Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Inspiring Confidence in Children and Family Services

Putting children first and meaning it

Strategic Review of the Delivery and Management of Children and Family Services

CONFIDENTIAL DRAFT REPORT

Prepared by PA Consulting Group for the HSE

1 October 2009.

Foreword

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

A priority for the HSE is to modernise the way its Children and Family Services are planned and delivered so that, within the resources available we can meet all the regulatory and statutory requirements and provide a quality and effective service. A strategic programme of work to achieve this was initiated in 2008. The change programme is evidenced based and draws from a number strategic developments and reports including:-

Social Work and Family Support Survey 2008

This involved the first ever detailed analysis of social work across all 32 local health offices. It included analysis of work practices, caseloads, team structures, management of unallocated cases, risk rating etc. This survey highlighted significant inconsistencies across the country. Services were clearly being provided much more effectively in some parts of the country than in others and this was not always due to the difference in the resources available.

The Report identified deficits within the social work system e.g. children in care with no allocated social worker, child protection cases on waiting list awaiting assessments, and social work staff turnover and variances in activity/work loads of social workers. These issues are currently being addressed through a range of actions in partnership with HIQA.

Task Force Report 2009

Following the Social Work Survey, a Task Force was established in February 2009 comprising senior practitioners in the field of Child Protection and senior Health Service Managers. The aim of the Task Force was to put in place a system to "accelerate the development of a national, unified and standardised approach to the delivery of Child Protection Services"

Central to its overall objective has been the development of a framework or 'user's manual' to ensure essential functions in a child protection assessment are accomplished in a consistent and standard manner across the country. This framework offers a powerful diagnostic and action tools for holistic assessment and supports effective decision making. Prior to this, the area of child protection assessments was extremely fragmented and inconsistent.

A high level implementation plan has been developed and is being rolled out to ensure the Task Force's recommendations are acted on. The following three elements of the Task Force recommendations relating to the standardised implementation of policy and procedures are currently being implemented.

Implementation at regional level of the national policy which clarifies for all staff their role in Child Protection

Common Duty System Framework

Child Protection Conference Standard Operating Procedure

Ryan Report

The Report of the Commission to Inquire into Child Abuse, commonly referred to as the Ryan Report, was published on 20th May 2009. The Government accepted the recommendations in full and took the decision to draft the implementation plan with the expressed aim of responding to each of the 20 recommendations. The Implementation Plan was published by the Office of the Minister for Children and Youth Affairs (OMCYA) in July 2009.

The Ryan Implementation Plan contained 99 recommendations of which 68 come directly under the leadership of HSE. Of these recommendations 8 have been prioritised and are included in the 2010 Service Plan, for implementation, as resources become available.

One of the most significant recommendations is a requirement for 200 additional Social Workers and a commitment was given by the Department of Health and Children that these posts would be sanctioned for recruitment in 2010. A recruitment process is currently underway.

National Foster Care Audit

In October 2009 the HSE carried out a national audit of our Foster Care services. The objective of this audit was to benchmark the HSE compliance with its statutory obligations in relation to foster care and relative care; to identify areas where services were working well; and to highlight areas for service improvement where the audit reveals deficiencies in service delivery. A national implementation plan is currently being drawn up to address the findings of the audit in conjunction with the HIQA.

Strategic Review of Management of Children and Family Services

This review commissioned in October 2009, to complement the recommendations of the Task Force Report, provides the other key element required for the change process. This review assessed current structures under a number of headings including:- management and governance in the context of being fit for purpose; ensuring and supporting best practice; facilitating public accountability; supporting effective interdisciplinary & interagency relationships; and consistency with international best practice with regard to Child Protection, assessment and intervention.

Children First clearly indicates that the protection of children is everybody's Business. However, social work professionals are the spine of the service as key professionals engaging with children and their families and so our findings relate mainly to this profession and to the management structure.

The key messages arising from this strategic review is that there are significant and in many cases unnecessary variations across LHOs in how Children First is being managed and delivered. This review also states that "there is no quick fix to address the management and delivery issues identified in this report. Strengthening the spine of the service will require change across a number of areas."

The Children and Families Services change programme will ensure

- Social work services are much more effective in using the resources available
- There is a standard approach to child protection across the country and consistency in how the children and family services are being delivered, by strengthening
- Collaboration and supports to people working with children and their families are strengthened
- Children and family social services are planned, managed and delivered to a high quality enabling the provision of services which meet and exceed national Regulations and Standards.

The key components of this strategic response are:

- Simplifying and streamlining the organisational structure for the delivery of the service to make it clearer and more accountable.
- Developing an evidenced based service delivery system.
- The implementation of formal child protection protocols to ensure standardised and consistent practice across the country (Task Force Report);

- The implementation of the National Child Care Information System;
- The implementation of the recommendations of the HSE's Strategic Review of the Delivery and Management of Children and Family Services;
- The recruitment of 200 additional social work staff and 65 related child care staff; and
- The implementation of the recommendations of the National Foster Care Audit.

Given the significant breadth and depth of this change programme, which involves major change in how our social care staff work and are managed, this change programme is being rolled out in a measured and planned way and will be undertaken in 2010 and 2011.

This programme provides a challenge for HSE Children and Family Social Services to begin a process of change and development whereby the existing statutory requirement to provide safeguarding and alternative care services is maintained while, at the same time, a new and overarching emphasis is placed upon the primary need to support families through the provision of comprehensive child care services.

This change process is putting in place the structures, services, staffing, systems and standardised protocols required to ensure the provision of effective and high quality statutory child care services.

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Contents

Part A includes:

1. Executive summary – overall findings and principal recommendations
2. Principal findings for the four assessment criteria used covering:
   - Management and governance of the delivery structure
   - Strategy and service development
   - Service delivery
   - How performance is managed.

There is significant anxiety within parts of the HSE and by external agencies on how the HSE is implementing *Children First*, the framework governing child protection in Ireland. The key question is whether the service is doing all that it can to protect children by promoting their wellbeing and providing appropriate supports for their families. The Office for the Minister for Children and Youth Affairs (OMCYA) conducted a review of *Children First* in 2008. It found that the protection framework is fundamentally sound but that it is not being implemented consistently.

The recent Implementation Plan on the Ryan Commission presented to Government by the OMCYA included 20 recommendations and 99 actions to address identified service deficits in child protection and welfare services. Six of these recommendations and 35 actions related to the management of children's services. The Implementation Plan clearly indicated that any future resources allocated to the HSE will depend on agreement on significant areas of service reform. This underlines serious intent to develop a service that puts the needs of children at the centre of service delivery.

Children First clearly indicates that the protection of children is everybody's business. However, social work professionals are the spine of the service as key professionals engaging with children and their families and so our findings relate mainly to this profession and to the management structure.

Key findings

- **There is an urgent requirement to set and communicate direction for the service.** What is the HSE fundamentally trying to achieve for children and their families? At the very heart of this question is what child protection practically means – is it essentially about managing risk and investigating alleged abuse or is it more about providing the supports needed for children and their families? There is no shared view about what the 'service model' should look like within the HSE. However, there is an emerging sense that the focus needs to shift to providing supports and specialist services for children and their families to prevent the risk of harm. This is happening in some parts of the HSE but not consistently. The HSE needs an overall strategy and service model that will provide guidance to local managers and practitioners on how they should be delivering services for children. This lack of overall direction has a profound effect on the outcomes children can expect in different parts of the country.

- **There are significant and, in many cases, unnecessary variations across LHOs in how *Children First* is being managed and delivered.** These variations can be traced to the different priorities and practices of the former Health Boards which have endured with the establishment of the HSE in 2005. This means that depending on where children at risk live in Ireland they can expect to receive different services from their Local Health Office. In some LHOs, children at risk and their families can expect to receive practical supports that help them to build 'upward spirals' to manage the challenges in their lives. For example, there is a national pilot programme in Dublin North to provide children at risk and their families with practical services.[1] Other LHOs are also taking similar approaches but in a more low-profile way. In some LHOs, it is unclear what children can expect from the HSE other than having the risk investigated, monitored and possibly with the final outcome of the child being put in the State's care.

- **More visible leadership is required across all levels of the service as well as tighter management**. Implementing the recommendations of this report, the Ryan Commission Implementation Plan and the report of the HSE's Task Force will not happen without visible leadership at all levels of the organisation.[2] To inspire confidence within the HSE and externally, tighter management is required on resources, quality of practice, outcomes for children. The current management 'style' tends to be reactive, crisis-driven and focused on individual cases. There is a lot of management 'traffic' around individual cases but much of this is not purposeful in the sense of building better delivery to secure better outcomes. At a fundamental level there is no clear understanding on the respective roles of professionals working with children and HSE managers. This contributes to a disconnect between service delivery at national, regional and local level.

- **Structures for delivering the service need to be simplified and clearer.** There is a distance between front-line staff and the top of the organisation which is unhelpful in terms of service delivery. In addition:
  - It is unclear where responsibility, authority and accountability lies for children and family services particularly at local level. At a fundamental level, this means that people within the HSE and outside do not know who is responsible for child protection.
  - At all levels of the delivery system, people can have responsibility without corresponding authority. There are some inherent tensions between two critical local roles – the Principal Social Worker (PSW) and the Child Care Manager (CCM). These can work well but they depend on the quality of relationships.
  - Roles have also been added over the years to manage specific issues, adding to the complexity of delivery. Roles and responsibilities therefore need to be simplified and clarified.
- **Connections with other services within the HSE and agencies need to be strengthened.** This was a central theme from our discussions and arguably has to be a central pillar of any change programme. Within the HSE, working and referring across services is still complicated. There are issues around how professional and service boundaries constrain referrals between services. A more profound issue relates to identified service gaps e.g. access to psychological services for children who clearly have behavioural issues but are not diagnosed as psychotic. This can often leave social workers managing very complex cases without appropriate service supports.
- **Supports to social workers and their managers are under-developed.** Social work professionals work in one of the most challenging areas in the HSE. The human scale of what they do is hugely significant. Like all other professionals, they must exercise their professional judgement on what children and their families need. Social work managers have a clinical governance role but also a key role in supporting staff. The approach to professional supervision and continuing professional development needs to be developed to support social work professionals.
- **There is inconsistent application of practice in implementing child protection and supports.** There are significant and unhelpful variations in practice across the LHOs, for example in relation to how cases are referred, how risk is assessed, thresholds between different levels of service required. Some variation is inevitable due to differences in need and services at local level and variations in professional judgement. However, the extent of the variation undermines confidence in the delivery system.
- **The service is not managed based on current intelligence.** The HSE currently produces a wealth of data on how children and family services are being delivered. However, this is not being routinely used by managers across the service to provide intelligence on how the service is being delivered, how resources are allocated and what outcomes the service is delivering for children. The current datasets are not perfect but they represent a sound starting point to develop 'intelligence-led delivery of services.

