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:	Carlow Kilkenny South Tipperary
Dates of inspection:	21, 22, 23, 24 May 2019
Number of fieldwork days:	4
Lead inspector:	Ruadhan Hogan
Support inspector(s):	Erin Byrne Sabine Buschmann Susan Geary Sharron Austin Lorraine O'Reilly
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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, 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 53 children in care and 16 young people in aftercare
- meeting with or speaking to 15 children
- interviews/meetings with the area manager, the principal social worker for the children in care team, the principal social worker for aftercare and the child in care reviewing officer
- home visits to eight foster care households
- separate focus groups with children in care social workers, child protection social workers, fostering social workers, team leaders for the children in care team, aftercare workers and with foster carers

- review of the relevant sections of 62 files of children in care as they relate to the theme
- phone calls/meetings with two parents of children in care.

Acknowledgements

HIQA wishes to thank the staff and managers of the service for their cooperation with this inspection, the children in care who completed questionnaires, and the children in care, parents of children in care, 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 Carlow Kilkenny South Tipperary service area had a population of children from the ages of 0-17 years of 63,009.*

The area is under the direction of the service director for Tusla, south region, and is managed by an area manager. There were three principal social workers in the area, who had responsibility for the children in care teams, child in care reviews and the foster care, leaving care and aftercare services.

The long-term children in care team, and the leaving care and aftercare team were based between Clonmel, Kilkenny and Carlow. Three 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 the same offices throughout the service area.

At the time of the inspection there were 321 children in foster care in the area. Of these, 101 children were placed with relatives and the remaining 219 children were placed with general foster carers and one was placed with private foster carers.

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 – 2016 (Tusla website, July 2018)

3. Summary of inspection findings

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

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

In this inspection, HIQA found that, of the seven national standards assessed:

- one standard was substantially compliant
- six were non-compliant, of which three were moderate non-compliance and three were major non-compliance.

The Carlow Kilkenny South Tipperary Service area experienced significant challenges in retaining social workers within the service. The most serious impact of this was that children in care were not allocated a social worker to oversee their placement and ensure their needs were met. This remained an on-going issue within the service area for a long period. For this reason, in addition to the findings from previous HIQA inspections of the area, HIQA met with the Tusla chief operations officer (COO) and service director for the south region in September 2018. The purpose of this meeting was to escalate the service in relation to the retention of social workers, the lack of professional oversight for children in care and the management of allegations.

Following the meeting, written assurances were provided by the Tusla COO outlining the measures to be put in place to address the areas of high risk. This inspection made findings in relation to those areas along with and in the context of evaluating the service that children in care received.

While there were still high numbers of social work vacancies, the area had ensured that staffing for the children in care teams was prioritised. Retention of social workers remained very poor and the senior management team had been ineffective at addressing the high turnover rates of social workers. Inspectors were concerned that staff who spoke with inspectors said they felt they would not be sufficiently protected in the event of making a protected disclosure. This information was brought to the attention of the service director for the south region.

Measures were put in place to address the risk associated with the high levels of unallocated children in care and included ensuring that safeguarding visits to children in care would be undertaken by other workers such as social care workers and fostering link workers. Social care workers were also assigned tasks to complete in the absence of an allocated social worker.

Inspectors did find that significant improvement had been made in how concerns and allegations against foster carers and other allegations made by children in care were correctly categorised, reported, assessed and investigated in a timely manner. The management of allegations and serious concerns against foster carers was of good quality. Safety plans that were required following reports of serious concerns and allegations were of good quality. However, there remained gaps in the governance and oversight of serious concerns and allegations.

The allocation of social workers to children in care was chaotic and was not child centred practice. Inspectors found significant practice and service delivery deficits. Children did not receive visits in line with statutory requirements, the recording of statutory visits was mixed and overall, the quality of visits was poor. Additionally, the oversight of statutory visits to children in care was poor. Systems to manage care planning were disorganised and negatively impacted children. The system for care planning and reviews was poorly managed and resulted in children's needs not being met. Care planning was significantly delayed and of poor quality.

This had a significant impact on children. Significant events involving children in care were not always responded to. Actions agreed at child in care reviews and recorded in care plans were not adequately addressed. Specialist supports as set out in care plans were not always provided. Appropriate child centred links with families were not always maintained on a consistent basis. Due to a delay or lack in the provision of supports, some children's placements in foster care ended in an unplanned manner.

The management of risk and associated safeguarding measures ensured children were visited. However, they were not reliable at ensuring children could disclose potential abuse. Children experienced frequent changes to their allocated social worker and long periods without a social worker. Inspectors found children were allocated multiple workers and received visits from multiple different Tusla professionals. Inspectors concluded that these measures were not effective as a small but significant proportion of children had little opportunities to disclose potential abuse to professionals who were familiar to them.

Aftercare services in the Carlow Kilkenny South Tipperary service area were under resourced and not well established. While business cases had been sought for additional aftercare staff, these requests had been refused by the Tusla service director. Where the social workers and aftercare workers completed assessments of need and aftercare plans, they were of good quality.

Work between the children in care teams and the aftercare team was disjointed and systems to ensure all eligible children were referred to the aftercare service were not effective. While children were involved in planning for their future, this was not always child centred.

There was a formal matching process in place. While the area did not have sufficient numbers of foster carers, they did their best to place children within the area. Where it was possible and appropriate, the area placed children with relative foster carers who knew the children. The area tried to ensure that children maintained their contacts with their local community when they were admitted to foster care.

HIQA received a significant number of reports of unsolicited information from members of the public in relation to the Carlow Kilkenny South Tipperary area. A proportion of the reports related to an alleged lack of response from the social work department to complaints. For this reason, this inspection methodology was expanded to establish how effective the areas policies and procedures were in the management of representations and complaints related to foster care services. Tusla had a formal process for individuals to make a representation or complaint. Inspectors found that complaints made via 'Tell us' were captured appropriately, however, verbal complaints were not recorded in the area's complaint's log and complaints made in writing directly to the area's management team were not appropriately captured and responded to. Inspectors also found that the management of complaints that had been recorded on the complaints register was poor as the responsiveness to these complaints was poor.

Governance and oversight from the senior management team was not effective at appropriately managing risks associated with care planning, particularly where children were not receiving the supports where required. Case management was poor quality as social workers did not receive regular supervision.

Managerial oversight throughout the service area was not effective at ensuring good quality service delivery. For example, inspectors found that prioritisation systems in the aftercare service had not been fully implemented at the time of the inspection. A new principal social worker had been appointed to oversee the children in care departments and she outlined what measures would significantly and

positively impact service delivery. She told inspectors that the retention of social workers was a key priority for her to address.

While, as stated, service delivery was poor, the staff team who spoke with inspectors were engaged, motivated and clearly wanted to provide the best service that they could. The staff team recognised the areas that they thought should be improved and demonstrated to inspectors a commitment to children in care.

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.

Summary of judgments under each standard and or regulation

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

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

National Standards for Foster Care	Judgment
Theme 2: Safe and Effective Services	
Standard 5: The child and family social worker	Non-compliant Major
Standard 6: Assessment of children and young people	Substantially compliant
Standard 7: Care planning and review	Non-compliant Major
Standard 8: Matching carers with children and young people	Non-compliant Moderate
Standard 10: Safeguarding and child protection	Non-compliant Moderate
Standard 13: Preparation for leaving care and adult life	Non-compliant Major
Standard 25: Representations and Complaints	Non-compliant Moderate

What children told us and what inspectors observed

During the inspection, inspectors spoke with 15 children living in foster care in the area. Inspectors received 69 completed questionnaires from children which expressed their views of the foster care service.

What children told us

Children were asked about their experience of foster care. Children and young people spoke positively about their foster carers. Some of the comments made by children and young people included:

- "The thing I like about my foster family is that they help me with everything. If I'm upset or need to talk I go to them and I get everything I need from them"
- "we can go on adventures"
- "I get to stay with my family. If I wasn't I would have been with some random family"
- "I like everything about living here and going to my mum's"
- "everyone is like a family and love each other the same"
- "everyone is helpful in the house if someone needs help we help each other"
- "I love everyone in this family. They always listen to my problems when I'm upset"
- "they always listen"
- "I honestly would love to stay where I am because if I ever got moved somewhere else I just wouldn't be myself anymore"
- "a lot of friends...a lot of pets..."
- "I'm happy just to be safe"

Forty three of the 69 children and young people who completed questionnaires had an allocated social worker. The majority of children and young people who had an allocated social worker saw their social worker regularly, felt they were listened to and felt they could make important decisions about their care. Two children commented "keep up the good work" and "the social worker is very kind".

Inspectors spoke with children who did not have an allocated social worker or experienced multiple changes of social workers. They clearly highlighted that they had a very poor experience of being in care as a result. Children told inspectors that they were tired of "sharing my story over and over", and that "there are so many social workers coming to me then going" and "I was without a social worker for over two years. One was appointed three weeks before I was due to turn 18". Children said they didn't feel listened to. Two children said "I just felt like I wasn't listened to"

and “I don’t get to talk because they always talk over me and I hate that... I sometimes have to say something important and they never listen to me”.

Forty one children out of 69 who completed questionnaires said they had a care plan. Thirty six of the 41 respondents said the decisions in their care plan were explained to them. Twenty three out of 69 children said they did not have a care plan or did not know if they had a care plan. Three children said “care plan means nothing. Things agree and promised not acted upon”, “don't know. I have never seen my care plan” and “care plan is overdue - should have been done in January two years ago”.

Twenty five of the 69 respondents (36%) said they were not invited to attend nor had attended their child care review. Children said the following about attending child care reviews:

- “I don’t go to my reviews because I don’t like them”
- “Why don't I know anything about it?”
- “I wasn’t safe with anyone who was there. I couldn’t wait to come home to (carers)”

Not all children were aware of the complaints process which was available to them. Of the 69 questionnaires which were completed by children, 45% or 31 out of 69 respondents indicated they were not informed about how to make a complaint.

Nine of the 16 respondents aged 16 years and over had an aftercare worker. One young person said “I met my aftercare worker for 5 mins” and another young person said “I am supposed to have an aftercare worker but never met them”. Seven respondents said they had an aftercare plan. All 16 respondents aged 16 years and over said that they were assisted to develop their independent living skills and all attended school/education.

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

Over the year prior to the inspection, the Carlow Kilkenny South Tipperary Service area experienced a significant challenge in retaining social workers within the service. The most serious impact of this was that children in care were not allocated a social worker to oversee their placement and ensure their needs were met. This remained an on-going issue within the service area for a long period. Tusla metrics for the Carlow Kilkenny South Tipperary area identified that throughout 2018, the percentage of children without an allocated social worker remained very high:

Percentage of children in care in the Carlow Kilkenny South Tipperary service area without an allocated social worker				
Year	January- March	April - June	July- September	October - December
2018	15%	47%	32.3%	30.8%
2019	38%	22%*		

Due to the high number of unallocated children in care throughout 2018, HIQA met with the Tusla chief operations officer (COO) and service director for the south region in September 2018 to escalate the service in relation to the retention of social workers, the lack of professional oversight for children in care and the management

* Figure relates to May 2019 as submitted by Tusla as part of the inspection

of allegations. The Tusla response to the escalation of the management of allegations and findings from this inspection are addressed under standard 10 of this report.

In relation to the escalation of the recruitment and retention of social workers in September 2018, the Tusla response outlined that the social worker staffing levels remained very challenging and this was a priority in the Carlow Kilkenny South Tipperary area. The COO stated that vacancies were being reviewed on a monthly basis by the regional workforce planner. Business cases for staff had been completed and approved. Social work vacancies were being filled from the national Tusla panel and bespoke recruitment campaigns were undertaken for specific roles.

While there were high numbers of social work vacancies, the area had ensured that staffing for the children in care teams was prioritised. At the time of the inspection, there were still a high number of staff vacancies in the children in care teams. According to data returned to HIQA, there was six whole time equivalent (WTE) social work posts vacant out of a total of 14.8 WTE posts or 40% vacancies. There was also one social work team leader post vacant. Five senior social worker practitioners had been assigned to the children in care team as a temporary measure. Additionally, there were 12.3 WTE social care workers and two social care managers working in the service. The principal social worker told inspectors that the team was approaching full capacity and work was required to hold onto staff.

Retention of social workers was very poor and the senior management team had been ineffective at addressing the high turnover rates of social workers on the children in care teams in the two years prior to the inspection. According to data returned to HIQA, the staff turnover rate was at 41% which, compared to the Tusla national turnover rate of 8.1% in March 2018, was exceptionally high. One social work team in Clonmel had a 100% turnover over the course of two years. Despite the high turnover, only two exit interviews had been carried out with staff to find out why they left the area. Additionally, the absenteeism rate in the child in care teams was at 38% which was also very high. Both the turnover rate and absenteeism rate impacted on service delivery. After the inspection, the service director outlined that staffing challenges needed to be balanced across the entire service and that some of the issues which influenced staff retention were outside of their control, such as the long history in the area of staff requesting transfer to other areas. He stated that the senior management team were proactive in addressing retention in the children in care teams, following a consultation with staff. These initiatives included the recruitment of extra senior social work practitioners to encourage retention of experienced staff. While these measures were welcomed, at the time of the

inspection, the effectiveness of these measures and the impact on staff retention could not yet be seen.

In relation to the escalation of the lack of professional oversight for children in care in September 2018, HIQA sought assurances on how risks associated with this lack of professional oversight would be managed. In response, Tusla outlined a plan to address these risks. This included:

- Auditing all unallocated children in care with a view to prioritising unallocated children to social workers
- Prioritising allocation of children who are:
    - Children engaged in Court proceedings
    - Children in private residential care
- Ensure that safeguarding visits to children in care would be undertaken by social care workers, fostering link workers.
- Allocating a social care worker to unallocated children in care to undertake specific tasks such as being a point of contact, visiting children, recording visits and actions, obtaining a school report for children and completing forms for child in care reviews.

- According to data returned to HIQA during the inspection, the number of children in care without an allocated social worker was 72 out of 321 or 22% of children. While this demonstrated a steady reduction in the number of unallocated children over the 12 months prior to the inspection, it was still very high. Inspectors reviewed 33 cases for their allocation history and found:

- Eleven children were not allocated a social worker at the time of the inspection
- In total, nine children had long periods of unallocation over the two years prior to the inspection
- 22 were allocated to a social worker at the time of the inspection. However, eleven of these 22 children had been allocated to a social worker between four days to four weeks prior to the inspection due to the recent increase in staff on the team. Five of these children experienced periods of unallocation prior to being allocated a social worker.

