly.

Social workers coordinated the care of children and the input of other professionals when this was required. Data submitted by the area identified that there were 28 children in care who had a diagnosed moderate to severe disability. The area manager told inspectors that approximately 57 children in care had enhanced placements which meant that these placements were provided with additional supports services or additional financial support based on the needs of the child. The area manager identified that there were good supports available in the area for children requiring services, for example, children and families had access to a therapeutic hub with one psychologist, two trainee psychologists, social care workers to complete individual work with children and two respite centres in the Dublin North East service area.

Inspectors reviewed the files of eight children with varying levels of disability for the purpose of reviewing children's access to specialist services and found that seven children had access to specialist services required. In two files reviewed children did not have an allocated social worker; however the principal social worker and a social care worker were ensuring that these children had the supports required. There was good co-ordination of services and social workers provided supports identified through the care planning process.

Social workers responded appropriately to significant events for children in care. Inspectors found that in seven files reviewed in which significant events had occurred; there were appropriate responses to significant events. For example, in two cases where a child's placement was at risk of breakdown, extra supports were put in place for the child, respite was made available in an effort to maintain the placement and children were referred to appropriate support services. Data submitted by the area showed that there were 12 unplanned endings in the last 12 months. Inspectors reviewed four files where there were unplanned endings and found that these children were offered appropriate supports in the transition period to their new placements. Several visits were undertaken to support the placement, child and foster carers. Fostering link workers advised there were many supports available locally and a significant level of co-working between the children in care and fostering teams occurred to prevent placement breakdowns.

Data submitted by the area indicated that there had been six notifications of children reported as missing in care. However, the data submitted was incorrect as four of those notifications were not related to children in foster care and therefore were not reviewed as part of this inspection. There were two notifications of children in care which related to foster care. Inspectors reviewed one of those files and found that the incident was appropriately responded to.

Data provided by the area prior to the inspection indicated that there were two complaints made by children in the 12 months prior to the inspection. However, during inspection fieldwork inspectors found that this was reported in error and there had been no complaints made by children in the last 12 months. Team leaders and social workers told inspectors that children were provided with information about the complaints process when they were placed in care and when they were visited by their social worker. Inspectors reviewed 16 files for this purpose and found that there was evidence that the complaints process was explained to nine children; however this was not evident in seven files reviewed. Of the 75 children and young people who responded to questionnaires, 42 (56%) said that their social worker had explained to them how to make a complaint, six children said that if they had made

a complaint that they had felt listened to and that the complaint was taken seriously. Four children indicated that they were happy with the outcome of the complaint; two children indicated that they were not happy with the outcome of the complaint and one child did not respond to this question.

There was no mechanism in place to monitor informal or verbal complaints to ensure they were appropriately responded to. As a result of the lack of recording of informal complaints centrally, the management of these complaints was not subject to review or analysed to identify trends in complaints made by children in care. The area manager acknowledged that there was no system in place to track informal complaints and that this required further development in the area. Team leaders indicated that they are trying to improve how complaints are written up.

Records with respect to children in care were held in both paper and electronic files. The National Child Care Information system (NCCIS) went live in this area in July 2018; however NCCIS was not yet fully embedded into practice in this service area at the time of the inspection. A dual system was operated where information was held on paper files and the management team used registers and trackers to support oversight. While some information was on this system for each child in care and all email correspondence was automatically migrated to the system, not all children's data had been migrated onto the system to date and as a result the social workers on the children in care team were using both paper and electronic files. Team leaders identified that the service did not have the appropriate hardware to complete the task of migrating this information to date. The area manager told inspectors that she was aware of each social workers usage of the system and that she anticipated that the use of this system would be increased in a phased way in this service area.

The quality of record keeping in this area was mixed. Inspectors reviewed 30 files for the purpose of reviewing quality of case records and found that 20 files showed evidence of good practice in record keeping for example, comprehensive templates were used to record home visits to children in a consistent way, chronologies and transfer summaries were available on files, and case notes were up-to-date and easily accessible. However, inspectors found that three children's files were of mixed quality and seven files were deemed to be of poor quality due to poor records of visits to the children, gaps in case notes, records which lacked detail and case information and case notes were not available on some files. Inspectors used this electronic system to access some records and found that the system operated slowly. There was no centralised way to save information or naming convention in operation. As a result, it was difficult to access information as social workers uploaded information in different folders and using different headings.

The majority of children in care were allocated a social worker; however a small number were unallocated at the time of the inspection. While there was a duty system in place in order to ensure these children were receiving safeguarding visits these visits were not always completed in line with regulations. There were monitoring systems in place; however these systems were not robust as there were a number of children who had not been visited in line with the regulations. There was no mechanism in place to monitor informal or verbal complaints to ensure they were appropriately responded to. The quality of record keeping in the area was mixed and some records were not available on the child's file. For these reasons the area was judged to be in moderate non-compliance with this standard.

Judgment: Non-compliant Moderate

Standard 6: Assessment of children and young people

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

Summary of inspection findings under Standard 6

Social workers carried out an assessment of need of children when they were placed in care. There was no stand-alone document which was specifically used in this area to outline children's needs when they were initially placed in care. Social workers told inspectors that children would always have an initial assessment completed by the duty social work team on coming into care. The area identified on the dataset that all children referred to Tulsa will have some type of an assessment of need in the form of an initial assessment, family support plan or a child protection plan. When a child is already in care the care plan was the document used to outline the child's assessment of need.

In line with the standards, an assessment of the child's needs should be carried out prior to a child being placed in foster care. In circumstances where a child is placed in an emergency, an initial assessment should be completed within one week of the placement and a comprehensive assessment completed within six weeks.

The service area identified that there were 31 children placed in foster care in the 24 months prior to the inspection. 31 children moved to an alternative foster placement in the last 24 months which included 21 children who moved to residential care, one child who moved home and six young people who are now over the age of 18.

However, the service area did not record the number of assessments that were carried out before the child was placed in care in the last 24 months. The service area also identified that the number of assessments of need that were on-going or number of assessments completed within six weeks following an emergency placement were not available. While the service area identified that all children had some form of an assessment of needs there was no mechanism in place to ensure that there was effective oversight of these assessments and that they were completed in line with the timelines prescribed by standards and regulations.

Inspectors reviewed ten files for the purpose of reviewing children's assessment of needs. Six assessments of need were held in the form of a care plan, two were in the form of court reports and two were contained in initial assessments. Inspectors found that these assessments were timely, comprehensive and included multidisciplinary professional consultation where required. However, two assessments of need held in the form of care plans were not signed off by a team leader in a timely way.

Overall, inspectors found that there were comprehensive assessments of need completed for children in care, which included multidisciplinary consultation. While there was no mechanism in place to ensure assessments were completed in line with the regulations, assessments reviewed were completed in a timely way and for this reason the area was judged to be compliant.

Judgment: 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.