We found a remarkable degree of agreement between people working in the HSE and other agencies on the key constraints limiting the effectiveness of child protection. There is an equally shared sense that there has to be a better way for delivering better outcomes for children across the services as a whole. The timing may now be opportune to address these constraints to build confidence in the ability of services to deliver better outcomes for children. Both the report of the Ryan Commission and the subsequent Implementation Plan have underlined the urgency of addressing these constraints and in so doing have given new impetus to addressing the needs of children.

However, we need to be underline two important messages:

- Firstly there is no single remedy or 'quick fix' to address the management and delivery issues identified in this report. Strengthening the spine of the service will require change across a number of areas.
- This points to a need for a clear, sensible and understandable change programme that inspires confidence within and outside the HSE. The scale of the change is not to be under-estimated and ultimately requires fundamental change at corporate and individual level to deliver and support services.

Based on the key findings of this review, the HSE needs to take action at a number of levels:

- Agree and communicate a clear service model for the future that focuses on outcomes for children. This should guide both managers and all practitioners on the priorities for engaging with children at risk.
- Bring consistency to how the HSE delivers services, strengthen collaboration and provide supports to people working with children and their families.
- Develop an intelligence-led system that uses data currently available to improve the service.
- Simplify and make clearer key roles and responsibilities across the delivery system. Our focus has been to propose changes that are absolutely necessary to:
  - Bring clarity to key roles – both internally and externally,
  - Ensure that the structure reflects and drives key functions.

  The HSE is currently 'reconfiguring' its services at national, regional and local level. Our proposals take as their starting point the structure agreed at national level and will be flexible to incorporate PCCC changes at local level. A key new role is the post of Assistant National Director for Children and Family Services. This post will provide clear leadership at senior level in the HSE and should, with appropriate authority and resourcing, provide the leadership to drive this change programme.

The review's recommendations are designed to progress these four priorities. All are essential and together they constitute a significant programme of service and cultural change the scale of which we do not underestimate. Together they will provide a clear framework within which everybody working with children can be clear of their own responsibility, accountability and authority for ensuring children's wellbeing.

2.1 Governance and management structure

The current roles and responsibilities are unclear and are overly complicated. The structure needs to be leaner, more transparent with clear lines of responsibility and accountability and line of sight from front-line services to senior management. This is essential for effective collaboration across agencies and services.

Our findings

The current management structure can be traced back to the Health Boards and did not fundamentally change with the establishment of the HSE. Changes have been 'grafted' to the structure as needs arose. These have helped to address pressing problems but have added to the complexity of delivery. Figure 1 outlines the current management structure. We found that:

There are significant variations in delivery structures across LHOs and roles are often unclear.

- The roles of Principal Social Worker and Child Care Manager (CCM) are central to delivering child protection yet they are particularly confusing and unclear. In four LHOs, the CCM has overall responsibility for children and family services. The model in most LHOs is that both PSW and CCM report to the General Manager (GM). The PSW tends to have most of the line management responsibility with CCM having minimal line management role. The PSW and CCM roles work well where there are strong relationships but it contains inherent tensions that are unhelpful and must be addressed.
- The role of GM and LHM is a critical connector between social workers and other PCCC services, linking strategy and implementation, and connecting 'corporate' management with what happens at local level for children. Their role varies between LHOs and it is unclear to what extent both roles are required for effective delivery.
- The Team Leader role is critical in allocating and assessing cases. They have a lot of authority, yet many do not have significant experience particularly in urban areas (see table 46, appendix A). They receive mixed levels of support depending on where they work.
- There are significant variations in team structures at local level as evident from figure 1. This makes it difficult for agencies and services to engage.

The structure is complex with unclear accountability, responsibility and authority for decisions.

- There is no clear line of sight from senior management to front-line delivery which makes delivery complex. It can also undermine confidence between different layers of the service.
- Authority for managing financial resources in unclear.
- It was not clear to external agencies or other HSE services who is responsible for child protection. This is a basic requirement for inter-agency collaboration.
- The HSE has added some roles for pragmatic reasons usually to respond to particular issues. The concept of 'lead role' defines current delivery including at senior management level – the service by an Assistant National Director who does not have operational responsibility across the country. The 'lead role' model has helped to address some complex issues e.g. residential care, unaccompanied minors. However, it is not an effective way of securing service change as the roles often do not the authority needed to deliver services.
- There are questions as to whether the HSE is using some roles e.g. specialist, senior practitioner, strategy role, to best advantage. The current structure leads to under-utilisation of this considerable resource.

The management style of service delivery tends to be reactive, crisis-driven.

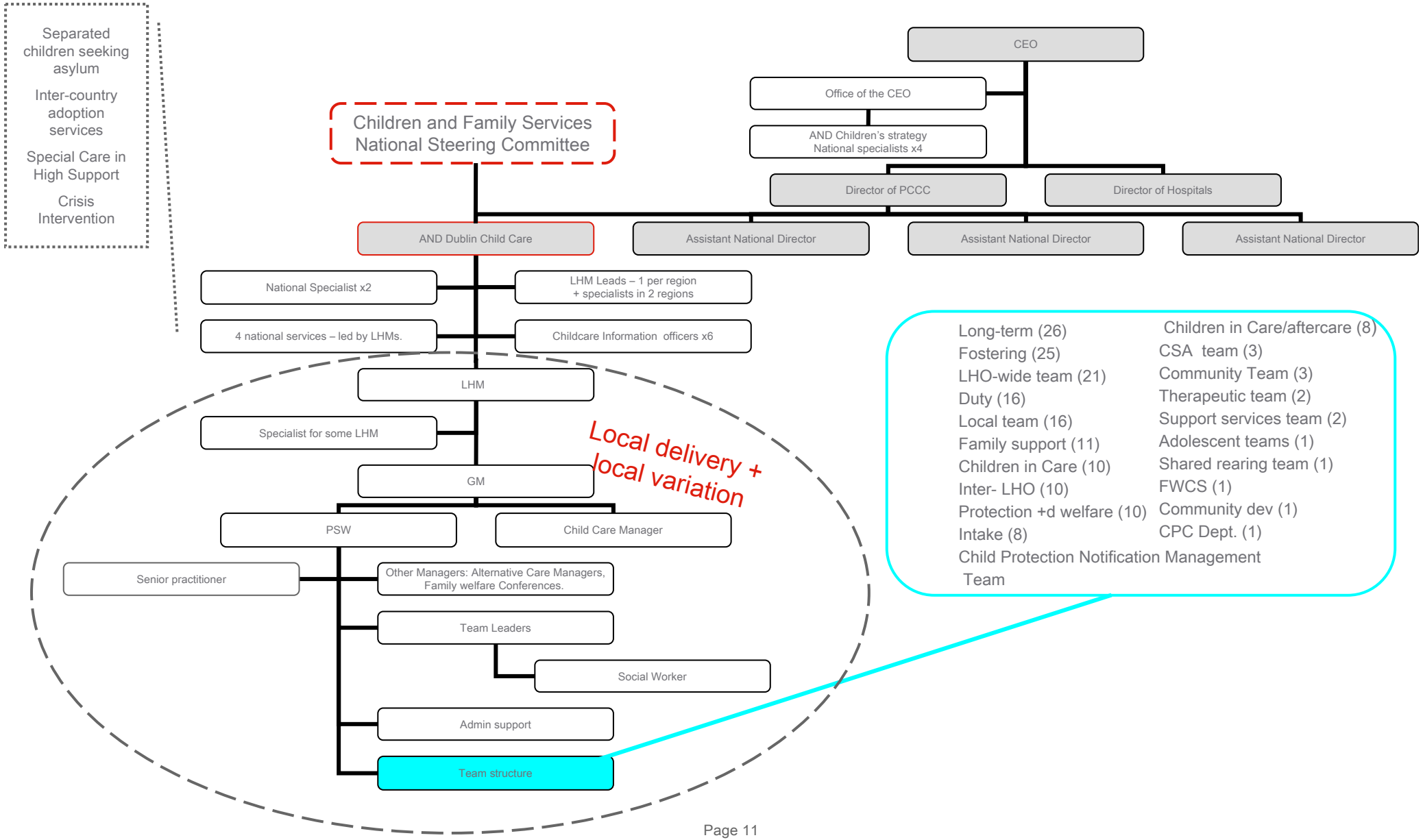
- Collective management structures vary between LHOs and are constrained by the poor quality of information that is used to inform decision-making on the service. There are some good practices of key PCCC local managers liaising with social work managers and other disciplines but this is not routine.
- There are very weak performance structures, as evident in Section 2.4. Formal escalation procedures are in place for Serious Untoward Incidents (SUIs). There is a tendency however to micro-manage on the basis of individual cases which can generate a lot of unhelpful 'management 'traffic'. This is not purposeful in developing services although it may be necessary for individual cases.