The allocation of social workers to children in care was chaotic. Children experienced frequent changes to their allocated social worker and long periods without a social worker. Inspectors found children were allocated multiple workers and received visits from multiple different Tusla professionals. Of the 33 children reviewed by inspectors for allocation history, 17 or 51.5% of cases sampled had changes of

between three and eight social workers in the two years prior to the inspection. 18 of these 33 children had periods of secondary allocation of a social care worker or a fostering link social worker. In addition to allocating secondary workers, inspectors also found instances where social work team leaders and principal social workers were allocated to children on a secondary basis for periods of time. EPIC workers who spoke with inspectors, as part of the inspection, expressed concern with this secondary worker practice, as children were being allocated to Tusla professionals who did not have the authority to make important decisions. They also said children understood these workers did not have the authority to make decisions.

While all of the above measures were put in place in response to the high numbers of unallocated children, it was not child centred practice. Inspectors also found other examples of poor practice due to the management of the allocation of social workers. For example, one social worker had given notice to leave their job and was due to finish in the week after the inspection yet was still allocated new children in care which resulted in more children in care becoming reallocated once this staff member left. Supervision records on files showed that children were allocated to that social worker for short period of time to undertake child in care reviews that were overdue, despite it being known they were to leave the job. This meant that these children in care did not have an allocated social worker to call on or work on their behalf. Overall, plans to manage risk associated with unallocated children resulted in children receiving a limited service.

Foster carers told inspectors that they experienced constant changing of social workers and they made repeated requests for services that had been agreed but subsequently were not arranged. Foster carers were also frustrated with the communication from the social work department and said that even when children were allocated a social worker, they did not get a response. Parents also told inspectors that they found it very difficult to get in touch with a social worker. Children told inspectors that were tired of telling their stories to new people. One child refused to meet a newly allocated social worker due to the high number of social worker changes. Inspectors found that engaging with children in this manner was ineffective and resulted in children actively disengaging with the service that was put in place to oversee their care.

Children did not receive visits in line with statutory requirements. According to data returned to HIQA prior to the inspection, there were 178 children who did not have a statutory visit in the three months prior to the inspection. Inspectors reviewed 33 children in care to establish if they had received the required statutory visits in the two years prior to the inspection. In total, inspectors found that 21 out of 33 children did not have visits in line with the timeframes set out in the regulations. 13

children who were allocated a social worker had not been visited in line with statutory requirements and a further two had inadequate visits as placements were breaking down. Eight children who were unallocated did not have visits in line with the regulations.

The recording of statutory visits was mixed. Of the 31 children reviewed by inspectors for records of visits, 19 had up-to-date records, while 12 did not. Some records were detailed, for example, they outlined the impact on children when their placement broke down and how children settled in new placements when they were moved. Other recording was poor as they did not identify where children were spoken with or who actually spoke to them.

Overall, the quality of visits was poor. Inspectors based this judgment on whether children were visited in the foster care home, seen on their own, if visits were recorded and if visits were in line with statutory requirements. Of the 31 children sampled for the quality of visits, 26 were found to be poor quality.

The oversight of statutory visits to children in care was poor. Oversight of statutory visits to children in care was managed by the social work team leaders who then reported to the principal social worker. Inspectors were informed that case supervision was the primary method of ensuring oversight. Inspectors reviewed 33 cases for evidence of appropriate case supervision and found that 25 did not have records of case supervision. Therefore, the area could not adequately oversee the quality of visits including establishing how many different professionals visited children. Additionally, while lists maintained by area management showed that 178 children did not have a visit from a social worker in the three months prior to the inspection, the area was not able to differentiate whether the last visit to a child was in line with regulations or not. Information technology systems also did not adequately assist the service area in maintaining oversight of statutory visits to children. Consequently the main methods for providing oversight were not reliable and effective at providing a better standard of service.

Appropriate child centred links with families were not always maintained on a consistent basis. Records showed that in some cases, regular supervised contact took place as required. The area established an access team to undertake and oversee access. For children who were subject to on-going Court proceedings, this was a positive initiative to take pressure off social workers in arranging access. However, other records showed that links with families were not encouraged in an appropriate manner. For one child, actions identified as part of care planning was not followed through in a timely manner resulting in a significant delay in establishing appropriate contact with family members. In another case, following a placement breakdown where siblings were separated, the sibling contact was not

being sufficiently facilitated and as a result the relationship drifted. In another case, a review of contact arrangements was significantly delayed and children told inspectors that their wishes were not being taken into account when they had raised concerns with how contact took place.

The area did not consistently ensure that care of children with a disability was appropriately coordinated with the input of other professionals for the purpose of care planning. Inspectors reviewed 15 children who were diagnosed with a disability. In eight out of 15, there were no identified issues with the co-ordination of services. Of the remaining seven, there were identified issues. Three children were unallocated at the time of the inspection and another three, while they had an allocated social worker, experienced significant periods of unallocation. These children did not have a consistent professional to oversee and coordinate their care. In another case, a child had identified therapeutic and psychology needs which services were not provided.

Significant events involving children in care were not always responded to. According to data returned by the area, there were no incidents of children missing from care. However, records showed that other incidents were not appropriately responded to. For example, one placement ended in an unplanned manner and that resulted in siblings being placed in two separate placements. These young children were moved to a new placement by a social worker who had never met them before. This move impacted significantly on the children as they were very upset. Again, this was not child centred practice. In another case, a child displayed behaviours that challenge towards foster carers and there was a delayed response from the social work department.

Staff who spoke with inspectors during focus groups and individually said they felt they would not be sufficiently protected in the event of making a protected disclosure. Social workers told inspectors that while they cautiously welcomed the appointment of the new principal social worker, they did not have confidence in the senior management team for some time. They said they had previously written to the area manager to highlight their concerns in relation to on-going support and guidance, however, the response they received did not provide them with sufficient assurances. When asked about the preparations for this inspection, staff said they did not feel supported and that senior management told them they would be reported to the relevant professional registration authority if their case notes were not up to date. As a result they said they were concerned for their professional registration. When asked about using protected disclosure policy, staff said that due to the senior management response to previously raised issues and the preparation for this inspection, they did not have confidence that making a protected disclosure

would actually provide them with adequate protection when raising concerns. This information was brought to the attention of the service director for the south region who told inspectors that there had been ongoing engagement with staff in relation to the upkeep of case notes. The area manager said that workshops were held with staff in order to support recording of case notes throughout the 12 months prior to the inspection. She also said that she had met with staff on several occasions to remind them of their responsibility to ensure that up-to-date case notes were maintained on childrens records. She stated that addressing performance issues with staff in meetings was part of her role as area manager to ensure staff were held to account for their practice, and that it was in this context that she had made reference to their professional reponsibilites.

The principal social worker told inspectors that while she was new to the children in care role in this area, she had significant experience in a similar role in a different Tusla area. She told inspectors that the retention of social workers was a key priority for her to address. She said that the application of basics through; clarification of roles and responsibilities, regular supervision, appropriate case load management, provision of support and good oversight of social work would help retention. She also said the retention of staff would address relationships with children, impact on the team and relationships with external professionals with whom Tusla rely on. All of which would significantly and positively impact service delivery.

While, as stated, service delivery was poor, the staff team who spoke with inspectors were engaged, motivated and clearly wanted to provide the best service that they could. The staff team recognised the areas that they thought should be improved and demonstrated to inspectors a commitment to children in care.

As stated, the retention of social workers was poor and there were ineffective measures in place to address the high turnover rates of social workers. The allocation of social workers to children in care was chaotic. Inspectors found that the frequent changes to social worker, the number of different workers visiting children, the lack of co-ordination of specialist services particularly for children with a disability had a significant impact on the service provided to children. For this reason, the area was judged to be in major non-compliance with the standard.

Judgment: Non-compliant Major

Standard 6: Assessment of children and young people

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

Summary of inspection findings under Standard 6

The Carlow Kilkenny South Tipperary service area recorded children's assessed needs, including the circumstances of the child and the urgency of need for placement, throughout a variety of documents such as an initial assessment, care plan or in reports produced for Court proceedings. According to data returned to HIQA prior to the inspection, there were 94 children placed in foster care in the 24 months prior to the inspection. Of these 94 children, 23 had moved to an alternative placement within the previous 24 months. The area management acknowledged that they did not routinely record any assessments of need for these 94 children in a stand-alone document and that assessments may not have been completed prior to their placement in foster care. However, they told inspectors that all children in foster care had assessments of need completed to determine if foster care was in the best interests of children.

Inspectors reviewed records for four children who were admitted to foster care in the 12 months prior to the inspection. Inspectors found that assessments of need for children in care were undertaken by social workers and the recording of these assessments depended on how they were taken into care and placed with new foster carers. For example, three cases related to children undergoing care proceedings and their assessments of need were recorded in Court documents and care plans. The fourth child reviewed changed placement in an emergency and their assessment of need was recorded in home visit records and on an initial assessment.

Inspectors found that while assessments of need were comprehensive, they were not always completed in a timely manner. One of the cases reviewed by inspectors related to a child with complex health needs and who remained under medical care prior to being discharged to their foster carers. This assessment was comprehensive, included the participation of children and families where appropriate and was completed prior to being placed with their foster carers. In the other three cases reviewed, the assessments of needs were also comprehensive and included the participation of children and families. However, they were not completed prior to the child being placed with foster carers. Additionally, one child moved placement following an unplanned ending and the assessment of need was not completed within six weeks of the placement being made as required.

While assessments of need were carried out on all children placed in foster care, the timeframes according to which assessments of need were carried out required improvement to ensure they were undertaken prior to their admission to care or as soon as possible for those children placed in an emergency. For this reason, the area was judged to be substantially compliant with this standard.

Judgment: Substantially compliant

Standard 7: Care planning and review

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

Summary of inspection findings under Standard 7

Care planning for children involves holding a child in care review meeting for each child who is placed in the care of the state. Following this meeting, a care plan is to be prepared which outlines how the needs of that child would be met. The 1995 Child Care (Placement of Children in Foster Care) Regulations state that a child in care review is to be held as often as may be necessary in the particular circumstances of the case, but in any event- within the first two months of a child being placed in care, every six months within the first two years of being in care and after that, not less than once in each calendar year. A new structure had been put in place during March and April 2019. The previous principal social worker for children in care was given sole responsibility for oversight of the child in care reviewing service. The area also employed a full time independent child in care reviewing officer to chair child in care reviews and a business support person to process requests and schedule reviews. Following the child in care review meeting, the social workers wrote the care plans for children.

The reviewing officer described to inspectors the process of organising reviews. The children in care social work team were responsible for the timing of a child in care review including prioritisation when a child in care review was to take place. Requests for a review meeting were sent to the reviewing service. Invitations were then sent to relevant individuals such as the child, parents, foster carers, social workers, link workers and child in care staff, advocates and other professionals, such as teachers, mental health professionals, disability key workers and youth workers, who were involved in the child's care. The child's allocated social worker, or if they were unallocated- a social care worker, met with children prior to the review and helped them prepare for the review. They also took their views if they did not wish to attend. Reports were submitted by relevant professionals as required. The reviewing officer said that due to the backlog of child in care reviews, the time allowed for preparation was limited and that social workers had little time to help children prepare for these meetings including encouraging their attendance. She said that changes of social workers and gaps in social work allocation impacted children's engagement in the process as the relationship with social workers was very important and if that wasn't there, the meeting became quite artificial. Of the 69 children and young people who responded to a HIQA questionnaire, 33 said they

were invited to attend their child in care review. Of the 41 children reviewed for care planning, records showed that just five children attended. The reviewing officer said that children's attendance at these meetings was poor and that was something she wanted to improve.

Systems to manage care planning were disorganised and negatively impacted children. Tusla metrics for the Carlow Kilkenny South Tipperary area identified that throughout 2018, the overall number of children in care without an up-to-date care plan fluctuated significantly over the 12 months prior to the inspection:

Percentage of children in care in the Carlow Kilkenny South Tipperary service area who did not have an up-to-date care plan				
Year	January- March	April - June	July- September	October - December
2018	7%	3%	61%	16%

At the time of the inspection the number of children without an up-to-date care plan increased to 47%. These fluctuating figures indicated that the area did not have sufficient systems to ensure children's care planning happened in a sustainable way, in line with the regulations. As a result, the number of children without up-to-date care planning spiked and required intensive work to clear backlogs.

Plans put in place to address the backlog of child in care reviews contributed to poor quality care planning. While there were 304 reviews held in the 12 months prior to 1st May 2019, there remained 191 child in care reviews overdue at the time of the inspection. Records showed that the area management put a plan in place in February 2019 to address the backlog in child in care reviews. This plan stipulated that 12 -16 child in care reviews would be chaired by the child in care reviewing officer and two social care managers each week. The plan specified that the social care manager would only chair reviews whereby there was an allocated social worker and where there were no complex issues. Additionally, a further social worker was to be identified and re assigned to chair child in care reviews. Inspectors found that 23 of 38 cases reviewed for care planning were held in the three months prior to the inspection- the period relating to the plan to address backlog in child in care reviews.

Inspectors found that the majority (22) of the 25 cases were sampled for quality of care planning were poor. Inspectors found that care planning for three children was good quality and these three children received a good service. Some of the records showed that the content of care in care reviews, such as the analysis of children's needs, participation of children and decision making was of good quality. However, the significant delay impacted on the quality. In the other child in care review

records, content was brief and did not sufficiently outline how children's needs would be met. Staff told inspectors that they were not satisfied with how some child in care reviews were chaired, as decisions on important issues such as children's contact with their birth families were to be addressed at future meetings. Records reviewed by inspectors confirmed this. Given the resource demands in the area and the requirement for efficiency, this was inefficient. Additionally, it resulted in decisions that were important for children and their parents, not being taken at child in care reviews which delayed these decisions being taken.

Care planning was significantly delayed. Overall, 38 cases were reviewed by inspectors to determine if child in care reviews were up-to-date and how long of a gap children experienced in this process. Inspectors found that of these 38 cases:

- Eight of these child in care reviews were significantly overdue, between two years and six months and 15 months.
- Of the remaining 30 cases:
    - Three happened within required timeframes. Two of these children received a good service while the third did not, due to a three month delay in writing a care plan.
    - 13 out of 30 sampled for timeliness had gaps of over two years between reviews
    - the remaining 14 had gaps of over a year between reviews

Inspectors found that actions agreed at child in care reviews and recorded in care plans were not adequately addressed. For example, inspectors found that actions related to permanency for children placed under voluntary care agreements, life story work to be undertaken with children, passport applications for children so they could go on holidays with foster carers and acting on children's wishes to change religion were not addressed by an allocated social worker. These were issues that were very important to children and caused them frustration and dissatisfaction with the service they received.

The outcomes of the reviews were discussed with children if they attended the reviews. Of the 69 children who completed questionnaires, 32 or 46% said that social workers had explained to them the decisions taken at their review while 21 or 30% said decisions were not explained to them. The reviewing officer told inspectors that decisions were always explained to children when they attended.