Summary of inspection findings under Standard 7

The management of child in care reviews and care planning was mixed. Data provided by the area in advance of the inspection showed that while the majority of children in foster care (341 out of 441 children) had an up-to-date care plan in line with regulations; a significant number of children (100) did not have an up-to-date care plan and 41 child in care reviews were overdue. The number of children without an up-to-date care plan had reduced to 67 by the first day of inspection. Most of the care plans that were undertaken were of good quality and written in a child-centred manner. Children, foster carers and parents were involved in the care planning

process. Child in care reviews were chaired by team leaders and monitored through a child in care register and supervision.

The process for carrying out child in care reviews was overseen by team leaders. There were no independent chairs for child in care reviews in this service area. Senior social work staff told inspectors that the scheduling of child in care reviews was managed through a child in care register maintained at team leader level and reviews were scheduled two months in advance. The register was reviewed during the inspection. It contained data such as the date of the most recent review, the date of the last review and the date for the next scheduled review. Team leaders entered dates of reviews when they had occurred and then scheduled when the next review was due. Scheduling and planning of reviews was discussed with the allocated social worker during supervision. The child in care reviews were chaired by child in care team leaders. The area had not yet fully implemented the new computer based system in the area. Team leaders told inspectors that when implemented the system will alert staff when care plans and reviews are due to be completed.

Not all child in care reviews occurred in line with statutory requirements. The area reported that there was 41 child in care reviews (9%) overdue at the time of inspection. The area manager identified that there had been a high turnover of staff in the last year. As a result, there was a relatively new social work team in the area and supports had been put in place for the development of the management team. A regional subgroup had also been established in the Dublin North East region with a view to streamlining the child in care review and care planning process. Further to this, the service area also held a learning day with social workers with respect to the child in care reviews and care planning process which involved discussions about enhancing children's participation in the process and shared learning from previous audits completed in the area.

Of the 24 children's files reviewed by inspectors for this standard, 14 child in care reviews (58%) were timely. There were some delays in some child in care reviews occurring in the previous 24 months as six of these 24 child in care reviews had occurred but were overdue by periods of between two and nine months. Four child in care reviews were overdue at the time of the inspection by periods of two to six months. The team leader advised that delays occurred for a variety of reasons, such as staff leave, at the family's request and or availability of professionals but that reviews were rescheduled if this occurred. The team leaders told inspectors that should delays occur due to a team leader being on leave, fostering team leaders would chair the reviews in their absence.

Children were involved in the care planning process. Of the files reviewed by inspectors, five out of 20 school aged children attended their reviews. However, it was clear from all of the files reviewed that children were asked for their views in relation to their care plan, as appropriate. Of the 75 children who completed questionnaires, 57 children (76%) stated that they had a care plan and the six children stated they did not have a care plan. The remaining young people were unsure if they had a care plan. Forty-three young people stated that someone talked to them about their care plan and 33 young people stated that they attended their child in care review. The majority of young people felt listened to.

Parents were involved in the care planning process when this was appropriate. From the children's files reviewed by inspectors, social workers contacted parents to invite them to reviews and should they not be in a position to attend, their views were obtained and documented in the review. Plans for family contact and access were detailed in the child's care plan when relevant.

Foster carers were involved in the care planning process. They attended child in care review meetings and their views were documented in the child in care review minutes. Fostering link social workers told inspectors that they visited foster carers before child in care reviews occurred to assist them in preparing for the meetings. Social workers informed inspectors that they encouraged foster carers to bring details of the child's appointments to reviews. Inspectors observed this detail in the care plans reviewed during inspection. An attendance sheet was signed on the day of the review and the relevant people were informed of the decisions made. The fostering link workers told inspectors that this occurred in a timely manner. One foster carer informed inspectors that when a placement commenced, a meeting occurred to identify what the child needed from the placement. She advised that her views were taken into account and actions occurred based on her views. She also stated that a plan in relation to contact with family members was put in place. She received a copy of the care plan and it was signed by the relevant people.

Voluntary consent for children in care was up to date on all of the 19 files inspected. A principal social worker informed inspectors that following a previous inspection, a file audit was undertaken in the area to ensure that admission to care forms were up to date. The files audits were observed by inspectors in one of the offices and were present on each file inspected. All 19 files had up-to-date admission to care forms. A team leader informed inspectors that the child in care register operating in the area was recently amended and had a new column in relation to the date for when voluntary care expired. A principal social worker told inspectors that all but one admission to care form was up to date and the local register had been updated

accordingly. The register was observed by inspectors during the inspection and showed the information as reported by senior social work staff.

Of the children's files reviewed under this standard, eight were in voluntary care. However it was not clear if re-unification, extending the voluntary consent of parents for the child to remain in care, or securing their legal status through a care order was considered at their child in care reviews, in line with best practice and the Tusla 'Practice Guidance on Voluntary Consent for Admission to Care', approved in July 2017. This guidance outlines a number of best practice principles in relation to voluntary consent, such as the social worker should keep in mind that voluntary consent does not last indefinitely and that timely reviews of such consent should occur in line with the child in care reviews. In some of these cases the foster carers had been granted enhanced rights, therefore re-unification was not being considered.

Unplanned endings or placements at risk of ending were well managed. In line with foster care standards when a placement was identified as being at risk of ending, a review is also held to assess the situation. While reviews were not always held when a placement was at risk of ending, this service area held strategy meetings when a placement was at risk of ending and this occurred in 21 cases. In line with foster care standards when a placement ends in an unplanned way a review is held in order to bring it to a formal conclusion and amend the care plan to take account of the changed circumstances. According to data submitted by the area, there were twelve unplanned endings in the past 12 months. However, data submitted indicated that there were only three reviews or disruption meetings held in the past 12 months following unplanned endings.

While the majority of children in foster care had up-to-date written care plans; information returned by the area prior to the inspection indicated that 100 children did not have an up-to-date care plan, this had reduced to 67 by the the first day of inspection, and 41 child in care reviews were overdue. According to the data set returned to HIQA, 341 (77%) of children in foster care had up-to-date care plans. Inspectors reviewed the quality of 24 care plans. Nineteen (79%) of the 24 care plans were up to date. Most of the care plans reviewed by inspectors were of good quality. Care plans considered the assessed needs of the children and most had clear aims and objectives. They all set out the arrangements made in relation to the children's placement, their education, their health, supports required by the child and foster carers, and supports for the families of children. They outlined the arrangements for the child to have contact with their families, if appropriate. Relevant professionals were consulted and the plan considered whether suitable supports were in place.

Four of the care plans were assessed as being of poor quality documenting 'ongoing' actions rather than identifying set time periods for actions to be completed or reviewed and the care plans were not approved in a timely manner. The area's local child in care review format policy noted that care plans should be updated as soon as possible after the review occurred and at the latest within seven days. Inspectors found that this policy was not always adhered to and there were delays in care plans being finalised. Twenty-one out of the 24 (88%) care plans were signed by the team leader and six of the 24 (25%) care plans reviewed by inspectors were not signed by the team leader within two months following the care plan being developed.