At a profound level, there are questions about the expectations of social work practitioners and PCCC managers. What should they legitimately expect of each other in terms of supports and quality assurance on service delivery? How can normal management disciplines be applied while respecting the professional judgement of professional social workers? Central to strengthening delivery is a shared recognition of each other's mutual role and how they support each other.

What this means for the future

The current complexity of roles means that it is difficult for people both within the HSE and externally to know who is responsible for child protection in the HSE and therefore how to engage. The structure should also help to drive a model of services that prioritises early supports for children and families to prevent escalation of risk.

Figure 1: Current management and delivery structure of child protection



2.2 Overall Strategy and Service Model

There is an urgent need to develop a service model for child protection that focuses on outcomes for children. It should be based on national policy and legislation as well as wider experience.

Our Findings

The framework for child protection is clearly articulated at national level through *Children First,* the wider policy framework set out in *The Agenda for Children's Services* and through legislation. However, the HSE has struggled to convert this national framework to a sensible and understandable model for delivering child protection that reflects international experience and research.

We found that there is confusion on the model for child protection which varies significantly between LHOs. At a most rudimentary level there are questions about what is child protection and how it differs – if at all - from promoting children's wellbeing and wider family/community supports? There is emerging agreement that the key to child protection is ensuring that there are services in place to support children and families through times of crisis. This is clearly the direction that some LHOs are moving towards.

The nature of child protection with its emphasis on risk can ironically create a risk-averse culture. The scale of the risk can be understandably 'enfeebling', acting as a barrier to putting needed supports in place for children and their families in case that they increase the risk.

The following concerns beg an urgent strategic response:

- There are strong anxieties that the needs of children are secondary to the needs of the delivery system. This applies both to HSE services and to inter-agency collaboration on children. The role of the education sector is particularly important but arguably this is where collaboration is weakest. Children can easily fall through the service cracks.
- The needs of children in care are particularly acute as the HSE becomes their parent on behalf of the State. HSE data shows that 40% of children are in care for more than 5 years. This raises important questions about how these children should be cared for and planning for their future. Research shows that the age of entry and the speed of action to either rehabilitate or find long-term alternatives is critical.[3] A child over the age of ten who is in care for a year is likely to be in care for the rest of their childhood.
- Moreover many of the children in care are severely affected by their experience of neglect and or abuse. These have long-term consequences with increasing evidence of damaging neurological effects, particularly on their 'executive functioning' - that is their capacity to manage their own behaviour and make wise decisions.[4] Some stakeholders also raised concerns about their security while in care.
- The HSE has still not agreed how it is going to implement the *Agenda for Children's Services* – the national policy framework for children and family services developed by the OMCYA. Apart from the obvious policy gap it presents, it underlines the HSE's difficulty in framing strategy and needs to be addressed as a matter of urgency.

Social work professions are the backbone of child protection service. Yet their positioning as a profession within the HSE and in other agencies is fraught. The profession itself feels under-valued and routinely undermined. This is particularly acute when interacting with the courts which in many ways has become a 'flashpoint' of systemic issues on child protection.

What this means for the future

The absence of a clear model for delivering child protection in the context of wider children and family supports is a major constraint in the current delivery structure. It means that the focus tends to be less on what the child needs and more on what the service is able to deliver. Developing confidence in child protection means that the HSE must develop a model for child protection that embraces children's wellbeing and family supports. Without this wider canvas to work from, practitioners on the ground will continue to operate within the bounds of what individual professionals are prepared to provide rather than what the child, the State or the HSE require. Developing supports for children and their families as well as investigating the risk will require a fundamental mind-shift in how people deliver child protection services.

2.3 Service Delivery

There are critical issues in service delivery that undermine confidence in and the competence of the delivery system. These include unnecessary variation in practice, uneven collaboration between services and agencies, inadequate supports for social workers, uncoordinated interaction with the courts service and unclear responsibility for budgets and resources.

Our Findings

There is unnecessary variation in how child protection services are delivered. Some variation is inevitable given that the needs of children and the localities they live in will differ. Individual professionals may also form different assessments of children's exposure to risk and how to support their wellbeing. The Ryan Commission Implementation Plan included examples to highlight the complex cases that social workers routinely manage. These cases show that it is not possible to standardise the delivery of services in a formulistic way.

However, the level of inconsistency evident is unhelpful and weakens confidence in what is being delivered for children and their families. This degree of variation is both a symptom of the lack of a national service model for children and family services and a legacy from the different practices that prevailed in the Health Boards. It means that children can expect to be assessed and treated differently depending on where they live and that ultimately their outcomes will be different. In particular there are variations in::

- How cases are allocated and the length of time children can expect to wait. In effect, 'unallocated' cases represent a waiting list (see appendix A for data on variations)
- How children and their exposure to risk of abuse is assessed. Social workers apply a number of assessment frameworks but there is no common assessment framework.
- Different definitions and 'threshold's apply across LHOs. For example a 'case' can refer to a family or an individual child. There is particular confusion as to 'threshold' levels for protection and welfare.

The HSE is fully aware of the level of variation across LHOs and has taken steps to address this. The recent report of the Task Force clarifies the key steps required for investigating child protection issues and where responsibility lies (see appendix B) although there is low awareness of these changes among social work managers

The needs of children come second to the demands of the service. This is well-documented and widely recognised in the HSE and externally.

- Children and their families have to interact with different services and agencies in different ways without the services conferring on what the child needs. This raises a bigger problem about how services are delivered.
- The quality of care planning is very mixed. They often deal with episodes in the life of a child rather than anticipating key transition points in their lives and providing appropriate supports.
- The effectiveness of case conferences is uneven – key people from across services are not always represented and decisions not followed-through afterwards.
- The HSE has failed some critical groups notably travellers and unaccompanied children. It is now addressing unaccompanied children..

Recognising these issues, some LHOs are beginning to change their service model so that they concentrate on what children need and not only investigating risk or alleged abuse. There are also some excellent practices in relation to strategy meetings and family conferences. However, they do not happen as a matter of course and how they are managed can vary.

Collaboration between services and agencies is uneven and for the most part unacceptable from the perspective of the child. There are some noteworthy examples of solid collaboration at local level but for the most part the lack of collaboration is a palpable source of frustration for people working in child protection in the HSE and other agencies.

- Within the HSE, different services may engage with the same child and family. There are important structural issues limiting collaboration. The service delivery areas are not co-terminus particularly in relation to CAMHS (Child and Adult Mental Health Services) which is a critical service for many children. It can be difficult to refer children between services so that it is seamless from the child's perspective. This is a deep and understandable source of frustration for all practitioners and managers working to protect children. An even bigger source of frustration is the ability to refer children for psychological assessment and treatment. Children who are not assessed to be psychotic but are still a significant risk to themselves present real problems for the HSE.
- The emerging Primary Care Team (PCT) structure and Primary Care Networks (PCNs) should provide an important forum for developing the multidisciplinary approach to putting services in place. Primary care services will be critical in identifying opportunities for early intervention to prevent children and their families from sliding into neglect and abuse. The operational social work linkages between PCTs / PCNs and the broader child protection services will therefore be crucial.

Collaboration across agencies is also mixed and the level of collaboration depends on the quality of local relationships. The OMCYA has piloted four Children's Services Committees to provide a forum for collaboration across agencies within particular localities. While new, the feedback is positive. However, it has taken a lot of energy and commitment to bring them this far. They have been carefully constructed to ensure that they have the right people on board. The picture outside of these areas is more mixed and for the most part external agencies find it difficult to engage with the HSE.

- In addition to the HSE, the Gardai also have a statutory role in protecting children. They have voiced critical concerns about the availability of out-of-hours service, difficulties in securing child case conferences in some areas and children in care who go missing. The availability of out-of-hours services was also highlighted in the Ryan Commission Implementation Plan and was consistently raised by other agencies.
- Some key educational agencies – notably the National Education Welfare Board - do not have formal links with the HSE. The NEWB is obliged to report to the HSE if there has been an education welfare offence. This would trigger wider concerns around neglect and welfare.
- On a more fundamental level, it is difficult for the HSE to engage with core educational providers. The governance structures of schools means that they operate independently. The Department sees its remit as being to 'educate' rather than the welfare of children. Interaction with educational bodies is a significant gap in developing the full range of supports for children and their families
- Inter-agency protocols exist particularly with the Gardai. However, agencies have not developed pathways to indicate what children can expect.
- External agencies are key deliverers of services for families and children. The HSE has significantly tightened its management of these agencies to ensure that services are delivered to identified children and families. This tighter management is perceptible on the ground and provides a good foundation for future service development.

Managing resources

There is a gap between the authority for budget and the authority to make decisions in relation to services. Front-line managers are correctly responsible for taking decisions in relation to supports and potential care arrangements for children. However, they do not have corresponding budgetary authority. This disconnect between national and local level makes it difficult to effectively manage the service.

A further specific resourcing issue identified during the review relates to the level of maternity cover required for social work services. The social work profession is predominantly female. In addition, their average experience is 8.4 years (see graph 46(a). Together they underline the potential implications for service delivery in providing cover for maternity leave.

Support for social workers

Professional supervision and Continuing Professional Development are key supports for social work professionals. In some LHOs – particularly Dublin – social workers have an average of 3 – 4 years experience. This underlines the importance of both professional supervision and CPD. The HSE has developed a supervision policy for all professions which will also apply to social workers. This focuses on individual supervision. However, it is unclear how senior social work managers and professionals will have access to supervision. We also found:

- A lack of understanding and clarity on the critical elements of CPD and how they contribute to overall practice development.
- Variation in how LHOs provide CPD. Some services have structured training while this is not the case elsewhere because of the embargo and other constraints..
- A key gap relates to the supports available for senior social workers. Many of them are either in senior positions and/or in post for some time and have not had structured opportunities for CPD.

Under the Health and Social Care Professionals Council Act (2005) social workers will have to be registered to practice. This will change the context within which CPD and professional supervision happen in the HSE. The new Council set up under the Act will enforce standards of practice and education for social workers.