Specialist support as set out in care plans were not always provided. Inspectors sampled eight cases where specialist supports were to be provided. One case record showed that a child who attended a special school, through which specialist supports were appropriately provided. However, as stated, children with a disability were not

consistently provided therapeutic supports such as speech and language and psychology interventions. One child who was severely disabled was assessed as requiring a specialist equipment, despite this, there was a significant delay in procuring the equipment which was provided during the inspection. Records showed that foster carers applied for specialist support for another child when they were not provided by the social work department. The other five children with complex needs were also not consistently provided with specialist supports in a timely manner as set out in care plans. Records showed delays in the provision of psychology and other specialist services. Two of these children were subsequently provided with the supports while the remaining three had not been at the time of the inspection. The area manager said the social workers were to source services through public systems prior to funding being sourced through Tusla for private services. Staff raised concerns with inspectors with the overly bureaucratic procurement system for services that were outside the public system. They told inspectors that this process added significant delays in the provision of services. The delay or in some circumstances, the non-provision of services was of particular concern to inspectors.

Due to a delay or lack in the provision of supports, some children's placements in foster care ended in an unplanned manner. According to data provided by the area, there were eight placements that ended in an unplanned manner in the year prior to the inspection. Inspectors reviewed records of six children whose placements ended before they should have. Two cases, that had allocated social workers who visited regularly, had good quality work undertaken. For example, in one case, records showed that several meetings took place to coordinate services including respite, educational supports and outreach support. Despite the hard work, the placement ended and the child moved to residential care. A third placement ended due to circumstances outside the control of the social work department. In the other three cases, services had not been put in place and the placements ended as a result. These cases had periods of unallocation and gaps in visits. Inspectors found that had services been put in place to support these placements, it was likely that children would have remained with their long term carers.

Placement plans were not in use in the area at the time of the inspection.

According to data returned to HIQA as part of the inspection, there were 127 children in the care of Tusla under a voluntary consent arrangement. The Tusla practice guidance in relation to this area outlines that voluntary consent should not be sought if reunification is seen not to be possible and should not be used indefinitely if it is not in the best interests of children. Inspectors found that ten children either: did not have admission to care forms, the date of duration of their placement had expired or the date of duration of the placement was blank and

hence not recorded. HIQA sought and subsequently received satisfactory assurances in relation to these children. HIQA also requested the area to carry out an immediate audit of the admission to care forms of all children in voluntary care with a view to ensuring that, in each case, the forms were completed in full, the probable duration of the placement was clearly outlined, the consent provided/signed by the parents was up-to-date and the voluntary consent of the parents was subject to ongoing formal review. A satisfactory service improvement plan was subsequently provided by the principal social worker.

Case management was poor quality as social workers did not receive regular supervision. Inspectors reviewed 25 children's records for case supervision and found that 23 did not have evidence of appropriate oversight from a social work team leader or principal social worker. Additionally, as previously stated, the information technology systems also did not adequately assist the service area in maintaining oversight. During interviews with inspectors, the principal social worker for the child in care team acknowledged that there wasn't a consistency in practice for children in care. As stated, she outlined what she thought was required to drive service improvement. She also provided inspectors with copies of service improvement plans that had been drawn up to address child in care reviews, provision of services for children and supervision of staff. Based on these responses and her response to a HIQA escalation relating to voluntary care, referenced above, inspectors were assured that actions would be taken as required.

Governance and oversight from the senior management team was not effective at appropriately managing risks associated with care planning, particularly where children were not receiving the supports where required. While auditing of children in care had taken place since HIQA escalated the service to the Tusla COO in September 2018, systems to formally prioritise children in care were not put in place until the appointment of the new principal social worker in April 2019. As a result, inspectors could not see that children were being systematically reviewed with a view to ensuring they received the right service at the right time.

The system for care planning and reviews was poorly managed and resulted in children's needs not being met. Child in care review meetings were not held within statutory timeframes and actions agreed at previous meetings and written up in children's care plans were frequently not followed through. As a result, children received a very poor service. For this reason, the area was judged to be in major non-compliance with the standard.

Judgment: Non-compliant Major

Standard 8: Matching carers with children and young people

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

Summary of inspection findings under Standard 8

There was a formal matching process in place. The area had a placement committee that was chaired by the principal social worker for fostering and aftercare. She told inspectors that meetings were held monthly or in-between as required. This committee oversaw the placement of children in foster care and considered if the carers had the capacity to meet the child's needs and whether the placement was suitable. A request for a placement for a child was brought to a placement committee for consideration. Children's details were logged on a list and this list was brought to the placement committee for consideration. This list included whether the requests were successful or not following consultation with the foster carers link social worker and was updated after the meeting. Inspectors reviewed minutes from a placement meeting in January 2019. This record showed that children's circumstances was discussed in detail and potential placements were suggested which was evidence of a good quality matching process. Due to the other minutes not being provided in a finalised format, inspectors were not able to evidence if these meetings were held regularly, and if matching was an ongoing and consistently applied process.

While the area did not have sufficient numbers of foster carers, they did their best to place children within the service. According to data provided to HIQA as part of the inspection, there were 14 available placements. One child was awaiting a placement at the time of the inspection. Ten children were placed outside of the area. Social workers and social work team leaders told inspectors that the area did not have a sufficient number of foster carers for the numbers of children who needed to be brought into care. At the time of the inspection, data provided to inspectors showed that there were no foster care households where the number of children exceeded the standards. Inspectors found this was positive as it indicated good practice in relation to ensuring appropriate numbers of children in foster care placements.

Where it was possible and appropriate, the area placed children with relative foster carers who knew the children. According to data returned to HIQA as part of the inspection there were 101 out of 321 or 31.5% of children in care placed with relative carers. The area had a safe process in place when a relative carer was being considered. Placements were visited by a member of the fostering team prior to the child being placed and there was managerial oversight of the process. During the

initial visits, information was to be provided to foster carers to outline the needs of the children and to find out if it could realistically work.

While the area tried to ensure children could meet with foster carers prior to their placement, this did not happen consistently. There was mixed feedback from the 69 children who returned questionnaires as part of the inspection. Thirty five (50%) children said they met or stayed with foster carers prior to being placed while twenty (29%) said they did not. Forty (58%) of children who answered the questionnaire said that they had been asked how they felt about moving to their new foster home while ten (14%) children said that they had not. Inspectors reviewed one case where a child visited a new foster carer prior to the placement proceeding, following the breakdown of their previous placement which was good practice. However, as stated, another case reviewed showed that children were moved in a traumatic manner to foster care placements following placement breakdowns, without the opportunity to visit.

The area tried to ensure that children maintained their contacts with their local community when they were admitted to foster care. Of the 69 children who answered questionnaires as part of this inspection, 52 children said they saw their family and friends as much as necessary, while six children said they did not. Thirteen children said that they had to change school when they moved to their new foster home while 50 remained in their school placements.

There was a significant delay in approving children for long term matches. Despite having approved 63 children for long term matching with foster carers there remained 222 out of 321 or 69% or children awaiting long term matching. The main reasons for this delay was that the long term matching process was inseparable from the foster care review system and the care planning system- both of which had significant delays. While progress was made in reducing the backlog of foster care reviews, there remained a significant number outstanding. In 2017 there were 241 out of 340 or 71% foster carers, that had not had a review in three years. This figure reduced to 156 out of 267 or 58% in 2018. At the time of the inspection, there were 92 out of 247 or 37% of foster carers whose foster care review was overdue. Also, as stated, the number of children whose care plan was overdue was 47%. The consequence of these backlogs was that a significant number of children awaited long term matching which impacted on having permanency in their foster care placement assessed and approved.

When children were put forward to consider the suitability of long term matching, the area had a thorough process. The local area foster care committee considered and approved children for long term matches with foster carers. This process

involved completing a foster care review and submitting the completed review along with a up-to-date care plan for children. Inspectors reviewed four cases that were presented at the foster care committee for suitability of a long term match. Inspectors found that all four had evidence of good quality matching. The reports submitted were comprehensive and the foster care committee made timely decisions on long term matches.

There were mixed findings relating to this standard. While there was a formal matching process in place for accessing foster placements, records provided to inspectors to review were not finalised. There was a significant delay in approving children for long term matches. Child centered practice was not consistently applied to ensure that children always visit foster care homes prior to their placement and appropriate contacts with communities are maintained following their admission to care. For this reason the area was judged to be moderate non-compliance with the standard.

Judgment: Non-compliant Moderate

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

Previous HIQA inspections of the Carlow Kilkenny South Tipperary service area, specifically, inspections of the fostering service in June 2017 and the child protection and welfare service in October 2017 found there were significant concerns with this service areas management of allegations. HIQA received notifications from Tusla and unsolicited information throughout 2018 which indicated that there remained concerns with how allegations made by children in care were being managed. As a result HIQA escalated the ineffective management of allegations to the Tusla chief operations officer (COO) and service director for the south region in September 2018. As part of this escalation, assurances were sought from Tusla on how they intended to address the ineffective management of allegations and assure themselves that measures put in place were working. A subsequent inspection of the child protection and welfare service was undertaken in January 2019 where HIQA inspected management of allegations across the entire service. This May 2019 inspection looked at how allegations made by children in care were being managed.

At the time of this inspection, there had been a significant improvement in how concerns and allegations against foster carers and other allegations made by children in care were correctly categorised, reported, assessed and investigated in a timely manner, in line with Children First (2017).

According to data returned to HIQA as part of the inspection, there were six allegations made against foster carers and 11 serious concerns made against foster carers by children in the 12 months prior to the inspection.

The management of allegations against foster carers was of good quality. Inspectors reviewed four allegations made against foster carers and found they were correctly categorised as allegations that required a response in line with Children First 2017. Preliminary enquiries were undertaken within five days, on all four reports, with three of the reports assessed as requiring an initial assessment. The fourth report was closed at preliminary enquiry stage as the child denied being subject to abuse. In all four cases, investigations were undertaken by an independent social worker and children were spoken with on their own. Of the three cases requiring initial assessments, two had had been completed at the time of the inspection. Both were comprehensive, had good quality analysis and clear outcomes recorded that informed decision making. While the outcome of both allegations was unfounded,

the social work department identified that further supports were required. One of the children had subsequently left the placement and the other remained with the foster carers. The third case was on-going at the time of the inspection and this child had also made the allegation once they had moved from the foster placement. As a result there was no ongoing risks identified. Inspectors escalated one file as a notification to An Garda Siochana had not been made where records indicated that it had. The area management provided satisfactory assurances that the notification was subsequently made.

The management of serious concerns was of good quality. Inspectors reviewed five reports of serious concerns made against foster carers, relating to four cases as one case had two serious concerns. All of the serious concerns reviewed were correctly classified. Records showed that children were met on their own in three cases. One of the five reports made by a child related to a previous foster placement and was subsequently deemed to be unfounded. The other four reports were in relation to three children in their foster placements. Two of these reports were well managed, had comprehensive assessments conducted in a timely manner and were deemed to be unfounded. The last case had two reports of serious concerns against the foster carers. The fostering teams response to the first of these reports was satisfactory. An outcome for this last report was yet to be reached at the time of the inspection.

Safety plans that were required following reports of serious concerns and allegations were of good quality. Two of the nine reports reviewed by inspectors required safety plans. These plans outlined adequate measures to ensure children's safety, were reviewed and monitored on an on-going basis.

According to data returned to HIQA as part of the inspection, there were 135 allegations relating to children in foster care. This figure related to all allegations made including allegations against a foster carers, made by a child against birth families, people in the community or made against the child themselves by another child. Inspectors reviewed four allegations made by children in care that were unrelated to their foster placements. One of these cases was escalated to the principal social worker as safety planning for children was inadequate. Assurances were subsequently received that outlined appropriate safeguarding measures. The remaining three allegations reviewed by inspectors had been investigated and the area demonstrated that these children were safe. Where appropriate, notifications to An Garda Siochana had been made.

There were gaps in the governance and oversight of serious concerns and allegations. Despite the management of allegations and serious concerns being of good quality, further work was required to ensure that actions undertaken were in line with the interim protocol on allegations and serious concerns. For example, only one of the four allegations showed that initial strategy meetings took place between

the fostering and child in care teams to decide the course of action, nor was the rational for not holding the meeting recorded. While three of the allegations had been concluded, only one had a record of an outcome meeting held. Additionally, the foster care committee had been notified in five of the seven reports of serious concerns and allegations where an outcome had been reached. In particular, this had implications for the oversight of these reports so that the area manager could assure herself that they had been appropriately investigated and reported to the foster care committee.

While the management of risk and associated safeguarding measures ensured children were visited, these measures were not reliable at ensuring children could disclose potential abuse. As stated there were on-going difficulties with the retention of social workers in the area. This presented significant difficulties in allocating a consistent social worker to children in care and thus reducing the likelihood that children would disclose their concerns or allegations to a familiar professional. This issue had been risk escalated by the area manager to the Tusla COO and a series of measures were enacted to mitigate against it. Meetings took place between the principal social workers for fostering and children in care, where lists of allocated and unallocated children in care and foster carers were reviewed, to ensure there were no dual unallocated placements. Lists of these placements were maintained and consequently, the service area had no dual unallocated placements. A plan was also put in place to manage this risk by assigning social care workers and fostering link social workers to carry out safeguarding visits to children in foster care.

However, there were adverse consequences to these measures, particularly assigning secondary workers to visit children. As stated, 17 out of 33 or 51.5% of children reviewed for allocation of social workers had changes of between three and eight social workers in the two years prior to the inspection. 18 of these 33 children had periods of secondary allocation of a social care worker or a fostering link social worker. Of the 15 children who were visited by inspectors, five said that they did not feel listened to by the numerous workers visiting their foster placement. Children also said that they would find it difficult to engage with Tusla professionals as a result of the numbers and frequency of professionals visiting them. Of the 69 children who completed a questionnaire, 41 (59%) children said they felt listened to and eight (11%) did not. The evidence collected during the inspection highlighted the impact on children of the safeguarding measures. Inspectors concluded that these measures were not effective as a small but significant proportion of children had little opportunities to disclose potential abuse to professionals who were familiar to them.

The majority of foster carers (92%) had completed mandatory Tusla training regarding their responsibilities as mandated persons as outlined in the Children First 2015 legislation. Foster carers completed an online training course and were issued a certificate following successful completion of the course. According to data provided by the principal social worker for fostering, the area did not have certificates for 33 of 438 foster carers. She told inspectors that some of these foster carers were professionals working in different roles and as such would have completed the training elsewhere. She also said a small proportion of foster carers who were as yet to complete the training were being followed up by relevant staff members to ensure they completed it.

While the area had made significant improvements in the management of allegations and serious concerns, due to difficulties with the retention of social workers and the high levels of unallocated children in care, safeguarding measures put in place to mitigate against this risk were not effective. A more coordinated approach was required to ensure engagement with children was child centred and children felt listened to. For this reason the area was judged to be in moderate non-compliance with the standard.