There were initially 100 (23%) children in foster care without an up-to-date care plan, but this figure had reduced to 67 by the first day of the inspection. The area manager told inspectors that overdue care plans should be captured in the caseload management tool but advised that this tool was not used by all team leaders. She told inspectors that should care plans not be up to date, the caseload was not manageable given that staff could not complete this function. She advised that there was a focus on the development of management oversight within the area, for example, to ensure that the caseload management tool was consistently implemented, and monthly to six weekly staff coaching sessions had commenced with principal social workers in 2018. Principal social workers told inspectors that many of the care plans which were overdue relate to children who had recently had a child in care review and some administration tasks were required in order to finalise the care plan. Social workers have been encouraged to schedule administration duties and team leaders are now requesting that care plans are developed prior to the child in care review in order to address this delay. While there was no formalised plan to address the backlog of children in care without an up-to-date care plan, the principal social worker told inspectors that it was anticipated that two social work posts and a team leader post will be filled and child in care reviews and care plans will be up-to-date by November 2019.

Children received specialist supports as agreed in their care plans. A review of the care plans of 10 children with disabilities and or complex needs showed evidence of the involvement of multidisciplinary input in response to all of the children's needs. The supports included specialist disability services, additional educational supports, occupational therapy, life story work and therapeutic supports. Care plans adequately outlined the arrangements in place to address children's long term therapeutic needs and in one case this was not applicable. However, in one case a child was waiting for two years in order to be assessed by disability services. Social workers told inspectors that there were large waitlists for therapeutic supports which can put pressure on placements but funding was approved if required and if all other

options had been exhausted. Senior social work staff informed inspectors that if needs were unmet, the child's case could be presented at the Integrated Case Management meeting. Social workers told inspectors that the use of the integrated area management meetings had assisted in accessing services for children with disabilities. Inspectors reviewed the minutes of these meetings and found that the meetings occurred regularly with robust discussions occurring in relation to the needs of the child. One example of good practice was that a child was referred to the integrated case management committee to proactively plan for when the child would be changing to a different therapeutic service due to the child's age.

The principal social workers used the child in care register in order to monitor child in care reviews and care plans. Case management was also used to monitor a child's last child in care review and when the next review was due. The principal social worker also received reports from the social worker with respect to the status of child in care reviews and care plans for children in care.

Not all children had placement plans. The development of a placement plan is outlined as a requirement in the National Standards for Foster Care, as well as in Tusla's alternative care handbook as a key social work task following the admission of a child to care. The requirement is that all children in care have a separate placement plan which is developed with the child, the allocated child in care social worker and the link worker, with the foster carers. The child's placement plan should detail how the aims and objectives set out in the care plan would be achieved and should outline the ways in which the child's needs would be met on a day-to-day basis.

Ten children out of 19 files reviewed had placement plans on file. Social work staff told inspectors that following the initial placement plan being completed on the commencement of placement of a child, subsequent placement planning is included within the child's care plans. While the child's placement was discussed as part of the care planning and review process, the care plan did not set out how a child's needs would be met on a day-to-day basis.

Care planning and child in care reviews were generally of good quality when undertaken. There was evidence of involving children, their parents and foster carers in the process and of care plans being implemented. However, a significant number of children did not have an up-to-date care plan and child in care reviews did not take place within statutory timeframes for all children. Placement plans were not used in the area in respect of each placement of a child which were consistent with the child's care plan. A placement plan should outline the specific needs of a child in their current placement and set out how the child's needs would be met by foster

carers on a day-to-day basis in line with the child's care plan. For these reasons, the area was judged to be in moderate non-compliance with this standard.

Judgment: **Non-compliant moderate**

Standard 8: Matching carers with children and young people

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

Summary of inspection findings under Standard 8

There was a process in place for the matching of children with foster carers. The social worker submitted a placement request form outlining information about the child's needs to the fostering team. There was a dedicated member of staff on the fostering team who received placement requests. Inspectors found that while placement requests were discussed between the fostering and child in care teams, there were no records of meetings or formal discussions between both teams in relation to children requiring a placement, their specific needs and possible foster carers available with the capacity to meet those needs. While the placement request forms detailed the child's needs a specific part of the form which may have been used to record consultation with the fostering team was not completed on the form. As a result, it was difficult to ascertain how these children were matched with suitable carers to meet their needs.

The service area had limited foster carers which had an impact on the quality of matching undertaken for children in the area. Social workers also told inspectors that there was a shortage of foster carers in the area and as a result there was no pool of foster carers available to enable matching. Data provided to inspectors identified that there were six available foster placements. However, these foster carers were only available as short term or respite placements. As a result of the lack of available placements in the area, a large number of children were placed outside the area and or in private placements.

There were 441 children in care in the area, 162 children were placed within the service area; however 279 children were placed outside the area. During the inspection the principal social worker identified that 85 of those placements outside the area were outside the Dublin region with the remainder 194 children placed within the greater Dublin area but not within the catchment of this service area. The area manager told inspectors that the numbers of children placed outside the area

was due to the geographic location and the population of the area. The area manager identified that recruitment of foster carers is a priority for the area and there was a regional fostering team in place which was dedicated to recruit foster carers in the Dublin North East region.

Data provided by the area identified that there were 31 new admissions to foster care in the past 24 months and that 31 children changed a placement in the past 24 months. Inspectors reviewed 11 files for evidence of matching of children in circumstances of an emergency and planned placement moves. Four of those 11 files related to children being moved to a relative foster care placement. When a new relative placement was being considered there was an initial assessment completed which involved joint visits by the fostering team and the child in care team in order to assess those carers for the proposed placement of a specific child and their specific needs. Three files reviewed related to a child being moved on an emergency basis to a general foster placement. Inspectors found that where children were moved on an emergency basis to general foster carers there were limited records of matching on file. Social workers told inspectors of the efforts made to complete matching; however these records were not on file.

In one file reviewed, it was evident how the lack of available foster carers impacted on the level and quality of matching considered for a child. In this case where a child's previous placement had broken down and they required an emergency placement, there were six short term placements for that child throughout one month duration. A placement request form had been submitted and a strategy meeting had been convened and a bridging placement had been identified. While there was some records which reflected that the child's needs were considered as part of the placement request, social workers advised that accessing foster care placements for teenagers in care was difficult due to lack of carers available.

In four cases reviewed children were moved in a planned way to general foster care placements. In two files of the four planned placement moves, there were placement request forms submitted and there were discussions between the children in care team and the relevant fostering team. Inspectors found in these two cases that there were transition plans in place and children's cultural background and the child's views were considered as part of the placement move. The allocated social worker met with carers and discussed the profile and needs of the children. It was also evident that the children had an opportunity to meet the carers prior to the placement move. In two of the above cases a psychologist was also involved in developing a transition plan for the child's move to a new placement. In the remaining two cases reviewed, while social workers advised that there were

meetings to discuss children's needs and the capacities of carers to meet those needs there was limited evidence on file to reflect these discussions.

Data submitted by the area identified that there were 12 placements where the number of unrelated children placed with foster carers exceeded the number recommended by standards. Inspectors reviewed three files where the number of children placed exceeded standards and found that one of those placements did not have an allocated social worker that monitored the placement at the time of the inspection. In one case reviewed there was evidence of regular strategy meetings as an additional mechanism to monitor and review the placement because it had exceeded numbers recommended by the standards. The principal social worker told inspectors that all placements where the number of children placed exceeded what was recommended by the standards were notified to the foster care committee. Inspectors reviewed area governance meeting minutes and found that these placements were also reviewed at area governance meetings.