Interface with the Courts

How the HSE interacts with the Courts is a 'flashpoint' of systemic weaknesses, exposing key deficits in how they deliver child protection. The current organisational structure complicates interaction with the Courts. Social workers often feel exposed in court and this is partly due to the lack of clarity on accountability. In addition, cases and service arrangements can be complex. This makes it difficult for the judiciary to identify individual case histories and to identify the appropriate individuals with the authority to take forward actions. These factors complicate already intricate and sensitive cases. There is little corporate-wide coordination of learning in relation to courts at local level. Individual LHOs will get legal opinion on cases even though similar cases may be before the courts in other LHOs.

The HSE has taken steps to improve its interaction with the Courts but it is still a significant area of corporate and individual stress. Tangible changes in how the HSE interacts with the Courts would also signal its intent to address wider issues on how it delivers better outcomes for children.

What this means for the future

The level of variation in delivering child protection services is unnecessary even allowing individual social workers the legitimate space to exercise their professional judgement. The root cause of these variations is the absence of a coherent service model together with how professionals collaborate with other to deliver services. The HSE is already putting in place initiatives to bring more consistency to practice at local level. However, it also needs to agree a clear strategy and service model, develop how professionals collaborate with other services and agencies, and build its supports for social workers. This will require changes in how social workers deliver services so that there is more consistency in how they apply their professional expertise in the context of emerging practice.

The emerging PCT and PCN delivery structure for primary and community care should address some of the service gaps that constrain social workers in providing the full range of supports that children need.

2.3 What the data tells us about service delivery

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The HSE collates data on its child protection services monthly and quarterly. This data forms the basis of the Annual Report on the Adequacy of Children and Family Services. In addition, the HSE conducted an extensive survey of social work and family support in 2008. Drawing on these sources we developed a service profile that facilitates review of the data across LHOs (see Appendix A). This illustrates the possibilities of immediately developing current data to a workable and valuable management information tool for all managers.

The data in Appendix A extracts some of the data available in the HSE in relation to: need, resources, service activity and outcomes. For illustrative purposes we have highlighted key performance issues under each.

1. Need: Distribution of resources does not correlate with the indicators of child population need

The SAHRU* index shows the size of the child population per LHO in the most deprived socio-economic group, who tend to be most at risk of child protection issues. Figure 2 shows the number of children in this vulnerable population per child protection staff member by LHO. It shows that resourcing is not influenced by the indicators of child population need.

2. Resources: There are variations in staffing levels that are not indicative of need

As figure 3 illustrates, there is a broad range of child protection workforce size across LHOs. Relating workforce to workload, or LHO population, does not entirely explain the differences in child protection staffing by area. The data suggests that child protection workforce is still predicated on legacy staffing levels from the old health boards, rather than the requirement for resources in each LHO.

There is also noteworthy variation in years experience and length of service of staff by LHO, ranging from 4 years in some of the busiest Dublin LHOs to 12 years in some rural LHOs with lower referral volumes.

Figure 2

Estimated Child Population in SAHRU Decile 10 per Total Staff Number

Table 49

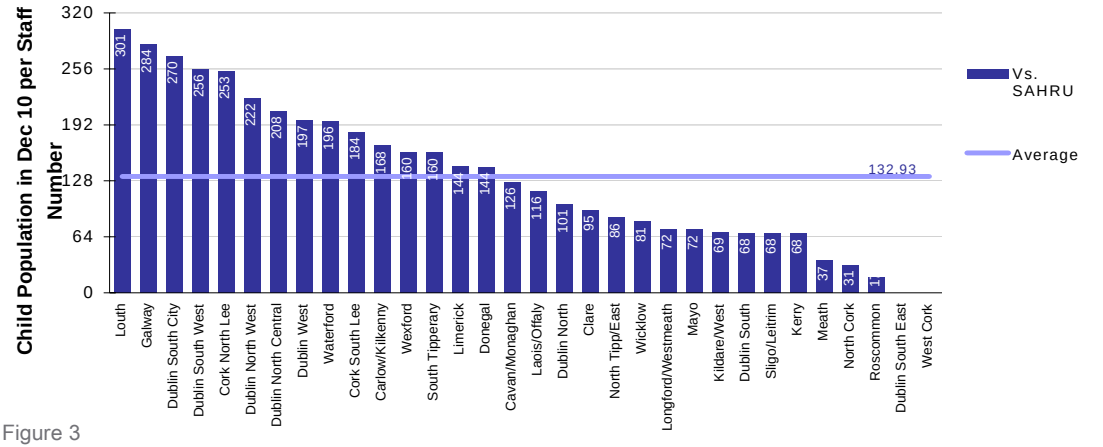
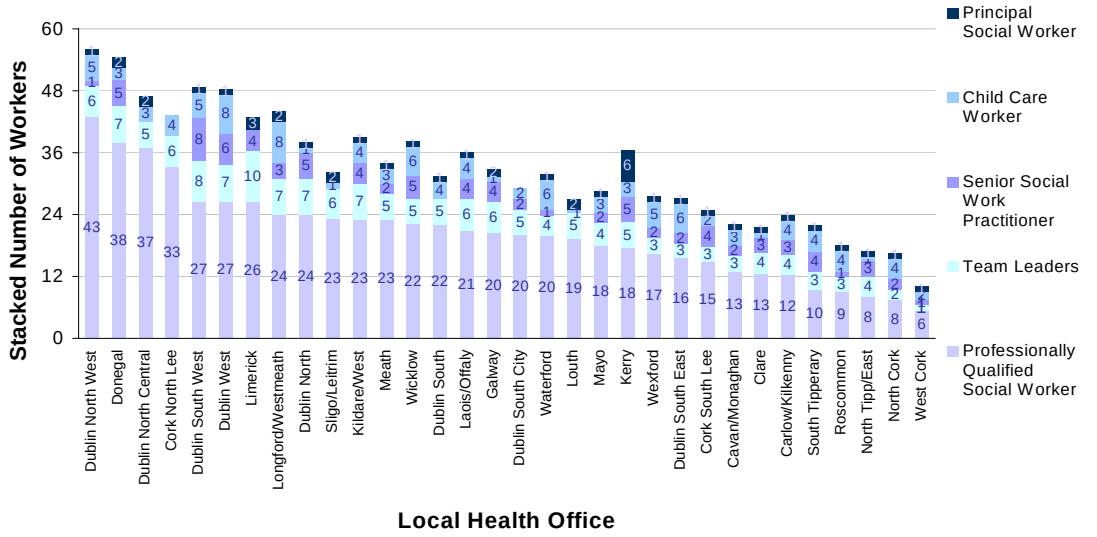


Figure 3

Numbers of Key Workforce by LHO

Table 24 Detail



*Small Area Health Research Unit - SAHRU - is a national deprivation index. SAHRU Decile 10 refers to the most deprived population groups.

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3. Service activity: The LHO approach to case allocation and management is inconsistent

'Welfare' is the overall most common reason for a referral (55% of all referrals) however by LHO, it accounts for between 96% and 6% of referrals, reflecting the different approaches and emphases taken by LHO.

Similar variance is in evidence regarding risk designation. The proportion of cases designated 'high risk' averages 41% nationally. At LHO level this ranges from 81% to 18%.

In some LHOs, a high proportion of cases (up to 70%) are not allocated to a social worker. Whilst the definition of case allocation varies, the data points to an unnecessary degree of variance in approach and suggests potential risk in unmanaged cases on waiting lists. The caseload per social averages 17.9 nationally. Further analysis shows significant differences by LHO, as the average caseload ranges from 4 to 40.

On average, each social worker spends 7.9 hours per week travelling – approximately one working day. This ranges from 2 hours to 16 hours, and does not seem to be determined by the geographical area covered by the LHO.

This analysis provides a starting point for understanding the areas and reasons for variance in service delivery by LHO.

4. Outcomes: The outcomes delivered for children vary by LHO

Available outcome information such as the proportion of the child population in care, and the length of stay in care, is highly variable by LHO. Neighbouring LHOs deliver very different outcomes for children. The data also shows that a considerable proportion of children in care, over 40%, have a length of stay of more than 5 years.

The number of children in residential care per 1,000 child population by LHO averages 0.54 but varies from 0.25 to 1.55. The number of children in foster care per 1,000 child population by LHO averages 3.24 but varies from 1.14 to 7.52.