Judgment: Non-compliant Moderate

Standard 13: Preparation for leaving care and adult life

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

Summary of inspection findings under Standard 13

Aftercare services in the Carlow Kilkenny South Tipperary service area were under resourced and not well established. At the time of the inspection, a small aftercare team comprising of a manager and three aftercare workers was providing a service to 57 young people between the ages of 16-18. Statistics provided by the principal social worker for aftercare showed that 166 young people aged 18-22 were provided an aftercare service in March 2019. Staff told inspectors that the service operated without two staff members for a four month period and one staff member for two years. Records showed that the principal social worker who oversaw the aftercare service had sought additional staff before the inspection. However, inspectors found that these requests had been refused by the service director. The service director told inspectors that developmental funding for the aftercare service for 2019 was not available.

There were measures put in place to support children to develop skills for independent living. The service director told inspectors that social care staff from a Tusla residential centre was redeployed to the area and these workers undertook specific pieces of work with children to help them develop skills for independent living. Additionally, foster carers were provided with training by the area in order to adequately support children during their transition to adulthood. The aftercare workers told inspectors that they assisted young people with attending appointments at community services and helped them source accommodation.

Systems to ensure all eligible children were referred to the aftercare service were not effective. According to data returned to HIQA as part of the inspection, of the 321 children in care, 57 were over the age of 16 and eligible for an aftercare service. Referrals had been made for 45 of these children. This implied that there were 12 children who did not have referrals made. Of the nine children reviewed by inspectors for an aftercare service, all but one child had been referred to the aftercare service. That child had three different professionals assigned in the year prior to the inspection and also experienced long periods of being unallocated. The principal social worker told inspectors that where children did not have an allocated social worker, referrals to the service were not being made. The aftercare team told

inspectors that referrals were dependent on the social workers as there was confusion as to when a referral should be made following the introduction of new aftercare legislation. The area manager told inspectors that she was aware of the delay in referring children to the aftercare service and she said she had highlighted it to social workers and social work team leaders. Despite the various communication between the area manager and the teams, children were not always referred when required.

While children were involved in planning for their future, this was not always child centred. Assessments of need and aftercare plans were completed in conjunction with children where appropriate, when they had been allocated an aftercare worker. However, as referenced earlier in the report, the impact of the numerous changes of social workers and delay in care planning also adversely impacted children and young people's preparation for leaving care up until the point at which aftercare workers were assigned. Five of the nine children and young people reviewed by inspectors for aftercare received a poor child in care service through either periods of unallocation, delays in child in care reviews and/or numerous changes of social workers and other professionals. Records showed that one young person approaching 18 years of age, who had spent their entire life in care, was engaged in aftercare planning meetings. Prior to the planning meeting, this young person had met only one of the Tusla professionals attending the meeting on one occasion. The young person did not know anyone else nor did anyone else know the young person, which was not child centred.

Work between the children in care teams and the aftercare team was disjointed, and the impact of the constant turnover of staff on the children in care teams meant there was not always a consistent link between the two teams. As stated earlier in this report, inspectors found that specialist support as set out in care plans were not always provided. Aftercare staff told inspectors that they had to complete work that should have been undertaken by social work teams as part of care planning for children. This included arranging psychological and psychiatric assessments for children and young people aged 16-18 who had complex needs. Therefore, the aftercare team had additional work to complete in order to prepare children for leaving care. The aftercare team did not always attend all children in care reviews for children approaching leaving care age. Additionally other work, such as the aftercare assessment of need did not happen collaboratively with children in care teams. Aftercare workers said that these assessments should be undertaken with the social workers who know the child best but in practice, this did not happen.

Where the social workers and aftercare workers completed assessments of need and aftercare plans, they were of good quality. According to data returned to HIQA, ten

of the 57 children entitled to an aftercare service were allocated an aftercare worker. Seven of the nine children reviewed by inspectors for an aftercare service were aged over 17 and a half years old and hence were less than six months away from leaving care. The assessment of need for four of these children was completed and was of good quality. Three of these four children were two months away from their 18th birthday and they also had good quality aftercare plans completed outlining all required needs. The other child was four months away from his 18th birthday and an aftercare plan had yet to be written up. However, the three remaining young people were not allocated an aftercare worker, nor was their assessment of need carried out.

A drop-in service for young people over the age of 18 and in receipt of an aftercare service was in place. The principal social worker told inspectors that the area operated three weekly drop-in sessions along with extra sessions in outlining rural areas. However, these sessions were discontinued because they were not well attended.

Prioritisation systems in the aftercare service had not been fully implemented at the time of the inspection. The principal social worker said that a prioritisation system for children in need of an aftercare service was developed; however, she acknowledged that it was not fully implemented. She said that older children at risk were prioritised over children aged 16 who were in stable foster care placements. Staff told inspectors that cases were prioritised on an informal basis through discussion with managers.

The principal social worker provided inspectors with copies of statistics relating to the aftercare service that was produced on a quarterly basis each year. These statistics outlined the numbers of young people in full time education, training, employment, allocated an aftercare worker and with an aftercare plan. The principal social worker provided reports to inspectors on the status of the aftercare service which highlighted challenges for the service such as staffing, late referrals to the aftercare service and appropriate accommodation for young people leaving care. The principal social worker also maintained statistics on young people who left care in 2017 and 2018.

There was no annual review report on the aftercare service produced.

Managerial oversight throughout the service area was not effective at ensuring good quality service delivery. The principal social worker with responsibility for the aftercare service also held responsibility for the fostering service. During interviews with inspectors she said that there were challenges with service delivery. Staffing in

the service was under resourced and she had made several unsuccessful requests for additional staffing for the aftercare service since 2015. She acknowledged that the service was not being delivered as best as it could have been as there was:

- delays in referring children to the aftercare service by the children in care teams due to social workers deficiencies on those teams
- a lack of implementation of prioritising all children in need of an aftercare service
- a lack of coordination between the children in care and aftercare teams
- delays in the completion of assessments of need and aftercare plans.

Staffing issues in the aftercare team had been risk escalated to the area manager. Despite this, the measures in place to manage the risk and improve service delivery were ineffective. The area manager emailed all social workers to remind them to process aftercare referrals which, according to aftercare workers resulted in an increase in the rate of referrals. However, there were little other measures put in place.

There were structures in place to facilitate planning for children in care who had complex needs or disabilities that required a multidisciplinary response. Aftercare steering committees were in place in the Carlow Kilkenny and South Tipperary Areas. The membership of these groups comprised of professionals from the relevant county council, mental health, substance misuse services, disability services, social welfare, children in care teams and the aftercare teams. The service director said that considerable work had been undertaken with adult disability services to ensure communication and service agreements were in place, to enable adequate planning for children with disabilities.

The aftercare team were required to provide young people who left care with support. The aftercare workers told inspectors that a significant proportion of their work was to provide support to young people who had left care. The service utilised an apartment for young people between the age of 17 and a half and 19 years. This service was managed by a homeless agency and provided accommodation to young people for a maximum of six months.

The area did have good practice in relation to the aftercare provision. One child who was previously in care but was not eligible for an aftercare service, was subsequently deemed eligible by the principal social worker and provided an aftercare payment, due to their vulnerability.

The service was poorly resourced and developed, was not meeting the requirements of the legislation, part of the national policy was not implemented and children received a delayed service that did not give them the required time to adequately

prepare for leaving care. For these reasons the area was judged to be in major non-compliance with the standard.

Judgment: Non-compliant Major

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 fida 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 a non-statutory agency.

Summary of inspection findings under Standard 25

HIQA receives unsolicited information from members of the public and professionals in relation to Tusla services which, along with inspections, inform HIQAs monitoring of Tusla services. From the period of the 1st January 2019 until the 21st May 2019, a significant number of reports of unsolicited information, ten in total, were received in relation to the quality of service delivery in Carlow Kilkenny South Tipperary foster care services. An equivalent high rate of unsolicited information was also received during 2018. All of the individuals who contacted HIQA in 2019 told inspectors that despite making a complaint to the social work department, they did not receive a response. Due to this lack of response from the social work department, this inspection methodology was expanded to establish how effective the areas policies and procedures were in the management of representations and complaints related to foster care services.

At the time of the inspection, Tusla had a formal process for individuals to make a representation or complaint. The Tusla 'Tell Us' policy provided guidance on how to make a complaint. Complaints could be made in a variety of ways and included verbally, in writing and through the formal complaints process on the Tusla 'Tell Us' website. Complaints in relation to specific staff members were required to be made in writing or through the 'Tell Us' website. The area had employed a consumer affairs officer (CAO) since November 2018 whose responsibility it was to provide oversight and monitor the progress of complaints including following up with the person identified to investigate the complaint. Complaints made through the 'Tell Us' website were forwarded to the CAO. Prior to the employment of the CAO, the area did not have a singular person fully responsible for the management and the monitoring and oversight of complaints. Therefore, complaints were managed on an ad hoc basis depending on who the complaint was made to. At the time of the inspection, the previous principal social worker for children in care was given responsibility for the management of complaints.

Complaints that were verbally made were not recorded in the area's complaint's log. In line with the 'Tell Us' policy, individuals could made a complaint to the social work department and could verbally express dissatisfaction with service provision to a social worker, social work team leader, principal social worker or area manager. Of the eleven complaints reviewed by inspectors, all related to complaints that were made via letter, email or through the 'Tell Us' Website. None of the complaints related to concerns relayed in person or over the phone. The principal social worker who was responsible for the management of complaints told inspectors that it was not clear how these other complaints were to be captured.

Complaints made in writing to the area were not appropriately captured and responded to. According to data returned to HIQA as part of the inspection, there had been 20 complaints in the 12 months prior to the inspection with 13 complaints open at the time of the inspection. A complaints register was maintained by the CAO and had been established when she began the role in November 2018. This register held details of when the complaint was made, details of the complainant and who was assigned to investigate the complaint. However, this complaints register referenced eleven complaints only and CAO had not been given details of 20 separate complaints referenced on the dataset returned by the area manager.

Email records showed that the CAO requested all managers in the area to notify her of any complaints that had been previously made, so they could be entered onto the register for monitoring and oversight purposes. The CAO told inspectors she continued to receive reports from Tusla employees in the area, relating to complaints that were previously made. For example, she said that the most recent report received was on the week before the inspection and related to a complaint made in 2017. One child, who completed a questionnaire as part of the inspection said that they wrote a letter of complaint in August 2018, with the help of their EPIC advocate, yet had never received a response from the area.

The management of complaints that had been captured on the complaints register was poor as the responsiveness to these complaints was poor. Inspectors reviewed all eleven complaints and found that only two were comprehensively investigated, albeit with delays, and at the time of the inspection were awaiting closure. Nine other complaints had been open for between one and ten months. One of the complaints was awaiting a decision on whether it was a formal complaint or not, with another deemed not applicable to the foster care service. Of the remaining six, one complaint was linked to one of the closed complaints. The other five were assigned to a complaints officer to investigate them just prior to the inspection.

The systems for capturing and managing complaints was in development. It was positive that the area had appointed a dedicated person to provide monitoring and oversight of complaints. However, it was likely that historical complaints and verbal complaints were not responded to. For this reason, the area was judged to be in moderate non-compliance with the standard.

Judgment: Non-compliant Moderate

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

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)

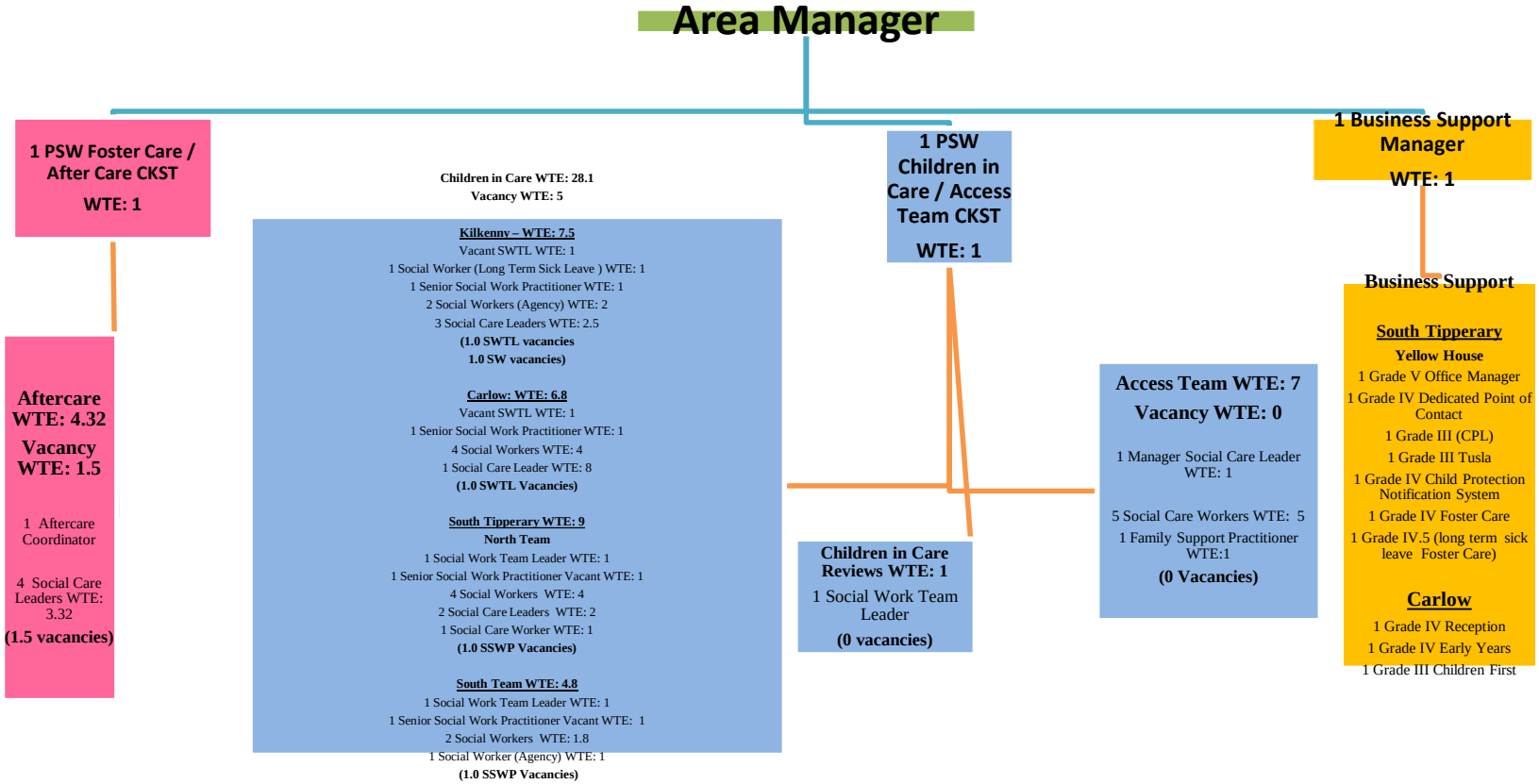
Theme 6: Workforce

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).
* 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 Carlow Kilkenny South Tipperary Service Area*



* Source: The Child and Family Agency

Action Plan

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

Provider's response to Report Fieldwork ID:	MON 0026251
Name of Service Area:	Carlow Kilkenny South Tipperary
Date of inspection:	21, 22, 23, 24 May 2019
Date of response:	12 September 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 Major

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

5.1 Retention of social workers was very poor and senior management had been ineffective at addressing the high turnover rates of social workers.