Practice in the area showed that social workers tried to ensure that when possible children maintained contact with their local community when placed in foster care. Of the 75 children who responded to questionnaires, 61 (81%) children said that they see their family and friends regularly, 29 (39%) said that they had to change school when they moved placement. Whereas 41 (54%) children said that they did not have to move school when they moved to their foster home and the remaining children did not answer this question. Sixty (80%) children identified that their culture and background was understood and promoted.

Questionnaires completed by children in care identified that 37 (49%) children said that they got to meet with their foster carers before they moved in. However, 28 (37%) children said that they did not meet with their foster carers before they moved in and nine children did not answer this question. Thirty three (44%) children said that they were asked how they felt before they moved, while 16 (21%) children said that they were not asked how they felt before they moved placement and 25 (33%) children did not answer this question.

While the capacity of the foster carers to meet the needs of the children is not always clear at the beginning of a placement, the suitability of long term matches between children in care and the foster carers is considered and approved by the foster care committee six months following the child's placement in order to make a timely decision for the child's future. When the Dublin North City area completed full relative foster care assessments they included the consideration of a long term match for the child that was placed with them as part of the assessment. For children placed in general foster care the area sought to complete children's long

term match as part of the foster carer's review, in order to avoid duplication in information gathering as similar information is gathered for both purposes.

There was a backlog of long term matches to be completed. Data submitted by the area showed that there were 72 children awaiting approval of long term placements and 32 children had been approved for a long term match in the previous 12 months. The area was in the process of completing foster care reviews and a schedule for reviews was in place and was being monitored through area governance meetings. Inspectors reviewed the minutes of foster care committee meetings where long term matches were discussed and found that care plans were submitted for children when a long term match was being considered and there were thorough discussions in respect to the child's long term match in the placement. However, the principal social worker told inspectors that it was not always possible to complete long term matches in the required timeframes. Inspectors found that there were considerable waiting times for some children to be long term matched. For example, in three cases, children had not been approved a long term match for several years. However, in one more recent placement children were long term matched within a 17 month timeframe.

While the area completed some level of matching for children when their placements were planned, the records of formal matching considered by social workers were not always available. The area had limited foster carers available and this also had a significant impact on the quality of matching undertaken for children and foster carers. There was a backlog of children awaiting approval of long term matches. As a result, this area was judged as substantially compliant with this standard.

Judgment: **Substantially compliant**

Standard 10: Safeguarding and child protection

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

Summary of inspection findings under Standard 10

Complaints, concerns, and allegations made by children in care were appropriately assessed, children were met with and appropriate safety measures were put in place where required. However, not all serious concerns and allegations were categorised correctly. In addition, not all serious concerns or allegations were managed in line with Children First (2017) or the interim protocol for managing concerns and

allegations of abuse or neglect against foster carers and section 36 (relative) foster carers.

Data submitted by the area showed that there were 23 child protection and welfare concerns pertaining to children in foster care in the past 12 months of which seven were open at the time of the inspection. There were also seven allegations made against foster carers of which two remained open at the time of the inspection. In addition, there were 20 serious concerns made against foster carers in the past 12 month and six of those remained open at the time of the inspection. Data submitted by the area indicated that there were 10 foster carers about whom an allegation or concern was upheld in the past 12 months. One child had been removed from foster care in the past 12 months due to a child protection and or welfare concerns.

Governance and oversight of all child protection concerns made by children in care required some improvement. Inspectors found that there was a lack of clarity among the social workers with regard to the procedures to be followed when allegations were made by children in care and whether they should be referred through the child protection system. Principal social workers told inspectors that they had a system in place to track both An Garda Síochána notifications and mandated child protection report forms, both of which were recorded on intake forms on the social work department's national childcare information system. However, child protection concerns which were not submitted on a mandated child protection report form or had not been notified by An Garda Síochána were not recorded and collated in the same way. Social workers told inspectors that there was no system in place to collate or track notifications which were not sent in on a mandated report or from An Garda Síochána. Inspectors found that some child protection concerns made by children in care were managed separately by the allocated social worker and these were monitored through supervision of the allocated social worker. As a result, not all child protection concerns were managed in line with Children First (2017). In addition, not all child protection concerns were collated and tracked centrally and some concerns were not subject to the same oversight mechanisms.

Inspectors reviewed three allegations and child protection concerns made with respect to children in care which did not pertain to their foster carers. In two child protection concerns reviewed inspectors found that they had been appropriately classified and reported to the duty social work team and assessed in line with Children First (2017). Strategy meetings were held and appropriate safety measures and additional supports were identified for the children. However, in one of these allegations, while steps were taken to safeguard the child and the child was in the process of being assessed by an external agency, this was a lengthy process which remained on-going ten months following the referral. A child protection report notification was not submitted; there were no strategy meetings held with the duty

social work department and no classification was made as to whether the allegation met the threshold for child protection. Therefore there was no initial assessment completed by the duty social work team and while this child protection concern was overseen by the team leader, there was one record of case management on this file. The concern was not tracked centrally and was not subject to the same oversight mechanisms as all concerns and allegations made by children in care.

Inspectors reviewed four allegations made by children against foster carers. The principal social workers told inspectors that there had been improvements in the management of allegations and serious concerns against foster carers in this area. Strategy meetings were held between both the fostering and the child-in-care team and duty social workers were involved in the strategy meeting, as required, to determine if the concerns reached the threshold for child protection. Allegations made against foster carers were tracked through the use of a register, through discussions at governance meetings and were also notified to the foster care committee.

In three allegations made against foster carers, inspectors found that they had been correctly classified as allegations and referred to the duty social work team in a prompt way. Inspectors found the children were met without delay and appropriate safety plans had been put in place. Social workers ensured that children and foster carers were provided with appropriate supports where this was identified as required. The foster care committee were also notified of the allegations; however these notifications were not always made in a timely way. The delay in notifying the foster care committee of serious concerns and allegations was also highlighted at a management meeting.

However, in one file reviewed, inspectors found that the allegation was not categorised correctly despite recommendations from the duty social work team that the threshold for a child protection concern had been reached. While inspectors found that the allegation was managed appropriately by the social work team and a range of supports were provided to the carers, the concern had not been processed in line with Children First (2017). The principal social worker identified that this decision was made in an effort to maintain the foster care placement. While the child had been met and the appropriate safety measures had been put in place this allegation was not subject to the same governance arrangements as other allegations; such as oversight by the foster care committee and the recording of this concern on the register. In addition, the allegation was not investigated by an independent social work team and an assessment completed in line with Children First (2017), and Tusla's own standard business processes.