Figure 4

Allocated Cases by LHO

Table 31

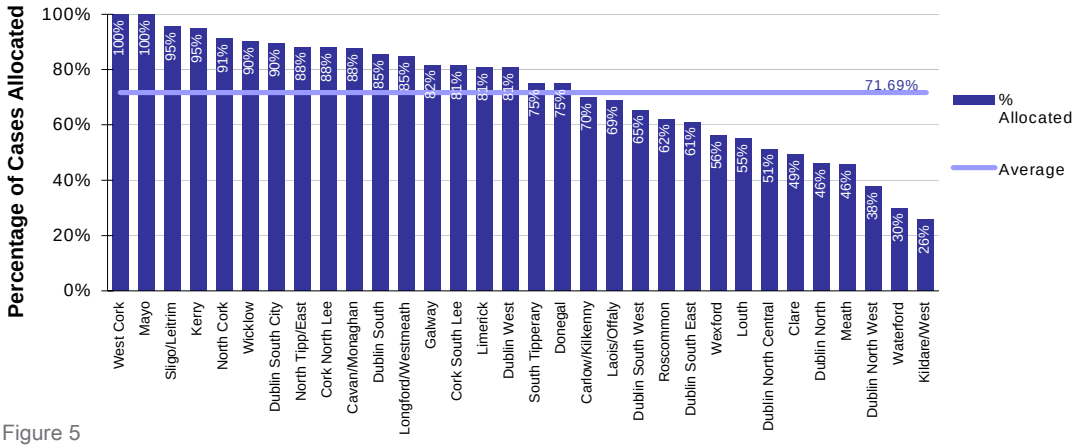
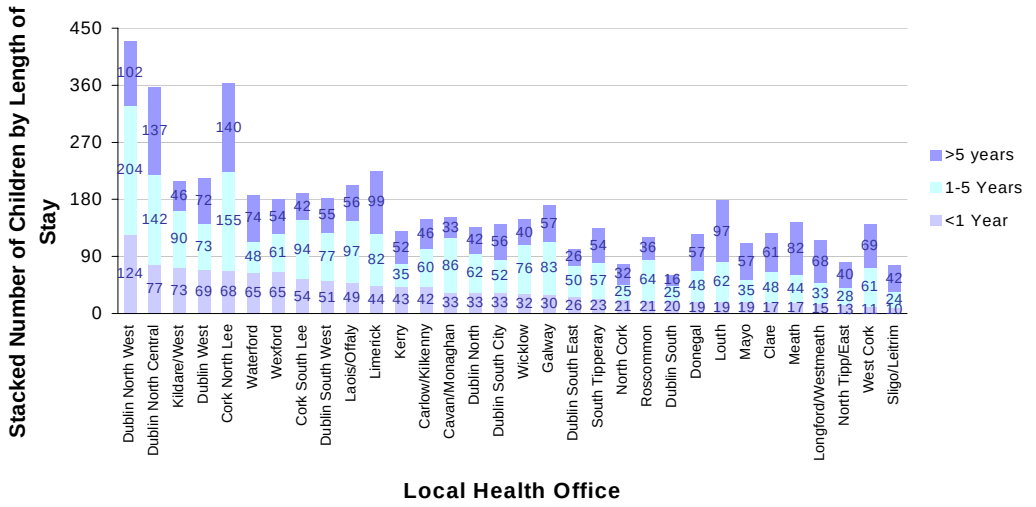


Figure 5

Length of Stay of Children in Care

Table 14



2.4 Performance management

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The service is missing key elements of an effective performance framework. The available child protection data set provides a good foundation for a future performance management infrastructure.

Our Findings

Performance management to deliver citizen outcomes is a central tenet of the Government's public sector reform programme.[5] The review considered whether current child protection structures have the capacity to monitor and evaluate performance, and to use this information to adjust policy and service delivery accordingly. This review found that there is a rich child protection data set but key elements of an effective performance framework are missing.

- **The HSE has made substantial progress in gathering data on its child protection service.** The HSE has comprehensive data collection processes in place, providing a rich dataset on a regular basis on most aspects of service delivery, excluding finance. Data collection is however limited to the child protection service, rather than reflecting the services and agencies that deal with children. The HSE publishes an annual report on children and family services which provides comprehensive information on performance of the service.[6] However, there is little evidence that this is being used to inform current and future delivery of the service.
- **Despite the wealth of data, there is an absence of management information.** Data is not collated and interpreted to distil key messages for those managing and delivering the service, such as demand levels, service activity and efficiency, and crucially the outcomes delivered for children. Managers are not routinely using existing data to inform their approach to service planning and delivery. This is partly because of a lack of confidence in the accuracy of the data and inconsistency in the definitions across LHOs. However, these quality issues would be addressed through more routine use of existing intelligence.
- **Financial management information in particular is limited:** There are significant inadequacies in the HSE infrastructure which make financial reporting on child protection difficult. Financial management information is not sufficient to manage the service as it cannot allocate and prioritise resources. Budgets are unclear, and accountability for spend is disconnected from decision-making regarding the service.
- **Desired outcomes and performance indicators are not defined:** The service would benefit from a clear, shared definition of success for children articulated into meaningful metrics that the service can use to monitor and manage delivery. This would inform goals and objectives at local level, and provide clarity on the performance of the service at all levels. Defining outcomes for the service is not easy but the process of doing so helps to shift mind-sets from the HSE *can* deliver to what it *should* deliver.

Addressing these issues would provide:

- the *intelligence* to focus the service on achieving the desired results for children
- all levels of the HSE will a clear picture of performance and efficiency.

The governance framework must also provide a structure for considering and using intelligence to drive the service. The available data is not used to inform discussion and review service performance at any of the routine local or national child protection fora. The data could be used to drive priorities and actions at local level as well as informing strategic decisions on the directions of the service and the allocation of resources. The reticence in applying data to develop services raises wider cultural issues relating to performance management in the HSE and is not confined to child protection.

What this means for the future

The existing data collection provides a foundation for performance management and allows for the immediate introduction of monthly management information. this management information would provide vital support to those managing and delivering child protection services, monitoring trends, practices and informing future policy and resource allocation. the collection of supporting data could be expanded to draw on other services (e.g. CAMHS) and agencies (e.g. gardai) to provide a holistic and system-wide view that is child-centred. The future development and enhancement of the service requires an articulation of what success looks like, supported by outcome metrics to show how the service is delivering. Creating a structure with the responsibility to review this information and the authority to act upon it would transform child protection to an intelligence led service.

Part B outlines proposals to build confidence in the management and delivery of child protection.

Section 3 outlines thinking behind the recommendations:

3.1 Foundations for the future

3.2 Six principles to guide future management and delivery

3.3 Elements of evolving strategy and service delivery model

3.4 Foundations for developing the Service

Section 4 outlines recommendations to:

4.1 Develop strategy and coherent service model

4.2 Deliver child-centred services consistently

4.3 Develop an intelligence-led delivery of services

4.4 Develop a clearer management structure

3. Looking Forward – Foundations for the Future

There is clear evidence from this review of the commitment and initiative of individuals in the HSE who work with children. They work with and manage services for the most vulnerable members of society in situations that can be highly stressful. Despite this evident commitment and competence, overall confidence in child protection is low. This review has found significant problems in service delivery which require action at a number of levels:

- Agree and communicate a clear service model for the future that focuses on outcomes for children. This should guide both managers and all practitioners on the priorities for engaging with children at risk.
- Bring consistency to how the HSE delivers services, strengthen collaboration and provide supports to people working with children and their families
- Develop an intelligence-led system that uses data currently available to improve the service
- Simplify and make clearer key roles and responsibilities across the delivery system.

All of these elements are essential and together they constitute a significant programme of service and cultural change the scale of which we do not underestimate. Together they will provide a clear framework within which everybody working with children can be clear of their own responsibility, accountability and authority for ensuring children's wellbeing. Ultimately, it is about people being clear about what's expected of them and ensuring that they have the supports to deliver services.

The Ryan Commission Implementation Plan clearly indicated that any additional resources would depend on significant service reform.

The temptation in a review like this is to propose significant structural change. Embarking on a journey of structural change can give a sometimes false assurance that change is happening. However, it can often distract from the main motivation for change and take up too much time and energy to implement. This review has shied away from major structural change. Our focus has been to propose changes that are absolutely necessary to:

- Bring clarity to key roles – both internally and externally,
- Ensure that the structure reflects and drives key functions.

The HSE is currently 'reconfiguring' its services at national, regional and local level. Our proposals takes as their starting point the structure agreed at national level and will be flexible to incorporate PCCC changes at local level. A key new role is the post of Assistant National Director for Children and Family Services. This post will provide clear leadership at senior level in the HSE and should, with appropriate authority and resourcing, provide the leadership to drive this change programme.

As a general rule, 'structural' change is designed to implement strategy and service models. This was not possible in this review as the service model is not defined. However, our proposals reflect our understanding of what the HSE's service model should include based on emerging practice. In this section we outline:

- Six Principles guiding our recommendations for the future. These set out what the proposals must achieve.
- Our thinking on the core elements of the future service model. These are based on what practitioners and academics have learned about child protection in Ireland and internationally.
- Foundations for the future which develops recommendations based on the four parts of our assessment framework.

3.1 Six Principles to guide future management and delivery

We have identified 6 principles to guide the future delivery of child protection and our recommendations. They are easy to understand, easy to identify with, and should garner widespread support across all practitioners and managers working with children and their families. They reflect what we found during the review, the national policy and legal framework, International experience and research on child protection. As such, they provide focus and rationale for making the changes that we recommend.

A clear requirement of the review is that recommendations should 'fit' with the overall reconfiguration programme that the HSE is developing. At this point, the national structure is being implemented while structures below regional management level are not yet fully determined.

We have also taken account of the Ryan Commission Implementation Plan which includes 35 actions on the management of child protection. Our recommendations complement the actions identified in the Implementation Plan.

Principle	What we mean by this
Structure capable of delivering change	• Future focused leadership at all levels of the HSE • Helps to drive delivery of clear service model that includes family and community supports
Child Focus	• Built around the child; not what the service can deliver with single point of contact for each child/family • Future focussed service planning for children based on predictable transition events
Simple and clear structure	• Clear points of authority, responsibility and accountability at national, regional and local level • Structured to deliver goals and manage risks
Confident	• People in the system are confident and people have confidence in the system. • Clarity about what the system is there to deliver and supports needed. • Consistency in how services are delivered
Taking responsibility and being accountable - Openness and transparency	• All professionals are responsible for Child Protection – not just social workers. • Supports collaboration between professionals, services and agencies - communication and trust • Professional delivery of services within the context of corporate accountability
Intelligence led	• Bring intelligence to decision-making on children's futures • Use intelligence for tighter management across all levels on service activity, outcomes and resources

3.2 Elements of evolving service delivery model

Social care and well-being is intrinsically and mainly about deprivation and neglect; about ameliorating the effects of these for individuals, families and communities; about supporting them in building upward spirals in their lives. Child abuse occurs across all circumstances; often it is about intervening in downward spirals, often it is about stopping abuse.