5.2 The allocation of social workers to children in care was chaotic and not child centred.

5.3 Children did not receive visits in line with statutory requirements.

5.4 The recording of statutory visits was mixed and the quality of visits was poor.

5.5 The oversight of statutory visits to children in care was poor.

5.6 Appropriate child centred links with families were not always maintained on a consistent basis.

5.7 The area did not consistently ensure that care of children with a disability was appropriately coordinated with the input of other professionals for the purpose of care planning.

5.8 Significant events involving children in care were not always responded to.

5.9 Staff who spoke with inspectors said they would not be sufficiently protected in the event of making a protected disclosure.

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:

5.1 Retention of social workers was very poor and senior management had been ineffective at addressing the high turnover rates of social workers.

5.1.1 This Action Plan will be reviewed by the Regional Service Director where a monthly progress report will be forwarded to the Chief Operations Officer until the

end of Q2, 2020. This will ensure greater governance and oversight at regional and national level.

The Area Governance Committee will continue to oversee the actions from this Inspection and the Area Rapid Improvement Plan to support implementation, identify and respond to the risks within the area.

The Area Manager and Service Director, in consultation with Tusla HR will continue to review and implement strategies for the ongoing prioritisation of Social Workers recruitment and retention. This will involve quarterly meetings to review the progress and effectiveness of strategies implemented. The area continues to prioritise the recruitment of social workers for the Children in Care team.

The risk associated with high staff turnover in the Children in Care Team and the control measures to mitigate risk will be reviewed by the PSW and Area Manager on a monthly basis. This will also be reported at Area Governance Committee Meeting. Staff retention initiatives will be kept under ongoing review.

Staffing levels of Children in Care have improved since the Inspection in May.

5.1.2 A comprehensive review of the staffing requirements is currently underway. The assessment will be complete by October 2019 and will make recommendations to the Area Management Team and Regional Service Director.

5.1.3 Six social work posts within the Children in Care team have been upgraded to Senior Social Work Practitioner grade to support and encourage staff retention.

5.1.4 A number of initiatives have been identified by the PSW in consultation with the team and Area Manager, to support and promote staff retention such as:

- Targeted team development and key learning days have taken place and are scheduled for September and October to improve practice. Planned events include extensive training initiatives as well as reflective learning events.
- Feedback will be sought from the team and will be used to assess the effectiveness of such events, as well as areas for improvement or interest for further team days.
- Training has been arranged on legal issues, reviews and care planning and Signs of Safety in September, October and November.
- Proposals have been submitted to the National Project Management Office for training on Lean Management with a specific focus on assisting social workers on time management.

- The Area will participate on a national staff retention group.

5.1.5 The area management team, in consultation with Social Workers, will continue to engage with the local third level colleges and offer a wide range of places to social work and social care students. The next planned event is 4th October 2019.

5.1.6 Exit interviews will routinely be conducted by managers and information from these will be collated by business support to identify themes and learning. This will be presented to the Area Management and Area Governance teams on a six monthly basis.

5.2 The allocation of social workers to children in care was chaotic and not child centred.

5.2.1 The ongoing review and service oversight will continue to prioritise the recruitment of Social Workers for the Children in Care team, as detailed in 5.1.1. Improvement in staffing levels has been achieved since inspection leading to increased allocation of social workers to children in care.

5.2.2 Tracking of social worker allocation and children in care will be undertaken by the Principal Social Worker through NCCIS, this will be reported to the Area Governance Committee on a quarterly basis.

5.2.3 A local area guidance document is in place in respect of children in care awaiting social work allocation. This ensures that there is clear criteria for allocation to a Social Worker and that children receive visits by a named member of staff who has reviewed the file and is under the direction of a Social Team Work Leader. Children in care without their own Social Worker will have dedicated Social Care staff and/or Fostering Link Social Worker who will carry out specified tasks.

5.2.4 Reviews of children awaiting allocation are carried out every 8 weeks. The information from these reviews is used to set priorities for allocation. The reviews are discussed monthly between Social Work Team Leader and Principal Social Worker at supervision**.**

5.3 Children did not receive visits in line with statutory requirements.

5.3.1 Principal Social Worker & Social Work Team Leaders will ensure that all children are visited in line with regulations. This will be recorded on NCCIS case files. A focus programme on completing statutory visits to the end of 2019 is in

place.

A report will be developed on a quarterly basis from NCCIS to track the compliance of statutory visits to Children in Care. Local audits will continue to take place between local QA and the Children in Care Team, to monitor adherence to the standard. Risks will be identified by the PSW and escalated to the local risk register for action and monitoring at Area Management and Governance Committee.

5.3.2 Supervision record has been amended to reflect all information required for oversight, management and compliance such as statutory visit date, Child in Care Review, Care Plan completion, decisions of the review and adherence/completion.

5.3.3 Alert system will be devised and implemented by NCCIS Team with regard to the compliance of statutory visits as per the standards and regulations.

5.4 The recording of statutory visits was mixed and the quality of visits was poor.

5.4.1 Details of all visits are being recorded on NCCIS and reviewed through supervision. This will also provide evidence that the child was seen alone.

5.4.2 The supervision record has been amended to reflect all information needed for oversight of compliance with statutory requirements.

5.4.3 The area commenced a focus group with Children in Care to obtain their views on what children and young people can tell us about how to improve their experience of social work visits. The feedback from these groups will be collated and disseminated to the Children in Care Teams at an event being organised by the Focus Group for December 2019.

5.4.4 Practice Workshops will be held regularly to train and support teams to ensure work is child focused. A mandatory Practice Workshop for the team will take place in October to refresh all team members on the requirements for visits to children in care and recording of same. This workshop will be repeated on a twice yearly basis to ensure new staff are aware of their duties and responsibilities to Children in Care.

5.5 The oversight of statutory visits to children in care was poor.

5.5.1 The supervision record has been amended to reflect all information needed for oversight of compliance with statutory requirements. Records of supervision

will be subject to audit on a 6 monthly basis and will be discussed at Area Governance Meetings.

5.5.2 There is a tracker in place which is supporting team leaders monitoring performance with regard to statutory visits. Challenges to meeting requirements will be brought to the PSW for attention in supervision. Progress will be monitored at Area Governance Committee meetings.

5.6 Appropriate child centred links with families were not always maintained on a consistent basis.

5.6.1 The area will initiate focus groups where possible with families of Children in Care to seek their views on how best to promote and sustain positive contact.

5.6.2 Children in Care reviews now include full discussion relating to contact between children and their families.

5.6.3 Supervision records have been amended to review current contact arrangements between children and their families.

5.7 The area did not consistently ensure that care of children with a disability was appropriately coordinated with the input of other professionals for the purpose of care planning.

5.7.1 The Area is operating the Joint Protocol for Interagency Collaboration between the HSE and Tusla to Promote the Best Interests of Children and Families. A workshop took place in June to appraise staff of the operation of the protocol.

Working groups at area and regional level have been established. The Area Manager and Principal Social Worker for Children in Care attends the Area Working Group. The Regional Service Director and Area Manager attends the Regional Meetings where cases that have been escalated at area level are subject to discussion and planning.

Local area groups between HSE Social Work Manager and Team Leaders have also been established and occur quarterly.

5.7.2 Data from NCCIS is being used to inform the Joint Protocol of Children in Care with a disability, tracking needs, monitoring supports provided by Tusla & HSE and future planning.

5.7.3 HSE services required to provide input to a Child's Care Plan are routinely invited to Child in Care Review by the Reviewing Officers.

5.7.4 Care plans of children with a diagnosed disability will be reviewed by Principal

Social Worker on an annual basis to ensure that they reflect responses to the identified needs.

5.8 Significant events involving children in care were not always responded to.

5.8.1 Workshops on significant events for Children in Care will be undertaken by the Regional Quality Risk and Improvement Manager and will be repeated as required to Children in Care Team to ensure a timely and appropriate response to significant events. Any event that relates to a Child in Care will be reviewed in supervision.

5.9 Staff who spoke with inspectors said they would not be sufficiently protected in the event of making a protected disclosure

5.9.1 Guidance on protected disclosures has been recirculated. Additional briefings relating to Protected Disclosures will take place by the end of Q3. Progress on this action will also be informed by information available from exit interviews with staff as detailed in 5.1.6.

5.9.2 The area continues to consult and engage with staff through staff regular newsletters, surveys, team events and the open invitation to engage with the Area Manager/Management. This feedback will be reviewed and presented at Area Governance Meetings.

5.9.3 The area will review the current mechanism to respond to feedback to ensure that staff ideas and views are taken into account.

5.9.4 A staff broadcast on Protected Disclosures will be issued by the Regional Service Director.

Proposed timescale:	**Person responsible:**
5.1 End of Q2 2020 • 5.1.1 Q2 2020 • 5.1.2 Oct 2019 • 5.1.3 Completed • 5.1.4 Q4 2019 • 5.1.5 Q2 2020	Regional Service Director, Area Manager, Principal Social Workers for Children in Care and Foster care and Business Support.
5.2 End of Q3 2019 • 5.2.3 completed • 5.2.4 Q4 2019	Area Manager, Principal Social Worker for Children in Care, Social Work Team and Social Care Manager.

5.3 End of Q4 2019	Principal Social Workers for Children in Care & Fostering, Social Work Team Leaders & NCCIS Support.
5.4 End of Q1 2020 • 5.4.1 completed • 5.4.2 Q4 2019 • 5.4.3 Q4 2019 • 5.4.4 Q4 2019	Principal Social Workers for Children in Care & Foster Care & Social Work Team Leaders.
5.5 End of Q4 2019	Principal Social Workers for Children in Care & Social Work Team Leaders.
5.6 End of Q1 2020 • 5.6.1 & 5.6.2 Commenced • 5.6.1 Q2 2020	Principal Social Workers Social Work Team Leaders and Child in Care Reviewers.
5.7 End of Q3 2019	Regional Service Director, Area Manager, Principal Social Worker for reviews, Social Work Team Leaders & NCCIS Support.
5.8 End of Q4 2019	Regional Manager QRSI Area Manager & Principal Social Workers Service Director
5.9 End of Q4 2019	Area Manager, Principal Social Workers & Business Support.

Standard 6 – Assessment of children and young people

Substantially compliant

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

Assessments of need were not always completed in a timely manner.

Action required:

Under **Standard 6** you are required to ensure that:
An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

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

6.1 Assessments of need were not always completed in a timely manner.

6.1.1 This assessment of need will be completed in line with National Standards for Children in Foster Care and Tusla Standard Business Processes. Staff will be reminded of the requirements of this standard by way of a refresher memo and discussion at team meetings. Team Leaders will highlight any challenges to meeting this standard in supervision with Social Workers and will report to the PSW.

Proposed timescale:	**Person responsible:**
6.1 End of Q3 2019	Principal Social Worker, Social Work Team Leaders, Social Workers Duty / Intake & Assessment & Child Protection & Welfare.

Standard 7 – Care planning and review

Non-compliant Major

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

7.1 Systems to manage care planning were disorganised and negatively impacted children.

7.2 Plans put in place to address the backlog of child in care reviews contributed to poor quality care planning.

7.3 The quality of care planning was poor.

7.4 Care planning was significantly delayed.

7.5 Actions agreed at child in care reviews and recorded in care plans were not adequately addressed.

7.6 Specialist supports as set out in care plans were not always provided.

7.7 Due to a delay or lack in the provision of supports, some children's placements in foster care ended in an unplanned manner.

7.8 Case management was poor quality as social workers did not receive regular supervision.

7.9 Governance and oversight from the area management team was not effective at appropriately managing risks associated with care planning, particularly where children were not receiving the supports where required.

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:

7.1 **Systems to manage care planning were disorganised and negatively impacted children.**

7.1.1 An alert system on NCCIS will be developed and implemented which will identify the need for a Child in Care review for the Social Worker and Foster Carer in advance of the review.

7.1.2 A diary of Children in Care reviews 2020 has been developed for all Children

in Care reviews for compliance and oversight. This will be maintained and updated by business support.

7.1.3 The NCCIS support team will provide monthly reports of the unallocated children in care, their allocations to a Social Care Leader and review of their information .i.e. reviews, care plans etc., for the attention of the Principal Social Worker who will report to Area Manager in supervision and to the Area Governance Committee.

7.1.4 Quarterly meetings are being held between the Principal Social Workers for Children in Care and Reviews and Reviewing Officers to ensure that reviews are prioritised correctly and take place in a timely manner.

7.2 Plans put in place to address the backlog of child in care reviews contributed to poor quality care planning.

7.2.1 A detailed plan is in place to prioritise and address the backlog of reviews. 100 reviews are scheduled per quarter. Based on figures there is a backlog of 92 reviews as a result. An additional reviewer will be appointed by the end of Q3 to address the issue of outstanding reviews.

7.2.2 Additional Business Support is assisting with the support, planning and recording of reviews.

7.2.3 Any child in care review that is postponed twice will be notified to the Principal Social Worker for Children in Care by the Principal Social Worker for Reviews.

7.3 The quality of care planning was poor.

7.3.1 The area has commenced a focus group with children / young people in care to obtain their views about how to improve their experience of care planning and also ensure their views and complaints are heard and addressed. These groups will also focus on how children and young people can become involved in the care planning process.

The area will continue to engage with EPIC in relation to the above.

7.3.2 An initial finding from these focus groups was that some young people who did not want to attend reviews asked the area to explore various means such as the use of an app to obtain their views and care planning. This is currently under review.

7.3.3 Contact will be made with parents of Children in Care through the Child and Family networks across the area and focus groups facilitated so they can tell us about their experiences of care planning and how improvements can be made.

7.3.4 Focus groups will take place annually with Foster Carers to obtain their views on how we can improve their experience of reviews and care planning.

7.3.5 The findings from feedback will be disseminated to staff and will inform the care planning process and reported to Area Governance.

7.3.6 A workshop on Care Planning is planned for October and will be repeated six monthly for new staff or as required. Local audits will continue to highlight any challenges to meeting this requirement.

7.4 Care planning was significantly delayed.

Refer to 7.1

7.4.1 The Principal Social Worker for Children in Care Reviews will set out a programme to address the backlog of outstanding Children in Care reviews to ensure compliance with National Standards, there are 100 reviews scheduled each quarter.

7.4.2 The NCCIS support team will provide the information for the purposes of tracking reports and will issue a report which will be sent to the Area Manager on a quarterly basis of the reviews that have occurred within the month and those that are due and overdue.