The majority of serious concerns reviewed were managed appropriately and immediate safety measures were taken when required. However, inspectors found

that not all serious concerns were managed in line with the interim protocol for managing serious concerns and allegations of abuse and neglect against foster carers and section 36 relative carers. There had been 20 serious concerns made against foster carers in the past 12 months and six of those remained open at the time of the inspection. Inspectors reviewed eight serious concerns made in relation to children in care. The majority of serious concerns reviewed (six) were managed appropriately and immediate safety measures were taken when required. However, while there was evidence that the foster care committee was notified of the outcome of the investigation of serious concerns, inspectors found there were no records of dates of the initial notifications to the foster care committee.

In this service area in an effort to ensure concerns were categorised correctly, when a concern was reported to the social work department, a social worker completed a screening interview prior to the categorisation strategy meeting. In one file reviewed, a concern had been classified as a serious concern although it related to physical abuse. In this case while the concern related to physical abuse, initial screening interviews were completed by the duty social worker and they were deemed to be serious concerns. The concerns were referred to the duty team and there were a number of strategy meetings held in which the duty team were involved and immediate safety measures were put in place. However, in this case, the children had not been met by a social worker for five weeks and while a verbal safety plan had been put in place, the formal safety plan had not been developed for five weeks and had not been signed off at the time of the inspection. There were also delays in notifying these serious concerns to the foster care committee.

In another serious concern reviewed, the child was met with in a timely way and a safety plan had been developed. This child protection notification was also deemed a serious concern despite elements of physical abuse being alleged and the duty social work team were not included in this strategy meeting. Inspectors found that screening interviews were held by the allocated social worker and an independent fostering social worker prior to the strategy meeting in order to determine if it had met the threshold for an allegation. Following the screening interview, it was determined that this concern did not meet the threshold of an allegation. While it was evident that the foster care committee were notified of the outcome of this serious concern, there were no records available of when the foster care committee was first notified. These examples raise a concern that doing a screening interview in advance of a formal initial assessment meant that children could be interviewed multiple times by different people, if the case subsequently went on to be investigated by the duty social worker and An Garda Siochána.

Appropriate safeguarding measures, such as developing a safety plan, were implemented when required when a child in foster care made an allegation or a

serious concern was reported. Inspectors reviewed fifteen files for both serious concerns and allegations and found that safety plans were in place for all files where they were required. However, there was a delay in the development of a formal safety plan in one case.

The quality of safety planning was good. Inspectors reviewed 12 files for the quality of safety planning. Inspectors found that all safety plans were of good quality and included assessment of the parental capacity to safeguard the child, safety plans addressed the identified risk and were monitored by the social work team for implementation. Appropriate supports had been put in place for children and foster carers and safety plans were monitored for implementation. Children were also involved in the development of safety plans when appropriate. However, in one case the safety plan had not been reviewed in a timely way and three safety plans were not signed. In another file reviewed while a verbal safety plan was discussed with the carers, inspectors found that there was a delay of five weeks in the development of a formal written safety plan.

There was good governance and management of child protection and welfare concerns made by children in care against foster carers; however improvements were required to ensure that all allegations made by children in care against other parties were also well managed. All allegations and serious concerns made against foster carers were tracked by the area, which allowed the management team to assess how the allegation was managed. These allegations and serious concerns made against foster carers were also reviewed and discussed at monthly leadership and governance meetings. In addition, these concerns and allegations were notified to the foster care committee and discussed at foster care committee meetings. Inspectors reviewed minutes of foster care committee meetings where the final notifications of the outcome of investigations of serious concerns and allegations were discussed which showed good oversight of allegations, serious concerns and safety plans. Safety plans were also monitored through the use of a tracker by the fostering team. However, these governance mechanisms were not in place to track child protection concerns or allegations made by children in care which did not pertain to those made against foster carers. As a result, appropriate systems were not in place to ensure that these concerns were managed and assessed in a timely way.

There were some good practices in place in the area to ensure that children were protected from abuse. Inspectors found that children had absence management plans which guided foster carers on steps to take if a child goes missing in care. In questionnaires received from 75 children, 63 said that their social worker told them who they could talk to if the felt unsafe. Sixty six children reported that they knew how to keep themselves safe. Social workers told inspectors that children are

provided with information regarding the complaints procedure when they are placed in care. Of the 75 children who responded to the questionnaires 42 children said that their social worker explained to them how to make a complaint.

In line with Children First (2017) foster carers are now considered mandated persons and are responsible for the mandatory reporting of any concerns of a child protection and welfare nature to the duty social work team as appropriate. The area manager identified that while foster carers have had training for mandatory reporting there was no mechanism to track and ensure that foster carers were sending in mandatory child protection reports as required. Social workers also told inspectors that while foster carers were reporting concerns to the allocated social workers, Child Protection and Welfare Report Forms were not always submitted by foster carers. In two cases reviewed, inspectors found that foster carers were informing link social workers and social workers who would report the concern to the duty social work department. However, inspectors found that one of those allegations made by a child in care against a member of the community cited earlier in this report had not been referred to duty and was managed by the child in care team.

There was a system in place to manage complaints in line with Tusla complaints policy. Data submitted showed that there were 19 complaints made by foster carers, parents, family members in the last 12 months. Inspectors reviewed the complaint log and found that seven complaints were open at the time of the inspection. Inspectors reviewed complaints which related to; lack of access, statutory visits not being carried out in line with required timeframes, and the number of social work changes for a child in care. Inspectors found that complaints reviewed were responded to appropriately and in line with policy. Some aspects of complaints were not reviewed due to issues raised being before the courts; however inspectors found that complaints were responded to and meetings to resolve the complaints were held. All principal social workers were dedicated complaints officers and all formal complaints were notified through the area manager's office who maintained a tracker of complaints. This enabled the area manager to monitor when they were received, actions taken on receipt of the complaint and whether it remained open or was resolved.

Data submitted by the area identified that there were no serious incidents regarding children in foster care service in the last 24 months. However, inspectors found that there was one serious incident which was managed and reported appropriately.

Complaints, concerns and allegations were assessed and safeguarding measures were in place as required. However, not all serious concerns and allegations were categorised correctly and therefore not assessed in line with Children First (2017) or the interim protocol for managing concerns and allegations of abuse or neglect

against foster carers and section 36 (relative) foster carers. There was good governance and management of child protection and welfare concerns made by children in care against foster carers; however improvements were required to ensure that all allegations made by children in care against other parties were also well managed. Child Protection and Welfare Report Forms were not being submitted to the social work department by foster carers as required. As a result, the area was judged to be substantially compliant with 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

There was a dedicated aftercare team that comprised of an interim aftercare manager and seven social care staff. The service also relied on two external voluntary services, with a total of five aftercare workers, to provide aftercare services to care leavers in the area. While the interim aftercare manager told inspectors they were responsible for the quality of service provided to all young people, they received reports only in relation to complex cases held by these services. Therefore the service area did not have a robust process or system in place to ensure that all eligible children were receiving a good quality aftercare service. Otherwise these services were governed through a service level agreement that was not available to inspectors at the time of inspection as it was held in the Tusla national office.

The aftercare manager developed a review of adequacy report and service plan for 2019. This report outlined information about young people using the service but did not describe the achievements of the service or review the capacity of the service to meet its objectives. However, the report did set out the priorities for the year ahead, including the need to manage unallocated cases and ensure a stable staff team is in place to provide the aftercare service.