Leaders of these services in HSE, as across the world, face dilemmas and opportunities in deciding how to direct resources, follow through on plans and vitally deliver the clarity, confidence, communication and in time the stability that is needed. Certain features must be designed into delivery e.g.:

- If children come into care act fast to rebuild family or alternative family care;
- if this is not possible after some weeks, then intensify efforts;
- after a few months more or perhaps a year then recognise that the child may be in care long term, avoid repeated admissions;

Parents, families and communities vary enormously. They all have strengths as well as weaknesses. They face different challenges. It is a professional task to recognise pro-actively what these might be; how unexpected transitions may effect stresses in personal and family coping, how predictable transitions may effect families as well as individuals.

Figure 6 illustrates the hierarchy of supports for children and families based on the Implementation Plan arising from the Ryan Commission.

The service model must cover 5 critical points

- Ensuring an effective system of referral management
- All areas need a professionally led team focused on supporting families, in some cases probably over decades. This needs to be proactive, and SW led. Refocusing professional work on this is a major task. Each case needs careful planning. (See Monageer)
- All children in care need to have their own social worker, from day one. Establishing their particular focus (and indeed file), and taking responsibility. There should be some degree of ceremony, respect – but again not too much.
- Interagency work needs good communication, feedback, letting people know what is happening,
- Forms and IT systems should be practitioner led, research informed and system delivered.

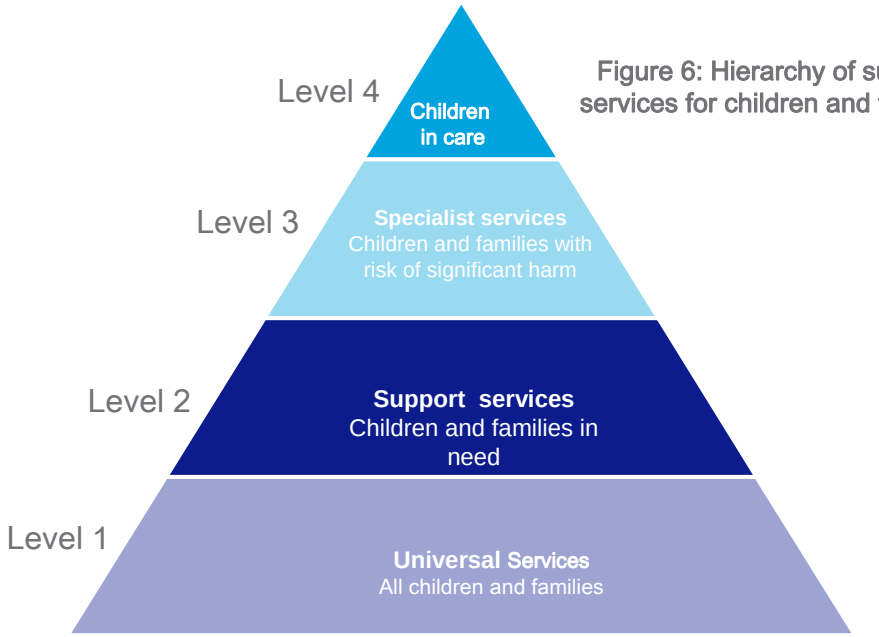


Figure 6: Hierarchy of support services for children and families

3.3 Foundations for developing the service

Figure 7 illustrates the foundations for building confidence in child protection services in the HSE. The four elements are based on the assessment framework for reviewing services.

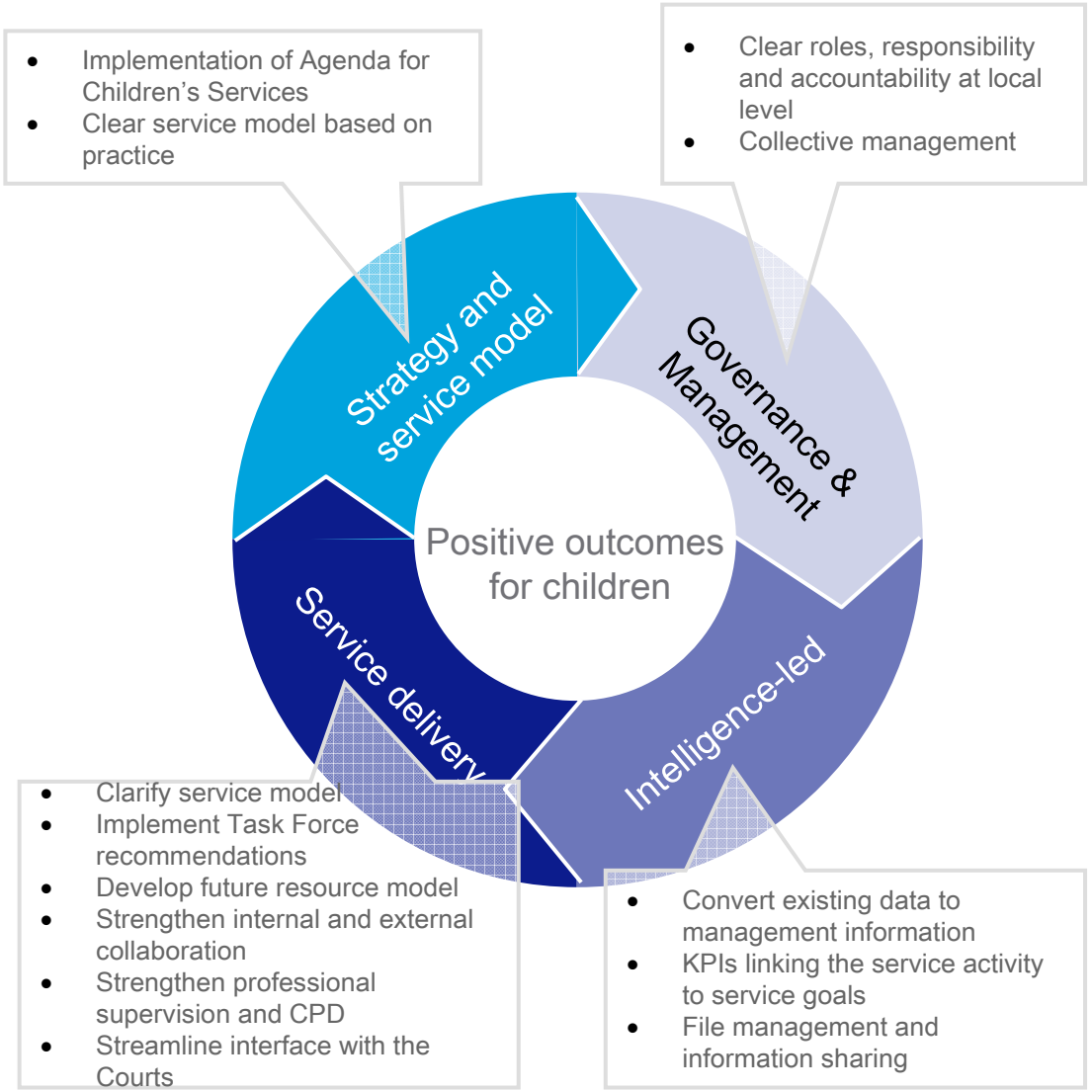
They are all essential building blocks of change although there may be slightly different timescales for implementing them.

- The first and most urgent requirement is to develop the service model which focuses on outcomes for children.
- We are proposing minimal change to the structure to avoid distracting from the overall change programme. Most of the change proposed can be implemented relatively easily.
- The HSE already has a number of initiatives to bring consistency in how services are delivered. The recommendations in this review support and complement these initiatives. In addition, we focus on a number of key areas central to effective service delivery – some of which can be implemented immediately, others will require longer timescale.
- The HSE can immediately make significant strides towards the 'intelligence-led' service delivery. It already collates data that, while not perfect, is a valuable starting point for looking at the service and collaborating across services.

On their own, individual recommendations will have limited impact. However, if implemented as a coherent programme of change, they should significantly affect how the HSE protects children.

This report also includes a proposed implementation plan. Making it happen will put significant demands on individuals at national, regional and local level to make them happen. The new Assistant National Director for Children and Family Services will play a key role and will need to be supported and resourced to do so. Once they are in post, they may want to vary the implementation plan to ensure that it reflects their priorities.

Figure 7: Overview of recommendations



4.1 Develop coherent service model

4.1.1 Develop immediate response to the Agenda for Children's Services

The Agenda for Children's Services is the Government's policy framework on children and family services. The HSE needs to adopt a detailed plan for implementing the Agenda to underline its overall commitment to children and family services and to inform its future service model. This is also a requirement of the Ryan Commission Implementation Plan.

4.1.2. Urgent priority to articulate and communicate service model

The HSE has an immediate need to articulate a clear model of services for children and families to guide how practitioners deliver services. An early priority of the new AND for Children and Family Services will be to develop this service model in conjunction with social work managers.

The service model should reflect the *Agenda for Children's Services* and include guidance on:

- Early intervention
- Family supports
- Permanency planning – managing expected and unexpected transitions
- Crisis management including out of hours services
- Children in care and aftercare
- Working with other agencies.

The development of the service model is an important opportunity to work with senior social work managers and other practitioners to get a shared view on how the HSE can support children and their families. It is therefore an early opportunity to put down some leadership 'markers' across the service. We would therefore recommend that the new AND should develop the service model through discussion with senior social work practitioners, CCMs, LHMs and other relevant practitioners working with children. While it a pressing need for the HSE, it is critical to develop a sustainable, coherent and workable model.

4.2 Child-centred service delivery

4.2.1 Implement recommendations of the Task Force to bring consistency to child protection process

The HSE set up a task force to review key processes governing child protection together with key roles and responsibilities. Appendix B illustrates the key steps in the child protection pathway. The HSE should urgently take steps to implement this level of consistency. It will provide assurance that LHOs are consistent in their approach to investigating child protection. In addition, the new AND for Children and Family Services needs to clarify key definitions and thresholds governing areas such as:

- Allocated/unallocated cases
- Case files – should they be defined in terms of families and/or children
- Definition and treatment of risk.