7.4.3 A report will be issued at the commencement of each quarter detailing what is due, activity in the previous quarter and outstanding tasks. This will be reviewed by the Principal Social Workers for Reviews and Children in Care and will be reported to the Area Manager and Area Governance Committee.

7.5 & 7.6 Actions agreed at child in care reviews and recorded in care plans were not adequately addressed. Specialist support as set out in care plans was not always provided.

7.5/6.1 Every review will commence with a check of progress of actions from the previous review.

7.5/6.2 Principal Social Worker & Social Work Team Leaders will complete file audits on a quarterly basis to ensure compliance with above (7.1, 7.2) and quality of care plans.

7.5/6.3 Outcomes of audits will be compiled and learning arising will be discussed at social work team meetings and incorporated into the Area's quality assurance database with the oversight of the Principal Social Worker for quality assurance and will be reviewed at Area Governance Meetings.

7.5/6.4 The designated chair for Children in Care reviews will alert via email Social Work Team Leaders that the review record is completed, and is available on NCCIS for their attention and sign off.

7.5/6.5 Business Support has established a process to ensure timely processing of funding requests for additional therapeutic support to ensure that no placement ends in an unplanned manner due to lack of additional supports. Delays in provisions of supports to children in care with a disability will be reported at Joint HSE/Tusla meetings.

7.7 Due to a delay or lack in the provision of supports, some children's placements in foster care ended in an unplanned manner.

Business Support has reviewed its processes to ensure timely processing of funding requests for additional therapeutic support to ensure that no placement ends in an unplanned manner due to lack of additional supports.

7.8 Case management was poor quality as social workers did not receive regular supervision.

7.8.1 Supervision has been scheduled for the year for all staff.

7.8.2 Principal Social Workers will conduct six monthly audits of supervision files to ensure compliance with Tusla's supervision policy. The outcome of these audits will be reported to Area Manager, Area Governance Committee and recorded on the Area's quality assurance database.

7.9 Governance and oversight from the area management team was not effective at appropriately managing risks associated with care planning, particularly where children were not receiving the supports where required.

7.9.1 This Action Plan and the associated Rapid Improvement Plan will be reviewed by the Regional Service Director where a monthly progress report will be forwarded to the Chief Operations Officer until the end of Q2, 2020. This will ensure greater governance and oversight at regional and national level.

The Area Governance Committee will continue to oversee the actions from this Inspection and the Area Rapid Improvement Plan to support implementation, identify and respond to the risks within the area.

7.9.2 The Area Governance Committee will review the data in relation to care planning and reviews on an ongoing basis. A report will be issued on a quarterly basis from NCCIS to the Area Manager, Principal Social Worker and Social Work Team Leader with regard to compliance, non-compliance and drift of care plans and reviews. This will be presented to the Area Governance Committee.

7.9.3 NCCIS will include all data relevant to Children in Care in the quarterly statistical report to the Area Management meeting and to the Area Governance committee.

7.9.4 The NCCIS support team will attend the Children In Care Review Oversight group meetings quarterly to provide an overview, analysis and trends of issues arising in the Children in Care service.

7.9.5 The Area Manager will continue to escalate cases to the Regional Service Director where children are not receiving the supports required, through the Need to Know process.

7.9.6 See 5.7.1 The Regional Service Director and Area Manager will continue to attend the regional HSE/Tusla Joint Protocol meetings and will escalate cases as required.

Proposed timescale:	**Person responsible:**
7.1 - End of Q1 2020 • 7.1.1 Q1 2020 • 7.1.2 Q3 2019 • 7.1.3 Q4 2019 • 7.1.4 Q3 2019	Principal Social Workers, Business Support, Social Work Team Leaders, NCCIS Support.
7.2 – End of Q3 2019	Business Support Manager, Principal Social Workers for Children in Care reviews and NCCIS Support.
7.3 - End of Q1 2020 • 7.3.1 Q3 2019 • 7.3.2 Q4 2019 • 7.3.3 Q1 2020 • 7.3.4 Q2 2020 • 7.3.5 Q2 2020 • 7.3.6 Q4 2019	Principal Social Workers for Children in Care and Foster Care, Social Work Team leaders, Senior Manager for Partnership Prevention and Family Support.

7.4 – End of Q1 2020 • 7.4.1 Q4 2019 • 7.4.2 Q4 2019 • 7.4.3 Q1 2020	Principal Social Workers for Child in Care reviews & Social Work Team Leaders.
7.5 & 7.6 – End of Q3 2019 • 7.6.1 Q3 2019 • 7.6.2 Q4 2019 • 7.6.3 Q1 2020 • 7.6.4 Q4 2019 • 7.6.5 Q3 2019	Principal Social Workers & Social Work Team Leaders, Child in Care Reviewers, Business Support.
7.7 Completed	Business Support
7.8 - End of Q4 2019	Principal Social Workers & Social Care Team Leaders.
7.9 –End of Q4 2019	Regional Service Director & Area Manager.

Standard 8 – Matching carers with children and young people

Non-compliant Moderate

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

8.1 While the area tried to ensure children could meet with foster carers prior to their placement, this did not happen consistently.

8.2 There was a significant delay in approving children for long term matches

Action required:

Under **Standard 8** you are required to ensure that:
Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

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

8.1 While the area tried to ensure children could meet with foster carers prior to their placement, this did not happen consistently.

8.1.1 Social Work Team Leaders will oversee a plan of introduction for children, parents and foster carers including a plan for any proposed move. The area utilises "This is Us" photobook of foster carers and will be shared with children in advance where possible.

8.1.2 Link workers will ensure foster carers have appropriate information prior to any possible placement.

8.2 There was a significant delay in approving children for long term matches.

8.2.1 Principal Social Worker & Social Work Team Leaders will undertake a review of children where long term matches have not been made. Any outstanding matches will be addressed at the next Child in Care review.

8.2.2 The Chairperson of the Foster Care committee will prepare a report every six months detailing long term matches agreed and any trends / details or issues that have arisen. This report will be disseminated to the Area Manager and Principal Social Workers for the Fostering and Children in Care Services.

Proposed timescale:	**Person responsible:**
8.1 – End of Q3 2019	Principal Social Workers for Children in Care & Fostering and Social Work Team leaders
8.2 – End of Q1 2020	Chairperson FCC & Principal Social Workers for Fostering & Children in Care

Standard 10 – Safeguarding and Child Protection

Non-compliant Moderate

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

1. There were gaps in the governance and oversight of serious concerns and allegations.

2. While the management of risk and associated safeguarding measures ensured children were visited, these measures were not reliable at ensuring children could disclose potential abuse.

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:

10.1 There were gaps in the governance and oversight of serious concerns and allegations.

10.1.1 In line with National Procedures the Fostering Principal Social Worker & Social Work Team Leaders will continue to notify the Foster Care Committee of all allegations and significant concerns in relation to Foster Carers. The Principal Social Worker for Fostering will continue to ensure that outcomes of assessments are forwarded to the Foster Care Committee.

10.1.2 The Principal Social Worker for Fostering and the Chair of the Foster Care Committee will be responsible for updating the tracking system of serious concerns and allegations on a monthly basis.

10.1.3 A quarterly report will be presented at the Area Governance Committee by the Principal Social Worker for Fostering in relation to all allegations / significant concerns made against Foster Carers.

10.1.4 Business support for NCCIS provides a monthly report to Social Work Team Leaders and Principal Social Workers in relation to new referrals relating to children in care. This ensures Social Work Team Leaders have oversight of all new referrals relating to Children in Care.

10.2 While the management of risk and associated safeguarding measures ensured children were visited, these measures were not reliable at ensuring children could disclose potential abuse.

10.2.1 Training workshops will be provided to staff undertaking direct work with children which will have a focus on difficulties that Children in Care have in disclosing potential abuse.

10.2.2 Workshops on managing referrals and significant events for Children in Care have been undertaken and will be repeated as required to ensure that staff are aware of the need to have a timely and appropriate response to significant events.

10.2.3 Social Workers will meet with children privately during statutory visits. Social Workers will ensure visits take place both within and away from the placement.

10.2.4 The frequency and quality of visits will be monitored through the supervision process and quarterly file audits undertaken by Social Work Team Leaders and Principal Social Worker.

Proposed timescale:	**Person responsible:**
10.1 – In Place	Principal Social Workers for Children In Care, Foster Care, Chair of the Foster Care Committee & Business Support.
10.2 – End of Q4 , 2019	Principal Social Workers & Workforce Learning & Development.

Standard 13: Preparation for leaving care and adult life

Non-compliant Major

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

1. Aftercare services in the Carlow Kilkenny South Tipperary service area were under resourced and not well established.

2. Systems to ensure all eligible children were referred to the aftercare service were not effective.

3. While children were involved in planning for their future, this was not always child centred.

4. Work between the children in care teams and the aftercare team was disjointed.

5. Prioritisation systems in the aftercare service had not been fully implemented at the time of the inspection.

6. There was no annual review report on the aftercare service produced.

7. Managerial oversight throughout the service area was not effective at ensuring good quality service delivery.

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

13.1 Aftercare services in the Carlow Kilkenny South Tipperary service area were under resourced and not well established.

13.1.1 An assessment of the staffing requirements to meet current service demands is currently underway at National and Area level with the aim of developing sustainable staffing for Aftercare. Following this, a Business Case for service development will be submitted for 2020 development considerations nationally. In the interim 2 temporary staff will be engaged to undertake focussed work on aftercare planning and support.

13.1.2 The Aftercare Manager's post has been created in the Area and is currently being regularised in accordance with a national agreement.

13.1.3 The vacant post in aftercare is currently in the recruitment process.

13.2 Systems to ensure all eligible children were referred to the aftercare service were not effective

13.2.1 All children aged between 16 to 18 have been prioritised to ensure that the area meets its requirements under legislation. To assist in planning for aftercare, a six monthly report will be generated through NCCIS on details of young people aged 16 and 17 years. This will ensure timely referral to aftercare service. These will be issued to Principal Social Workers and Social Work Team Leaders.

13.2.2 Supervision record forms have been amended to incorporate discussion of aftercare referrals for when a child is aged 16 years.

13.2.3 The Aftercare team are invited to all children in care reviews for all young people aged 16 and 17 years.

13.2.4 Business support to the children in care review service will track aftercare referrals and ensure that all young people eligible for Aftercare are referred prior to the care plan/review meeting in their sixteenth year.

13.3 While children were involved in planning for their future, this was not always child centred.

13.3.1 The Area is conducting focus groups with young people in care and will obtain their views on what children and young people can tell us about planning for aftercare.

13.3.2 Young people aged 17 years will be prioritised for allocation to a social worker and this allocation will take into account the need for stability in relationships and care planning at this transitional stage.

13.4 Work between the children in care teams and the aftercare team was disjointed

13.4.1 Principal Social Workers for Aftercare and Children in Care along with the Aftercare Manager will undertake workshops on Aftercare services and legislative requirements to Children in Care and Aftercare Teams.

13.5 Prioritisation systems in the aftercare service had not been fully implemented at the time of the inspection.

13.5.1 The Area has developed and is implementing a prioritisation protocol for Aftercare. This has been disseminated to Aftercare and Children in Care Teams.

13.6 There was no annual review report on the aftercare

Service produced.

13.6.1 The Principal Social Worker for Aftercare and Aftercare Manager will prepare an annual review report for 2019 which will be reviewed and discussed at Area Governance and Area Management Meeting.

13.7 Managerial oversight throughout the service area was not effective at ensuring good quality service delivery

13.7.1 Aftercare will be prioritised in supervision between the PSW for Aftercare and Area Manager. The PSW for Aftercare will advise the Area Manager regarding allocation, needs assessments and aftercare plans at each supervision session.

Proposed timescale:	**Person responsible:**
13.1 – End of Q2 2020 • 13.1.1 Q4 2019 • 13.1.3 Q4 2019 • 13.1.3 Q3 2019	Service Director, regional HR, Area Manager, Business Support Manager & Principal Social Worker for Fostering and Aftercare.
13.2 – End of Q3 2019	Principal Social Care Worker for Child in Care reviews and Social Work Team Leaders and Business Support Manager.
13.3 – End of Q4 2019	Principal Social Worker for Children in Care, Fostering and Aftercare.
13.4 – End of Q3 2019	Principal Social Worker for Fostering and After Care and After care Manager.
13.5 – End of Q3 2019	Principal Social Worker for Fostering and After Care and After care Manager.
13.6 – End of Q1 2020	Area Manager, Principal Social Workers for Fostering and After Care, After Care Manager & Principal Social Worker for Children in Care.
13.7 - End of Q3 2019	Area Manager & Principal Social Worker for After Care.

Theme 1: Child Centred Services

Standard 25 – Representations and Complaints

Non-compliant Moderate

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

25.1 Complaints that were verbally made were not recorded in the area's complaint's log.

25.2 Complaints made in writing to the area were not appropriately captured and responded to.

25.3 The management of complaints that had been captured on the complaints register was poor as the responsiveness to these complaints was poor.

Action required:

Under **Standard 25** you are required to ensure that:
Health Boards have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fida 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 a non-statutory agency.

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

25.1 Complaints that were verbally made were not recorded in the area's complaints log.

25.1.1 Workshops have taken place and will be repeated as necessary with all staff on the Tell Us Feedback and Complaints Policy and Procedure; these will have a focus on children being aware of how to make a complaint. All Social Workers will be asked to issue Tusla leaflets on complaints and explain the process to children and young people.

25.5.2 All staff will record verbal complaints on a standard template for input on NIMS.

25.2 Complaints made in writing to the area were not appropriately captured and responded to.

25.2.1 All written complaints received will be entered on NIMS. All NIMS registered complaints will be acknowledged in writing, which will ensure that complaints are properly captured and responded to.

25.2.2 All Principal Social Workers in the area are delegated Complaints Officers.

Two additional Complaints Officers have been assigned to manage complaints.

25.2.3 NIMS User Access Training has been arranged for all Area Complaints Officers.

25.3 The management of complaints that had been captured on the complaints register was poor as the responsiveness to these complaints was poor

25.3.1 All open complaints recorded on NIMS will be reviewed by the Complaints and Feedback Management Team on a monthly basis for compliance with Tell Us Policy and Procedure.

25.3.2 The responsiveness to complaints will be audited on a quarterly basis by the PSW for Complaints and Business Support. The outcome of these audits will be reviewed and discussed at the Area Governance Committee as well as discussion at Area Management and Team meetings.

25.3.3 Feedback on complaints including trends will be discussed and disseminated at team meetings so that staff are fully aware of issues arising and any learning can be shared.