The aftercare team told inspectors that eligibility for an aftercare service was determined in line with the National Aftercare Policy for Alternative Care. The aftercare manager told inspectors that they met with the PSW for children in care twice a year to ensure that children were referred at 16 years of age. The team noted that they do get some late referrals but this had reduced of late. According to data provided by the area, a small number, seven children who were eligible for aftercare had not been referred to the service at the time of inspection. Children were referred by their social worker. One aftercare worker was dedicated to receiving referrals and undertaking the assessment of need for children. In circumstances where this staff member did not have the capacity to respond to referrals, the cases were distributed among the team.

The aftercare manager provided inspectors with up-to-date figures relating to the service that showed that 281 young people were using the service. Twenty young people who were awaiting an assessment of need were assigned to the aftercare worker responsible for carrying out assessments of need. The aftercare manager told inspectors that these cases were then monitored using the tracker in place and discussed in supervision, to ensure they received assessments within four months of referral. This meant that the service had the ability to maintain good oversight of referrals on the waiting list, and to ensure they were allocated for assessment in a timely manner. Two hundred and thirty five of 281 children and young people had an up-to-date aftercare plan and five young people required an updated plan. The remaining plans related to young people under the age of 17.5 years, who did not yet require a plan to be completed. The tracker in use by the service provided the aftercare manager with up-to-date information on the progress of assessments of needs and aftercare plans, and supported their oversight of this aspect of service provision.

When the assessment of need was complete, children were allocated to an identified aftercare worker or to the duty system, based on the level of needs of the child. While the service did not have information leaflets for children regarding the service, records showed that children were given adequate information about aftercare as part of their assessment. Young people who used the aftercare service also told inspectors they were given adequate information about the service. Seven (of 11) questionnaire respondents said they knew what money they were entitled to. Three said they were not sure and one young person said they did not know what their financial entitlements were.

Children in care were involved in the referral to the aftercare service. Referrals required the signature of children and their consent was sought for the aftercare service to consult with relevant people. In all but one file reviewed by inspectors,

children were involved in developing their assessment of need and aftercare plan. The child's social worker continued to have primary responsibility for children up to 18 years of age, and aftercare workers told inspectors they attended child in care reviews to contribute to planning for children leaving care.

Inspectors reviewed files of seven children over the age of 16 years who were referred to the aftercare service. Three were referred between the ages of 16 and 17 years, three were over 17 when they were referred and it was not evident on file when the seventh case was referred. An aftercare needs assessment had been carried out on five of the seven files reviewed, with the two remaining children being under the age of 17.5 years at the time of inspection*. Four of the five assessments completed were carried out in a timely way with appropriate consultation with children. One assessment was not timely and did not include input from the child although efforts were made to involve them.

Five of the files reviewed had an aftercare plan and two of these were good quality. These plans identified the needs of children along with appropriate supports to meet these needs. One further plan had identified all the needs of the child but did not put appropriate supports in place to address one issue. Due to the poor quality assessment completed for the fourth child, the plan in place did not address specific needs. Efforts had been made to involve this child but it was not possible due to the timing of developing the assessment and aftercare plan. In the fifth case, despite having complex needs the referral to aftercare was delayed. While the aftercare service prioritised the case for assessment and planning, there was considerable interagency work yet to be completed in order to plan this child's smooth transition to adulthood. The aftercare manager advised that in complex cases, they accommodate early referrals where possible in order to better plan the transition for children to adult services. However, the late referral of the case reviewed by inspectors had an impact on the ability of the service to plan for this child's transition. Six young people aged 16 to 18 years answered the question on the questionnaire related to aftercare plans. Four respondents said that they had an aftercare plan and that their aftercare worker listened to them, while two young people said that they did not have an aftercare plan.

The steering committee met four times in the year before this inspection. The aftercare manager provided inspectors with a draft review of the steering committee from August 2018 to June 2019 which showed that the committee considered the needs of children with complex needs or disabilities that required a multidisciplinary

* Aftercare legislation requires that assessments of need are carried out by the time children reach 17.5 years.

response. Referrals to the committee were sent by aftercare workers and social workers. The committee was chaired by the aftercare manager and was attended by relevant Tusla staff and two aftercare managers from the voluntary services along with representatives from the local authority, Health Service Executive disability and mental health services, and relevant community organisations relating to housing/homeless services. Housing, mental health and disability were the three main issues that were managed by the committee.

The two main challenges identified in the draft review of the steering committee related to a lack of long term supports for young people with mild learning disabilities and insufficient long term supports for young people with mental health difficulties. Ten of the 31 referrals in this period related to 17 year olds, five related to 18 year olds and the remainder were 19 years and over when they were referred. The draft report noted an increase in the number of 17 year olds referred, but identified that they received no referrals regarding 16 year olds. Sending referrals to the steering committee at an earlier age would allow more time to coordinate and plan for young people with complex needs leaving care.

The aftercare team operated a duty system to ensure that young people who were assessed as not requiring allocation to an aftercare worker had a point of contact in the event that their circumstances changed. In addition, the team operated a drop-in service one afternoon per week. This service was open to former care leavers and young people who were assessed as not requiring an aftercare worker but availed of the drop-in service for practical assistance or information.

The aftercare manager told inspectors about efforts to engage with young people in aftercare. There were three main ways the service achieved this. First, there was a community-based voluntary organisation who provided facilities and weekly events for care leavers. The service also ran a football night to encourage young male care leavers to engage with supports and their community. Finally, services in the area also organised BBQs for care leavers up to four times a year.
There were 215 young people in the 18-22 age group. One hundred and thirty four young people were engaged in training and education as follows:

- 39 (29%) were still in secondary schools
- 30 (22%) were in post-leaving cert courses
- 27 (20%) were in full-time third level
- 37 (28%) were in full-time training
- 1 (1%) was in part-time training

The accommodation arrangements of the 215 young people in the 18-22 age group were as follows:

- 119 (55%) remained with their former foster carers
- 31 (14%) were in residential aftercare
- 12 (6%) were in residential care
- 1 (1%) were in independent housing
- 14 (7%) were in private rented
- 5 (2%) were in social housing
- 3 (1%) were in prison
- 5 (2%) were homeless
- 10 (5%) lived with their birth family
- 7 (3%) lived in college accommodation
- 8 (4%) lived in other arrangements.

Inspectors met with or spoke to 10 young people in aftercare as part of this inspection. Young people were positive about the support they received from aftercare workers. They spoke about the difficulties they experienced in transitioning to adulthood and how aftercare workers had helped them with this.
Young people expressed mixed feelings about the supports connected to education. They understood that the system gave them a chance to get an education but expressed fear that failing exams would mean losing their financial supports and accommodation, resulting in them becoming homeless. Young people described needing different levels of support from aftercare workers at different times, depending on what was happening in their lives, and that this was respected by aftercare workers.