The HSE's current data on children and family services provides rich information on the varying practices that apply across LHOs and the outcomes they deliver. The AND for Children and Family Services should review the implications of this data to understand resourcing and practice of service delivery.

4.2.2 Develop future resource model that reflects need

A central finding from this review is that the current allocation of resources does not necessarily reflect children's need. The recent Survey6) provided valuable information on the allocation of resources across LHOs. Appendix A illustrates where resources are located. We recommend that:

- Data on resources should be routinely collected either through the ChildCare Data set or annually through the section 8 review, Survey of Adequacy of Children and Family Services.

- Additional posts allocated to the HSE under the Ryan Implementation Plan should be allocated on the basis of need rather than automatically where the original post was vacated. This should help to redress the resource imbalance and particularly prioritise the Dublin area.
- The AND for Children and Family Services should continually review resource allocation levels with LHMs and local managers of children and family services to ensure that they correspond to need.
- The AND should review the relationship between resourcing and service delivery and in particular propose options to provide cover for maternity leave where it is affecting service delivery. Options to consider include the possibility of 'roaming' teams to provide cover where it is needed.

4.2.3 Strengthen collaboration with other services in the HSE.

There are some significant structural constraints that affect cross-service working. The HSE is addressing these constraints as part of its current transformation programme. Pending this wider programme of change, the following measures could strengthen cross-service working:

- More structured multi-disciplinary fora at local level to collectively review cases and services. The new Manager of Children and Families Services at local level will convene these fora. These fora will help to:
  - Address cross-service issues for individual children and ensure that services are targetted in a focused way for individual children and their families. This will provide a basis for setting outcomes for children and families from external providers.
  - Identify wider service issues affecting families
  - Review range of supports provided by all services for children.

These fora will be 'intelligence-led' drawing on data available to practitioners.

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- A key barrier limiting cross-service working is how professionals talk to each other. How professions value themselves and their professional standing becomes a factor. Elsewhere, we make recommendations to strengthen CPD and professional supervision. These will enhance cross-professional working. PCT's and PCNs will also stimulate new ways of working for primary services and this should have a knock-on effect in child protection.
- Review how the service interacts with children to listen to their concerns in line with the recommendations of the Ryan Commission Implementation Plan.

4.2.4 Strengthen collaboration with other agencies

This is a challenge that goes beyond the HSE and raises more fundamental questions on inter-agency working in the public sector and also about the professional standing of social work practitioners

- In the past year, the HSE has tightened its management of services delivered through the voluntary sector. These relationships need to be further managed so that:
  - there are clear national and local arrangements in place governing service delivery
  - Services are delivered for identified families and children rather than through programmes.
- The new Manager of Children and Family Services at GM level will play a key role in collaborating with other agencies. For the most part, collaboration on the ground depends on the quality of local relationships. The Manager will help to facilitate these relationships by putting local arrangements in place as appropriate. An early priority is to develop collaboration with the Gardai and the NEWB. Engaging with all educational bodies will be central to future services.

- Develop pathways to facilitate inter-agency working.
- Collaboration with other agencies should focus on sharing information and intelligence. Current data sets are not geared towards inter-agency working but they could be refined and adapted to make them meaningful. Within the limits of data protection, information sharing should also identify the needs of individual families who need support. The proposed National Chlldcare Information System will assist collaboration but does not depend on it.
- The AND for Children and Family Services will play key role in developing national framework for inter-agency working which will form the parameters of local relationships.

4.2.5 Strengthen professional supervision and CPD

The HSE has agreed a staff supervision policy and this needs to be implemented urgently. The policy covers roles and responsibilities of the organisation, the supervisor and supervisee; the contract; This will ensure that there is a rigorous process of professional supervision in place before the statutory requirements under the Health and Social Care Professionals Act 2005 applies. However, it does not explicitly address the needs of social work managers. Their needs also need to be addressed. These could be addressed through informal group supervision or through CPD. The most realistic option is through CPD.

The ultimate responsibility for CPD lies with individual social workers and their managers. However, we are recommending that the HSE should support the development of CPD by:

- Clarifying the implications of the registration process with the Health and Social Professionals Council and the National Social Work Qualifications Board
- Engaging with Schools of Social Science to see how they could support CPD for the HSE.
- Developing a framework for delivering CPD that covers:
  - Professional competence and practice
  - Management competence. All social work managers will be required to manage people and their service and need to be supported in this.
  - Personal competences.

  Delivery of CPD will be through a number of routes.
- Programmes of CPD support should be concentrated initially to :
  - Develop competences of social workers who have most recently completed their qualifications. The Survey on Social Work Services conducted in 2008 suggests that some LHOs – particularly in Dublin – have particular development needs because of low average experience. Dublin also coincides with the highest volumes of referrals.
  - Develop management competences of all social work managers. The HSE is currently developing programmes to build leadership competence throughout all services. The option of prioritising social work managers for a pilot customised programme should be assessed.

4.2.7 Streamline interface with the Courts System

Simplifying the management and delivery structure for child protection should yield improvements in how the service interfaces with the Courts. In addition, the AND for Children and Family Services should take responsibility to support LHOs in interacting with district courts and the High Court through:

- Taking a coordinating role in relation to court representation in the short-term. This should include support to social work professionals and managers who represent the HSE through, for example, an expert witness programme and/or coaching. This would both professionalise how the HSE interacts with the Courts and develop the confidence and competence of individuals representing the HSE.
- Overseeing the consolidation and sharing of legal opinion on practice and related guidance.

Our understanding is that the HSE is planning to set up its own Legal Service. Once this is established it will be a critical central resource for LHOs in coordinating court cases.

4.3 Performance Management: Developing an intelligence-led system

4.3.1 Implement immediate management information based on existing data

Existing data collection processes provide sufficient data with which to develop a monthly management information report, covering aspects such as:

- Access: including demand for services
- Efficiency: including activity by LHO
- Integration: reflecting joint-working internal and external to the HSE
- Outcomes for children.

Appendix A provides a template to illustrate how this data could be presented and applied to provide individual LHO performance and aggregate performance at regional and national level. The proposed categories currently apply to HealthStat. There is scope to expand data gathered at local level to include delivery of services for children, family conference, strategy meetings which some LHOs are already collating.

4.3.2 Develop outcome-based performance metrics

Linked to the development of the service model, the system requires a shared definition of what success looks for children, translated to a set of clear metrics to monitor benefits delivered.

4.3.3 Clarify budget and expenditure reporting

The budget allocated to each function of the future model at LHO level must be clarified. It is essential that local managers are aware of the budgetary framework within which service decisions are made. This requires:

- Clarification of the budget at national, regional and LHO level
- Development of monthly financial reporting on expenditure.

4.3.4 Develop a workforce model for the service

The analysis of existing data shows variance in workforce allocation and utilisation at LHO level. The refreshed structure provides an opportunity to re-visit resourcing by LHO, based on child population need and service demand. The operational consistency promoted by the taskforce work will also help the service move towards more uniform caseload levels.

These factors will be important to incorporate in a workforce model showing how resources will be organised in the new structure.

4.3.5 Long-term development of intelligence-led system

Both the Ryan Commission Implementation Plan and the Knowledge Management Strategy provide detailed proposals for the longer term development of information systems and information sharing. The HSE is committed to implementing these recommendations in conjunction with the OMCYA and the Department of Health and Children. These cover

- Integrated case management to facilitate delivery of services
- Development of National Child Care Information System to support front-line staff and managers across all agencies interacting with children.

4.4 Towards a clearer structure

In line with our six principles, we are proposing changes to the management structure to ensure that there are clear points of accountability, responsibility and authority at national, regional and local level for children and family services.

Our proposals reflect a number of 'givens':

- The HSE is currently re-configuring its national structure and senior lines of responsibility at regional level. This includes a new and potentially crucial element in providing leadership for children and family services – the post of Assistant National Director for Children and Family Services.
- At this point it is unclear what the structure below the proposed Regional Operations Director is likely to be. Our understanding is that at a minimum the HSE is likely to combine some of the smaller LHOs to bring more consistency in LHO size. However, the scale of any re-configuration at local level is unclear at this point and any wider management implications.
- The PCT and PCN will be the central axis around which primary care services will be provided to children and their families. Social work services will therefore need to interact operationally with PCTs and PCNs to ensure that primary supports as well as more therapeutic supports are in place for children at risk. PCT's will be population-based and the local social work structure needs to be co-terminus with PCT/PCN boundaries.

Within these 'givens' there is still some uncertainty around the future overall model of delivery of PCCC services. For this reason, we are proposing the minimum changes required to bring clarity to people's roles in the context of what child protection and welfare require.

We considered two principal options to adapt the structures.

1. A 'command and control' type model with all services reporting to the new AND for Children's Services post.
2. An integrated model of delivery that positions children and family services within the overall PCCC framework.

We briefly outline what the first option might look like, its benefits and drawbacks. It is a very attractive option for bringing clarity and transparency to the management structure and strengthening social work. It would also give real 'bite' to the new Ass. National Director role.

However, it suffers from a real disadvantage in that it is contrary to the stated ambition of the HSE which is towards service integration. This model would be akin to developing a national service. It would also create new risks of further isolating social work from other services and professions to the detriment of children.

On balance therefore we have opted for the integrationist model. We are also proposing that core elements of a future service model (children in care and children's wellbeing) should be reflected in the management structure at local level to help drive change in children and family services.

We are assuming that the HSE will streamline the LHO structure with smaller LHOs being amalgamated. This means that the proposed structure should be viable in all LHOs. If this amalgamation does not happen the proposed structure at local level will need to be adjusted to reflect the needs of smaller LHOs.

3.2 Option 1: 'Command and Control' management structure for Children and Family Services

Key Features of this option are:

- ❑ The local structure reports directly to the AND for Children and Family Services
- ❑ There are no formal operational connections to the PCCC and regional structure
- ❑ Local structure – defined on the basis of case loads allocated by team. Variations of this structure at local level could include dedicated managers for children in care and for children's well being as outlined in option 2.