Proposed timescale:	**Person responsible:**
25.1 – End of Q3, 2019	Principal Social Workers for reviews & Complaints & Business Support
25.2 – End of Q3, 2019	Principal Social Workers for reviews & Complaints & Business Support
25.3 – End of Q4, 2019	Business Support Manager & Area Manager

Action Plan

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

Provider's response to Report Fieldwork ID:	MON 0026251
Name of Service Area:	Carlow Kilkenny South Tipperary
Date of inspection:	21, 22, 23, 24 May 2019
Date of response:	12 September 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 Major

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

5.1 Retention of social workers was very poor and senior management had been ineffective at addressing the high turnover rates of social workers.

5.2 The allocation of social workers to children in care was chaotic and not child centred.

5.3 Children did not receive visits in line with statutory requirements.

5.4 The recording of statutory visits was mixed and the quality of visits was poor.

5.5 The oversight of statutory visits to children in care was poor.

5.6 Appropriate child centred links with families were not always maintained on a consistent basis.

5.7 The area did not consistently ensure that care of children with a disability was appropriately coordinated with the input of other professionals for the purpose of care planning.

5.8 Significant events involving children in care were not always responded to.

5.9 Staff who spoke with inspectors said they would not be sufficiently protected in the event of making a protected disclosure.

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:

5.1 Retention of social workers was very poor and senior management had been ineffective at addressing the high turnover rates of social workers.

5.1.1 This Action Plan will be reviewed by the Regional Service Director where a monthly progress report will be forwarded to the Chief Operations Officer until the

end of Q2, 2020. This will ensure greater governance and oversight at regional and national level.

The Area Governance Committee will continue to oversee the actions from this Inspection and the Area Rapid Improvement Plan to support implementation, identify and respond to the risks within the area.

The Area Manager and Service Director, in consultation with Tusla HR will continue to review and implement strategies for the ongoing prioritisation of Social Workers recruitment and retention. This will involve quarterly meetings to review the progress and effectiveness of strategies implemented. The area continues to prioritise the recruitment of social workers for the Children in Care team.

The risk associated with high staff turnover in the Children in Care Team and the control measures to mitigate risk will be reviewed by the PSW and Area Manager on a monthly basis. This will also be reported at Area Governance Committee Meeting. Staff retention initiatives will be kept under ongoing review.

Staffing levels of Children in Care have improved since the Inspection in May.

5.1.2 A comprehensive review of the staffing requirements is currently underway. The assessment will be complete by October 2019 and will make recommendations to the Area Management Team and Regional Service Director.

5.1.3 Six social work posts within the Children in Care team have been upgraded to Senior Social Work Practitioner grade to support and encourage staff retention.

5.1.4 A number of initiatives have been identified by the PSW in consultation with the team and Area Manager, to support and promote staff retention such as:

- Targeted team development and key learning days have taken place and are scheduled for September and October to improve practice. Planned events include extensive training initiatives as well as reflective learning events.
- Feedback will be sought from the team and will be used to assess the effectiveness of such events, as well as areas for improvement or interest for further team days.
- Training has been arranged on legal issues, reviews and care planning and Signs of Safety in September, October and November.
- Proposals have been submitted to the National Project Management Office for training on Lean Management with a specific focus on assisting social workers on time management.

- The Area will participate on a national staff retention group.

5.1.5 The area management team, in consultation with Social Workers, will continue to engage with the local third level colleges and offer a wide range of places to social work and social care students. The next planned event is 4th October 2019.

5.1.6 Exit interviews will routinely be conducted by managers and information from these will be collated by business support to identify themes and learning. This will be presented to the Area Management and Area Governance teams on a six monthly basis.

5.2 The allocation of social workers to children in care was chaotic and not child centred.

5.2.1 The ongoing review and service oversight will continue to prioritise the recruitment of Social Workers for the Children in Care team, as detailed in 5.1.1. Improvement in staffing levels has been achieved since inspection leading to increased allocation of social workers to children in care.

5.2.2 Tracking of social worker allocation and children in care will be undertaken by the Principal Social Worker through NCCIS, this will be reported to the Area Governance Committee on a quarterly basis.

5.2.3 A local area guidance document is in place in respect of children in care awaiting social work allocation. This ensures that there is clear criteria for allocation to a Social Worker and that children receive visits by a named member of staff who has reviewed the file and is under the direction of a Social Team Work Leader. Children in care without their own Social Worker will have dedicated Social Care staff and/or Fostering Link Social Worker who will carry out specified tasks.

5.2.4 Reviews of children awaiting allocation are carried out every 8 weeks. The information from these reviews is used to set priorities for allocation. The reviews are discussed monthly between Social Work Team Leader and Principal Social Worker at supervision**.**

5.3 Children did not receive visits in line with statutory requirements.

5.3.1 Principal Social Worker & Social Work Team Leaders will ensure that all children are visited in line with regulations. This will be recorded on NCCIS case files. A focus programme on completing statutory visits to the end of 2019 is in place.

A report will be developed on a quarterly basis from NCCIS to track the compliance of statutory visits to Children in Care. Local audits will continue to take place between local QA and the Children in Care Team, to monitor adherence to the standard. Risks will be identified by the PSW and escalated to the local risk register for action and monitoring at Area Management and Governance Committee.

5.3.2 Supervision record has been amended to reflect all information required for oversight, management and compliance such as statutory visit date, Child in Care Review, Care Plan completion, decisions of the review and adherence/completion.

5.3.3 Alert system will be devised and implemented by NCCIS Team with regard to the compliance of statutory visits as per the standards and regulations.

5.4 The recording of statutory visits was mixed and the quality of visits was poor.

5.4.1 Details of all visits are being recorded on NCCIS and reviewed through supervision. This will also provide evidence that the child was seen alone.

5.4.2 The supervision record has been amended to reflect all information needed for oversight of compliance with statutory requirements.

5.4.3 The area commenced a focus group with Children in Care to obtain their views on what children and young people can tell us about how to improve their experience of social work visits. The feedback from these groups will be collated and disseminated to the Children in Care Teams at an event being organised by the Focus Group for December 2019.

5.4.4 Practice Workshops will be held regularly to train and support teams to ensure work is child focused. A mandatory Practice Workshop for the team will take place in October to refresh all team members on the requirements for visits to children in care and recording of same. This workshop will be repeated on a twice yearly basis to ensure new staff are aware of their duties and responsibilities to Children in Care.

5.5 The oversight of statutory visits to children in care was poor.

5.5.1 The supervision record has been amended to reflect all information needed for oversight of compliance with statutory requirements. Records of supervision will be subject to audit on a 6 monthly basis and will be discussed at Area Governance Meetings.

5.5.2 There is a tracker in place which is supporting team leaders monitoring performance with regard to statutory visits. Challenges to meeting requirements will be brought to the PSW for attention in supervision. Progress will be monitored at Area Governance Committee meetings.

5.6 Appropriate child centred links with families were not always maintained on a consistent basis.

5.6.1 The area will initiate focus groups where possible with families of Children in Care to seek their views on how best to promote and sustain positive contact.

5.6.2 Children in Care reviews now include full discussion relating to contact between children and their families.

5.6.3 Supervision records have been amended to review current contact arrangements between children and their families.

5.7 The area did not consistently ensure that care of children with a disability was appropriately coordinated with the input of other professionals for the purpose of care planning.

5.7.1 The Area is operating the Joint Protocol for Interagency Collaboration between the HSE and Tusla to Promote the Best Interests of Children and Families. A workshop took place in June to appraise staff of the operation of the protocol.

Working groups at area and regional level have been established. The Area Manager and Principal Social Worker for Children in Care attends the Area Working Group. The Regional Service Director and Area Manager attends the Regional Meetings where cases that have been escalated at area level are subject to discussion and planning.

Local area groups between HSE Social Work Manager and Team Leaders have also been established and occur quarterly.

5.7.2 Data from NCCIS is being used to inform the Joint Protocol of Children in Care with a disability, tracking needs, monitoring supports provided by Tusla & HSE and future planning.

5.7.3 HSE services required to provide input to a Child's Care Plan are routinely invited to Child in Care Review by the Reviewing Officers.

5.7.4 Care plans of children with a diagnosed disability will be reviewed by Principal Social Worker on an annual basis to ensure that they reflect responses to the identified needs.

5.8 Significant events involving children in care were not always responded to.

5.8.1 Workshops on significant events for Children in Care will be undertaken by the Regional Quality Risk and Improvement Manager and will be repeated as required to Children in Care Team to ensure a timely and appropriate response to significant events. Any event that relates to a Child in Care will be reviewed in supervision.

5.9 Staff who spoke with inspectors said they would not be sufficiently protected in the event of making a protected disclosure

5.9.1 Guidance on protected disclosures has been recirculated. Additional briefings relating to Protected Disclosures will take place by the end of Q3. Progress on this action will also be informed by information available from exit interviews with staff as detailed in 5.1.6.

5.9.2 The area continues to consult and engage with staff through staff regular newsletters, surveys, team events and the open invitation to engage with the Area Manager/Management. This feedback will be reviewed and presented at Area Governance Meetings.

5.9.3 The area will review the current mechanism to respond to feedback to ensure that staff ideas and views are taken into account.

5.9.4 A staff broadcast on Protected Disclosures will be issued by the Regional Service Director.

Proposed timescale:	**Person responsible:**
5.1 End of Q2 2020 • 5.1.1 Q2 2020 • 5.1.2 Oct 2019 • 5.1.3 Completed • 5.1.4 Q4 2019 • 5.1.5 Q2 2020	Regional Service Director, Area Manager, Principal Social Workers for Children in Care and Foster care and Business Support.
5.2 End of Q3 2019 • 5.2.3 completed • 5.2.4 Q4 2019	Area Manager, Principal Social Worker for Children in Care, Social Work Team and Social Care Manager.
5.3 End of Q4 2019	Principal Social Workers for Children in Care & Fostering, Social Work Team Leaders & NCCIS Support.

5.4 End of Q1 2020 • 5.4.1 completed • 5.4.2 Q4 2019 • 5.4.3 Q4 2019 • 5.4.4 Q4 2019	Principal Social Workers for Children in Care & Foster Care & Social Work Team Leaders.
5.5 End of Q4 2019	Principal Social Workers for Children in Care & Social Work Team Leaders.
5.6 End of Q1 2020 • 5.6.1 & 5.6.2 Commenced • 5.6.1 Q2 2020	Principal Social Workers Social Work Team Leaders and Child in Care Reviewers.
5.7 End of Q3 2019	Regional Service Director, Area Manager, Principal Social Worker for reviews, Social Work Team Leaders & NCCIS Support.
5.8 End of Q4 2019	Regional Manager QRSI Area Manager & Principal Social Workers Service Director
5.9 End of Q4 2019	Area Manager, Principal Social Workers & Business Support.

Standard 6 – Assessment of children and young people

Substantially compliant

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

Assessments of need were not always completed in a timely manner.

Action required:

Under **Standard 6** you are required to ensure that:
An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

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

6.1 Assessments of need were not always completed in a timely manner.

6.1.1 This assessment of need will be completed in line with National Standards for Children in Foster Care and Tusla Standard Business Processes. Staff will be reminded of the requirements of this standard by way of a refresher memo and discussion at team meetings. Team Leaders will highlight any challenges to meeting this standard in supervision with Social Workers and will report to the PSW.

Proposed timescale:	**Person responsible:**
6.1 End of Q3 2019	Principal Social Worker, Social Work Team Leaders, Social Workers Duty / Intake & Assessment & Child Protection & Welfare.

Standard 7 – Care planning and review

Non-compliant Major

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

7.1 Systems to manage care planning were disorganised and negatively impacted children.

7.2 Plans put in place to address the backlog of child in care reviews contributed to poor quality care planning.

7.3 The quality of care planning was poor.

7.4 Care planning was significantly delayed.

7.5 Actions agreed at child in care reviews and recorded in care plans were not adequately addressed.

7.6 Specialist supports as set out in care plans were not always provided.

7.7 Due to a delay or lack in the provision of supports, some children's placements in foster care ended in an unplanned manner.

7.8 Case management was poor quality as social workers did not receive regular supervision.

7.9 Governance and oversight from the area management team was not effective at appropriately managing risks associated with care planning, particularly where children were not receiving the supports where required.

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:

7.1 **Systems to manage care planning were disorganised and negatively impacted children.**

7.1.1 An alert system on NCCIS will be developed and implemented which will identify the need for a Child in Care review for the Social Worker and Foster Carer in advance of the review.

7.1.2 A diary of Children in Care reviews 2020 has been developed for all Children in Care reviews for compliance and oversight. This will be maintained and updated

by business support.

7.1.3 The NCCIS support team will provide monthly reports of the unallocated children in care, their allocations to a Social Care Leader and review of their information .i.e. reviews, care plans etc., for the attention of the Principal Social Worker who will report to Area Manager in supervision and to the Area Governance Committee.

7.1.4 Quarterly meetings are being held between the Principal Social Workers for Children in Care and Reviews and Reviewing Officers to ensure that reviews are prioritised correctly and take place in a timely manner.

7.2 Plans put in place to address the backlog of child in care reviews contributed to poor quality care planning.

7.2.1 A detailed plan is in place to prioritise and address the backlog of reviews. 100 reviews are scheduled per quarter. Based on figures there is a backlog of 92 reviews as a result. An additional reviewer will be appointed by the end of Q3 to address the issue of outstanding reviews.

7.2.2 Additional Business Support is assisting with the support, planning and recording of reviews.

7.2.3 Any child in care review that is postponed twice will be notified to the Principal Social Worker for Children in Care by the Principal Social Worker for Reviews.

7.3 The quality of care planning was poor.

7.3.1 The area has commenced a focus group with children / young people in care to obtain their views about how to improve their experience of care planning and also ensure their views and complaints are heard and addressed. These groups will also focus on how children and young people can become involved in the care planning process.

The area will continue to engage with EPIC in relation to the above.

7.3.2 An initial finding from these focus groups was that some young people who did not want to attend reviews asked the area to explore various means such as the use of an app to obtain their views and care planning. This is currently under review.

7.3.3 Contact will be made with parents of Children in Care through the Child and

Family networks across the area and focus groups facilitated so they can tell us about their experiences of care planning and how improvements can be made.

7.3.4 Focus groups will take place annually with Foster Carers to obtain their views on how we can improve their experience of reviews and care planning.

7.3.5 The findings from feedback will be disseminated to staff and will inform the care planning process and reported to Area Governance.

7.3.6 A workshop on Care Planning is planned for October and will be repeated six monthly for new staff or as required. Local audits will continue to highlight any challenges to meeting this requirement.

7.4 Care planning was significantly delayed.

Refer to 7.1

7.4.1 The Principal Social Worker for Children in Care Reviews will set out a programme to address the backlog of outstanding Children in Care reviews to ensure compliance with National Standards, there are 100 reviews scheduled each quarter.

7.4.2 The NCCIS support team will provide the information for the purposes of tracking reports and will issue a report which will be sent to the Area Manager on a quarterly basis of the reviews that have occurred within the month and those that are due and overdue.