Feelings of loneliness were also named by some young people. Young people who had struggled with their mental health felt that aftercare workers were not equipped to support them with this. Young people said that they got support from aftercare when they reached out to the service for help, but also described the difficulty they had doing this when they were experiencing mental health problems. Some young people also raised their fear that they didn't know who to call in an emergency outside office hours. Aftercare was described as "always there if you need anything". Young people felt they were treated like adults but recognised that "you have to put the work in". "If you want it for yourself, you have to do it".

Three of the seven children's files sampled were referred after they had reached 17 years of age, one assessment of need was not timely or of good quality and there was insufficient coordination of services for one child with complex needs who would be 18 in the coming months. A small number (7) children had yet to be referred to the aftercare service. Therefore some improvements were required to ensure that children were referred at an early stage, especially those with complex needs. However, there were good systems in place to ensure oversight of the assessments

of need and the majority of assessments and aftercare plans reviewed by inspectors were good quality. Improvements were also required in relation to the oversight of children referred to external aftercare service providers, to ensure that the aftercare service provided to these children was in line with standards and legislation. Therefore the area was judged to be substantially compliant with this standard.

Judgment: Substantially 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*

***National Standards for Foster Care* (April 2003)**
Standard 9: A safe and positive environment Foster carers' homes provide a safe, healthy and nurturing environment for the children or young people.
Standard 10: Safeguarding and child protection Children and young people in foster care are protected from abuse and neglect.
Standard 13: Preparation for leaving care and adult life Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.
Standard 14a — Assessment and approval of non-relative foster carers Foster care applicants participate in a comprehensive assessment of their ability to carry out the fostering task and are formally approved by the health board* prior to any child or young person being placed with them. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 5 Assessment of foster parents* *Part III, Article 9 Contract*
Standard 14b — Assessment and approval of relative foster carers Relatives who apply, or are requested to apply, to care for a child or young person under Section 36(1) (d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board. ***Child Care (Placement of Children with Relatives) Regulations, 1995*** *Part III, Article 5 Assessment of relatives* *Part III, Article 6 Emergency Placements*

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

***National Standards for Foster Care* (April 2003)**
Part III, Article 9 Contract
Standard 15: Supervision and support Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.
Standard 16: Training Foster carers participate in the training necessary to equip them with the skills and knowledge required to provide high-quality care.
Standard 17: Reviews of foster carers Foster carers participate in regular reviews of their continuing capacity to provide high-quality care and to assist with the identification of gaps in the fostering service.
Standard 22: Special Foster care Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.
Standard 23: The Foster Care Committee Health boards* have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 5 (3) Assessment of foster carers* ***Child Care (Placement of Children with Relatives) Regulations, 1995***

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

***National Standards for Foster Care* (April 2003)**
Part III, Article 5 (2) Assessment of relatives

National Standard for Foster Care (April 2003)
Theme 3: Health and Development
Standard 11: Health and development The health and developmental needs of children and young people in foster care are assessed and met. They are given information, guidance and support to make appropriate choices in relation to their health and development. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 6 Assessment of circumstances of child* *Part IV, Article 16 (2)(d) Duties of foster parents*
Standard 12: Education The educational needs of children and young people in foster care are given high priority and they are encouraged to attain their full potential. Education is understood to include the development of social and life skills.
National Standards for Foster Care (April 2003)
Theme 4: Leadership, Governance and Management
Standard 18: Effective policies Health boards have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 5 (1) Assessment of foster carers*
Standard 19: Management and monitoring of foster care agency Health boards* have effective structures in place for the management and monitoring of foster care services. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part IV, Article 12 Maintenance of register*

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

Part IV, Article 17 Supervision and visiting of children

Standard 24: Placement of children through non-statutory agencies

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

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

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

Theme 5: Use of Resources

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

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

National Standards for Foster Care (April 2003)

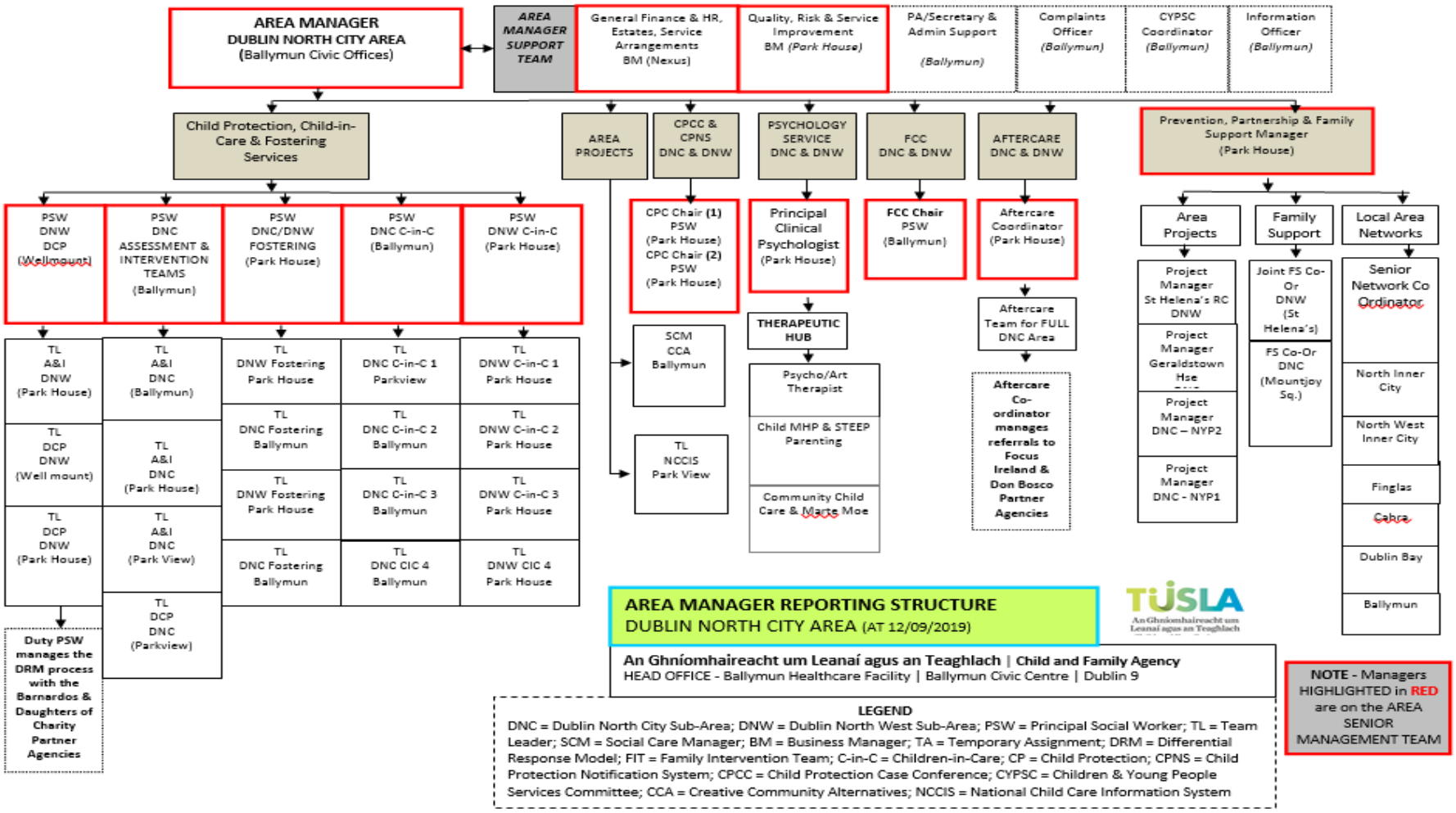
Theme 6: Workforce

Standard 20: Training and Qualifications

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

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

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



* Source: The Child and Family Agency

Action Plan

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

Provider's response to Report Fieldwork ID:	MON 0027322
Name of Service Area:	Dublin North City
Date of inspection:	12-15 August 2019
Date of response:	25/10/2019

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

Theme 2: Safe and Effective Services

Standard 5 – The child and family social worker

Non-compliant Moderate

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

Not all children in foster care had an allocated social worker.