7.4.3 A report will be issued at the commencement of each quarter detailing what is due, activity in the previous quarter and outstanding tasks. This will be reviewed by the Principal Social Workers for Reviews and Children in Care and will be reported to the Area Manager and Area Governance Committee.

7.5 & 7.6 Actions agreed at child in care reviews and recorded in care plans were not adequately addressed. Specialist support as set out in care plans was not always provided.

7.5/6.1 Every review will commence with a check of progress of actions from the previous review.

7.5/6.2 Principal Social Worker & Social Work Team Leaders will complete file audits on a quarterly basis to ensure compliance with above (7.1, 7.2) and quality of care plans.

7.5/6.3 Outcomes of audits will be compiled and learning arising will be discussed at social work team meetings and incorporated into the Area's quality assurance database with the oversight of the Principal Social Worker for quality assurance

and will be reviewed at Area Governance Meetings.

7.5/6.4 The designated chair for Children in Care reviews will alert via email Social Work Team Leaders that the review record is completed, and is available on NCCIS for their attention and sign off.

7.5/6.5 Business Support has established a process to ensure timely processing of funding requests for additional therapeutic support to ensure that no placement ends in an unplanned manner due to lack of additional supports. Delays in provisions of supports to children in care with a disability will be reported at Joint HSE/Tusla meetings.

7.7 Due to a delay or lack in the provision of supports, some children's placements in foster care ended in an unplanned manner.

Business Support has reviewed its processes to ensure timely processing of funding requests for additional therapeutic support to ensure that no placement ends in an unplanned manner due to lack of additional supports.

7.8 Case management was poor quality as social workers did not receive regular supervision.

7.8.1 Supervision has been scheduled for the year for all staff.

7.8.2 Principal Social Workers will conduct six monthly audits of supervision files to ensure compliance with Tusla's supervision policy. The outcome of these audits will be reported to Area Manager, Area Governance Committee and recorded on the Area's quality assurance database.

7.9 Governance and oversight from the area management team was not effective at appropriately managing risks associated with care planning, particularly where children were not receiving the supports where required.

7.9.1 This Action Plan and the associated Rapid Improvement Plan will be reviewed by the Regional Service Director where a monthly progress report will be forwarded to the Chief Operations Officer until the end of Q2, 2020. This will ensure greater governance and oversight at regional and national level.

The Area Governance Committee will continue to oversee the actions from this Inspection and the Area Rapid Improvement Plan to support implementation, identify and respond to the risks within the area.

7.9.2 The Area Governance Committee will review the data in relation to care planning and reviews on an ongoing basis. A report will be issued on a quarterly

basis from NCCIS to the Area Manager, Principal Social Worker and Social Work Team Leader with regard to compliance, non-compliance and drift of care plans and reviews. This will be presented to the Area Governance Committee.

7.9.3 NCCIS will include all data relevant to Children in Care in the quarterly statistical report to the Area Management meeting and to the Area Governance committee.

7.9.4 The NCCIS support team will attend the Children In Care Review Oversight group meetings quarterly to provide an overview, analysis and trends of issues arising in the Children in Care service.

7.9.5 The Area Manager will continue to escalate cases to the Regional Service Director where children are not receiving the supports required, through the Need to Know process.

7.9.6 See 5.7.1 The Regional Service Director and Area Manager will continue to attend the regional HSE/Tusla Joint Protocol meetings and will escalate cases as required.

Proposed timescale:	**Person responsible:**
7.1 - End of Q1 2020 • 7.1.1 Q1 2020 • 7.1.2 Q3 2019 • 7.1.3 Q4 2019 • 7.1.4 Q3 2019	Principal Social Workers, Business Support, Social Work Team Leaders, NCCIS Support.
7.2 – End of Q3 2019	Business Support Manager, Principal Social Workers for Children in Care reviews and NCCIS Support.
7.3 - End of Q1 2020 • 7.3.1 Q3 2019 • 7.3.2 Q4 2019 • 7.3.3 Q1 2020 • 7.3.4 Q2 2020 • 7.3.5 Q2 2020 • 7.3.6 Q4 2019	Principal Social Workers for Children in Care and Foster Care, Social Work Team leaders, Senior Manager for Partnership Prevention and Family Support.
7.4 – End of Q1 2020	Principal Social Workers for

• 7.4.1 Q4 2019 • 7.4.2 Q4 2019 • 7.4.3 Q1 2020	Child in Care reviews & Social Work Team Leaders.
7.5 & 7.6 – End of Q3 2019 • 7.6.1 Q3 2019 • 7.6.2 Q4 2019 • 7.6.3 Q1 2020 • 7.6.4 Q4 2019 • 7.6.5 Q3 2019	Principal Social Workers & Social Work Team Leaders, Child in Care Reviewers, Business Support.
7.7 Completed	Business Support
7.8 - End of Q4 2019	Principal Social Workers & Social Care Team Leaders.
7.9 –End of Q4 2019	Regional Service Director & Area Manager.

Standard 8 – Matching carers with children and young people

Non-compliant Moderate

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

8.1 While the area tried to ensure children could meet with foster carers prior to their placement, this did not happen consistently.

8.2 There was a significant delay in approving children for long term matches

Action required:

Under **Standard 8** you are required to ensure that:
Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

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

8.1 While the area tried to ensure children could meet with foster carers prior to their placement, this did not happen consistently.

8.1.1 Social Work Team Leaders will oversee a plan of introduction for children, parents and foster carers including a plan for any proposed move. The area utilises "This is Us" photobook of foster carers and will be shared with children in advance where possible.

8.1.2 Link workers will ensure foster carers have appropriate information prior to any possible placement.

8.2 There was a significant delay in approving children for long term matches.

8.2.1 Principal Social Worker & Social Work Team Leaders will undertake a review of children where long term matches have not been made. Any outstanding matches will be addressed at the next Child in Care review.

8.2.2 The Chairperson of the Foster Care committee will prepare a report every six months detailing long term matches agreed and any trends / details or issues that have arisen. This report will be disseminated to the Area Manager and Principal Social Workers for the Fostering and Children in Care Services.

Proposed timescale:	**Person responsible:**
8.1 – End of Q3 2019	Principal Social Workers for Children in Care & Fostering and Social Work Team leaders
8.2 – End of Q1 2020	Chairperson FCC & Principal Social Workers for Fostering & Children in Care

Standard 10 – Safeguarding and Child Protection

Non-compliant Moderate

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

1. There were gaps in the governance and oversight of serious concerns and allegations.

2. While the management of risk and associated safeguarding measures ensured children were visited, these measures were not reliable at ensuring children could disclose potential abuse.

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:

10.1 There were gaps in the governance and oversight of serious concerns and allegations.

10.1.1 In line with National Procedures the Fostering Principal Social Worker & Social Work Team Leaders will continue to notify the Foster Care Committee of all allegations and significant concerns in relation to Foster Carers. The Principal Social Worker for Fostering will continue to ensure that outcomes of assessments are forwarded to the Foster Care Committee.

10.1.2 The Principal Social Worker for Fostering and the Chair of the Foster Care Committee will be responsible for updating the tracking system of serious concerns and allegations on a monthly basis.

10.1.3 A quarterly report will be presented at the Area Governance Committee by the Principal Social Worker for Fostering in relation to all allegations / significant concerns made against Foster Carers.

10.1.4 Business support for NCCIS provides a monthly report to Social Work Team Leaders and Principal Social Workers in relation to new referrals relating to children in care. This ensures Social Work Team Leaders have oversight of all new referrals relating to Children in Care.

10.2 While the management of risk and associated safeguarding measures ensured children were visited, these measures were not reliable at ensuring children could disclose potential abuse.

10.2.1 Training workshops will be provided to staff undertaking direct work with children which will have a focus on difficulties that Children in Care have in disclosing potential abuse.

10.2.2 Workshops on managing referrals and significant events for Children in Care have been undertaken and will be repeated as required to ensure that staff are aware of the need to have a timely and appropriate response to significant events.

10.2.3 Social Workers will meet with children privately during statutory visits. Social Workers will ensure visits take place both within and away from the placement.

10.2.4 The frequency and quality of visits will be monitored through the supervision process and quarterly file audits undertaken by Social Work Team Leaders and Principal Social Worker.

Proposed timescale:	**Person responsible:**
10.1 – In Place	Principal Social Workers for Children In Care, Foster Care, Chair of the Foster Care Committee & Business Support.
10.2 – End of Q4 , 2019	Principal Social Workers & Workforce Learning & Development.

Standard 13: Preparation for leaving care and adult life

Non-compliant Major

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

1. Aftercare services in the Carlow Kilkenny South Tipperary service area were under resourced and not well established.

2. Systems to ensure all eligible children were referred to the aftercare service were not effective.

3. While children were involved in planning for their future, this was not always child centred.

4. Work between the children in care teams and the aftercare team was disjointed.

5. Prioritisation systems in the aftercare service had not been fully implemented at the time of the inspection.

6. There was no annual review report on the aftercare service produced.

7. Managerial oversight throughout the service area was not effective at ensuring good quality service delivery.

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

13.1 Aftercare services in the Carlow Kilkenny South Tipperary service area were under resourced and not well established.

13.1.1 An assessment of the staffing requirements to meet current service demands is currently underway at National and Area level with the aim of developing sustainable staffing for Aftercare. Following this, a Business Case for service development will be submitted for 2020 development considerations nationally. In the interim 2 temporary staff will be engaged to undertake focussed work on aftercare planning and support.

13.1.2 The Aftercare Manager's post has been created in the Area and is currently being regularised in accordance with a national agreement.

13.1.3 The vacant post in aftercare is currently in the recruitment process.

13.2 Systems to ensure all eligible children were referred to the aftercare service were not effective

13.2.1 All children aged between 16 to 18 have been prioritised to ensure that the area meets its requirements under legislation. To assist in planning for aftercare, a six monthly report will be generated through NCCIS on details of young people aged 16 and 17 years. This will ensure timely referral to aftercare service. These will be issued to Principal Social Workers and Social Work Team Leaders.

13.2.2 Supervision record forms have been amended to incorporate discussion of aftercare referrals for when a child is aged 16 years.

13.2.3 The Aftercare team are invited to all children in care reviews for all young people aged 16 and 17 years.

13.2.4 Business support to the children in care review service will track aftercare referrals and ensure that all young people eligible for Aftercare are referred prior to the care plan/review meeting in their sixteenth year.

13.3 While children were involved in planning for their future, this was not always child centred.

13.3.1 The Area is conducting focus groups with young people in care and will obtain their views on what children and young people can tell us about planning for aftercare.

13.3.2 Young people aged 17 years will be prioritised for allocation to a social worker and this allocation will take into account the need for stability in relationships and care planning at this transitional stage.

13.4 Work between the children in care teams and the aftercare team was disjointed

13.4.1 Principal Social Workers for Aftercare and Children in Care along with the Aftercare Manager will undertake workshops on Aftercare services and legislative requirements to Children in Care and Aftercare Teams.

13.5 Prioritisation systems in the aftercare service had not been fully implemented at the time of the inspection.

13.5.1 The Area has developed and is implementing a prioritisation protocol for Aftercare. This has been disseminated to Aftercare and Children in Care Teams.

13.6 There was no annual review report on the aftercare Service produced.

13.6.1 The Principal Social Worker for Aftercare and Aftercare Manager will prepare an annual review report for 2019 which will be reviewed and discussed at Area Governance and Area Management Meeting.

13.7 Managerial oversight throughout the service area was not effective at ensuring good quality service delivery

13.7.1 Aftercare will be prioritised in supervision between the PSW for Aftercare and Area Manager. The PSW for Aftercare will advise the Area Manager regarding allocation, needs assessments and aftercare plans at each supervision session.

Proposed timescale:	**Person responsible:**
13.1 – End of Q2 2020 • 13.1.1 Q4 2019 • 13.1.3 Q4 2019 • 13.1.3 Q3 2019	Service Director, regional HR, Area Manager, Business Support Manager & Principal Social Worker for Fostering and Aftercare.
13.2 – End of Q3 2019	Principal Social Care Worker for Child in Care reviews and Social Work Team Leaders and Business Support Manager.
13.3 – End of Q4 2019	Principal Social Worker for Children in Care, Fostering and Aftercare.
13.4 – End of Q3 2019	Principal Social Worker for Fostering and After Care and After care Manager.
13.5 – End of Q3 2019	Principal Social Worker for Fostering and After Care and After care Manager.
13.6 – End of Q1 2020	Area Manager, Principal Social Workers for Fostering and After Care, After Care Manager & Principal Social Worker for Children in Care.
13.7 - End of Q3 2019	Area Manager & Principal Social Worker for After Care.

Theme 1: Child Centred Services

Standard 25 – Representations and Complaints

Non-compliant Moderate

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

25.1 Complaints that were verbally made were not recorded in the area's complaint's log.

25.2 Complaints made in writing to the area were not appropriately captured and responded to.

25.3 The management of complaints that had been captured on the complaints register was poor as the responsiveness to these complaints was poor.

Action required:

Under **Standard 25** you are required to ensure that:
Health Boards have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fida 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 a non-statutory agency.

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

25.1 Complaints that were verbally made were not recorded in the area's complaints log.

25.1.1 Workshops have taken place and will be repeated as necessary with all staff on the Tell Us Feedback and Complaints Policy and Procedure; these will have a focus on children being aware of how to make a complaint. All Social Workers will be asked to issue Tusla leaflets on complaints and explain the process to children and young people.

25.5.2 All staff will record verbal complaints on a standard template for input on NIMS.

25.2 Complaints made in writing to the area were not appropriately captured and responded to.

25.2.1 All written complaints received will be entered on NIMS. All NIMS registered complaints will be acknowledged in writing, which will ensure that complaints are properly captured and responded to.

25.2.2 All Principal Social Workers in the area are delegated Complaints Officers. Two additional Complaints Officers have been assigned to manage complaints.

25.2.3 NIMS User Access Training has been arranged for all Area Complaints

Officers.

25.3 The management of complaints that had been captured on the complaints register was poor as the responsiveness to these complaints was poor

25.3.1 All open complaints recorded on NIMS will be reviewed by the Complaints and Feedback Management Team on a monthly basis for compliance with Tell Us Policy and Procedure.

25.3.2 The responsiveness to complaints will be audited on a quarterly basis by the PSW for Complaints and Business Support. The outcome of these audits will be reviewed and discussed at the Area Governance Committee as well as discussion at Area Management and Team meetings.

25.3.3 Feedback on complaints including trends will be discussed and disseminated at team meetings so that staff are fully aware of issues arising and any learning can be shared.

Proposed timescale:	**Person responsible:**
25.1 – End of Q3, 2019	Principal Social Workers for reviews & Complaints & Business Support
25.2 – End of Q3, 2019	Principal Social Workers for reviews & Complaints & Business Support
25.3 – End of Q4, 2019	Business Support Manager & Area Manager