The guidance document for managing unallocated cases required review.

Not all children were visited in line with regulations and systems in place to monitor and oversee statutory visits were not always effective.

The quality of visits to children in care was mixed.

The quality of record keeping was mixed. There were gaps in some case notes, lack of detail and case notes were not available on some files. There was no centralised way to save children records on the electronic system.

Some case management records were of poor quality.

There were no mechanisms in place to monitor informal or verbal complaints to ensure they were appropriately responded to.

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:

- Children waiting allocation will be managed via a waiting list system held by the Principal Social Worker, with tracking of care planning and statutory visits taking place, and in responding to any issues which arise.
- A bespoke campaign for recruitment of PQSW's for Dublin North and Dublin north City areas has commenced.
- Guidance document for managing unallocated cases to be reviewed at DNE regional sub group.

- Going forward, area to record last 2 statutory visits on registers.
- Monthly reports to be sent to the PSW from the Information Officer detailing stat visits that are due within the month and any stat visits that are newly overdue. This report will be used in supervision between the PSW & Team Leader to ensure that care plans and statutory visits are taking place within the required timeframes.
- Internal audits to continue with focus on cases found to be poor quality. Audits will focus on ensuring that children are seen in private; and the visits are recorded. Findings of audits will be shared at team meetings and will be the focus of the 'Learning Days' (approx. 3-4 per year) with the Children in Care Teams.
- Mandatory complaints training to be completed by all staff in the area. Verbal complaints form to be circulated to all staff and all staff to use form and forward to AM office for monitoring, tracking and learning.
- Complaints to be standing agenda item at supervision.
- Complaints leaflet to be sent to all children in care through their carers. Follow up discussion will occur with Social Worker during next visit.

Proposed timescale: March 31st 2020	**Person responsible:** Area Manager & PSW's CIC & Fostering

Standard 7 – Care planning and review

Non-compliant Moderate

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

Not all children (100) had an up-to-date care plan.

A small number of care plans were not of good quality and not all care plans had been signed off by a team leader, in a timely manner.

Not all child in care reviews were held in line with the requirements of the regulations.

Child in care reviews were not always held following a placement breakdown

There was insufficient evidence to reflect case management of care planning and reviews on some files.

Placement plans were not consistently completed and updated when required for all children.

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:

- Monthly reports to be sent to PSW's from Information Officer to provide additional governance in relation to completion of care plans and scheduling of CICR's - This report will be used in supervision between the PSW & Team Leader to ensure that care plans and statutory visits are taking place within the required timeframes.

- Internal audits to continue with focus on care plans that were of poor quality and will ensure supervision records on file. Findings of audits will be shared at monthly team meetings and will be the focus of the 'Learning Days' which take place twice per year in the Children in Care Teams.

- PSW will review outstanding care plans for sign off through regular reports from NCCIS

- All disruptions will be tracked at the Fostering Governance Meeting to ensure that disruption meetings/care plan reviews take place in a timely manner following an unplanned ending of a placement.

• Placement plans to be completed upon placement of a child in a new placement. Some placement plans may not be on the current file – an audit will be conducted to ensure that the placement plan is on the current file. For those children who do not have a Placement Plan, one will be completed at the next visit.	
Proposed timescale: 31st March 2020	**Person responsible:** Area Manager & PSW's CIC & Fostering

Standard 8 – Matching carers with children and young people **Substantially compliant**	
The provider is failing to meet the National Standards in the following respect: There were not enough foster placements available in the area in order to enable robust matching of children. Records of comprehensive matching of children's needs with the capacity of the foster carers to meet those needs were not available. Long term matches were not completed within the required timeframes. There was a backlog of long term matches to be completed. **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:** • The area has a dedicated resource for foster care recruitment. • There is a national campaign for recruitment of foster carers. • A matching record form is to be embedded in Fostering Teams. • Long Term Matches are taking place in the context of Foster Care Reviews. The area has a plan to complete all Foster Care Reviews by November 2019.	
Proposed timescale: **31st March 2020**	**Person responsible:** Area Manager & PSW's CIC & Fostering

Standard 10 – Safeguarding and Child Protection

Substantially compliant

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

Not all allegations and concerns were categorised correctly. As a result not all allegations were managed in line with Children First (2017) or in line with the interim protocol for managing concerns and allegations of abuse or neglect against foster carers and section 36 (relative) foster carers.

There were delays in notifications of serious concerns and allegations to the foster care committee and records of some initial notifications were not always available.

Governance and management of all child protection and welfare concerns made by children in care required improvement.

Mandatory reports of child protection and welfare concerns were not being submitted to the social work department by foster carers as required.

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:

- A register for all child protection and welfare concerns will be maintained in the area. All child protection and welfare concerns will be recorded on NCCIS through intakes.
- Oversight of notifications of serious concerns and allegations to be tracked at fostering and children in care governance meeting with PSW for fostering leading out.
- Children First Officer to attend joint fostering and children in care team meeting to discuss how to support foster cares make mandatory reports.
- A Learning Day on 10/10/2019 will provide training in relation to recording and responding to child protection and welfare concerns

Proposed timescale: 31st March 2020	**Person responsible:** Area Manager & PSW's CIC & Fostering

Standard 13: Preparation for leaving care and adult life

Substantially compliant

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

Improvements were required to ensure that all children, especially those with complex needs, were referred to the aftercare service on reaching 16 years, or as soon as possible thereafter.

The service area did not have a robust process or system in place to ensure that all eligible children referred to external providers were receiving a good quality aftercare service, that was in line with legislation.

Action required:

Under **Standard 13** you are required to ensure that:
Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

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

- Aftercare team to present at area team meeting focusing on young people with complex needs and the need for early referrals.
- List of young people turning 16 to be brought to governance meeting by PSW's in CiC (2 times per year).
- Aftercare worker to alert social worker if referral is required to steering committee.
- Report from partner agencies on all cases allocated to be issued to Aftercare manager in advance of quarterly meeting with partner agencies.
- File audit action plan to be fully implemented.

Proposed timescale: 31st March 2020	**Person responsible:** Area Manager & Aftercare Manager