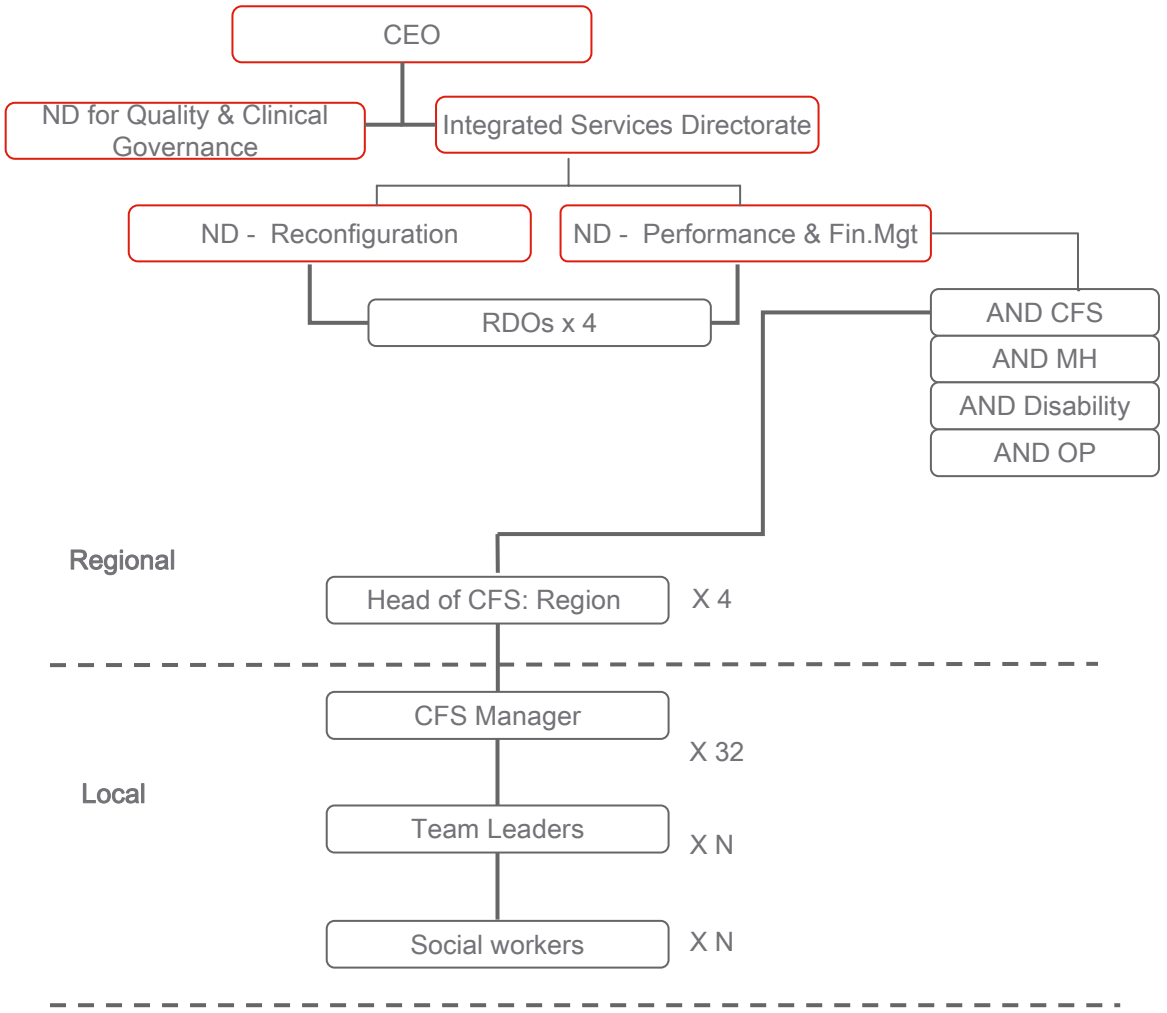
The strengths of the option are:

+ Strengthens the 'spine' of social work department
+ Brings clarity to both the strategic and operational structure with a clear line of sight from top to bottom
+ Able to deliver change in relation to Child Protection – bringing consistency of implementation of Children First
+ Focussed on child protection *and* families/welfare
+ At local level focus on individual cases

Weaknesses

– The potential effort in strengthening social work could distract from the core purpose – delivering positive outcomes for children.
– The structure does not encourage move to emerging service model
– It is removed from PCCC and could be isolating from core services and make cross-service interaction more difficult
– The signalling and messages run counter to integration messages of the HSE.
– It is potentially isolationist and stigmatising for social work professionals.

Figure 8: 'Command and control' management structure

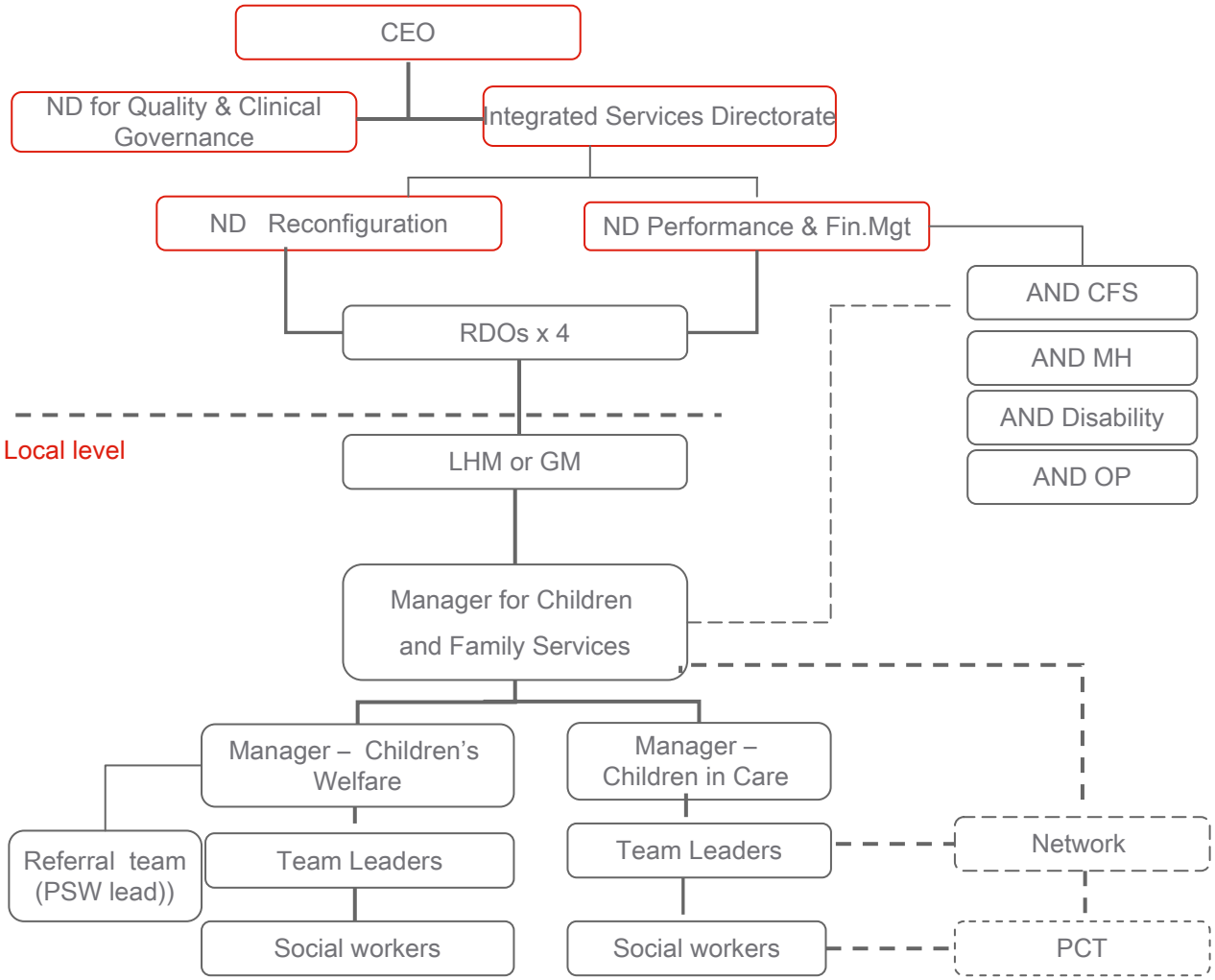


Option 2: Recommended option: 'Integrated PCCC model'

Key features of integrationist option:

- The AND for Children and Family Services will provide overall direction although operational responsibility will be through the RDOs. This is in line with the HSE's current reconfiguration programme. The AND will be allocated a team from the current specialist roles who will have responsibility for overseeing development of core services.
- The re-configured PCCC structure is the primary delivery route for Children and Family Services i.e. via Regional Director and LHM or the GM
- A full GM post for Children and Family Services – this will be the direct point of contact for inter-agency and inter-service collaboration at local level. There will be management responsibility for Children in Care and for other children and family services related to children's welfare. This single role replaces the current roles of CCM and PSW, which are not required under the new structure.
- The core delivery structure below manager level i.e. Team Leaders and social worker - will be similar to what exists at present. There will be a dedicated referral team led by a PSW to handle all referrals.. They will report to the Manager for Children's Welfare to minimise the potential number of service handover points for children.
- The new structure will be integrated to Primary Care Teams and Networks to ensure that families are getting supports early. Team Leaders will play a central role with PCTs/PCNs. Key Worker will co-ordinate service for children. Key worker will be determined by referral path into the system e.g. through family services, child protection referral. Child Protection Team Leader retains accountability where there is a Child Protection issue
- Senior social work practitioners will have a key role in particular difficult cases and in providing CPD and professional supervision.

Figure 9: Integrated Model

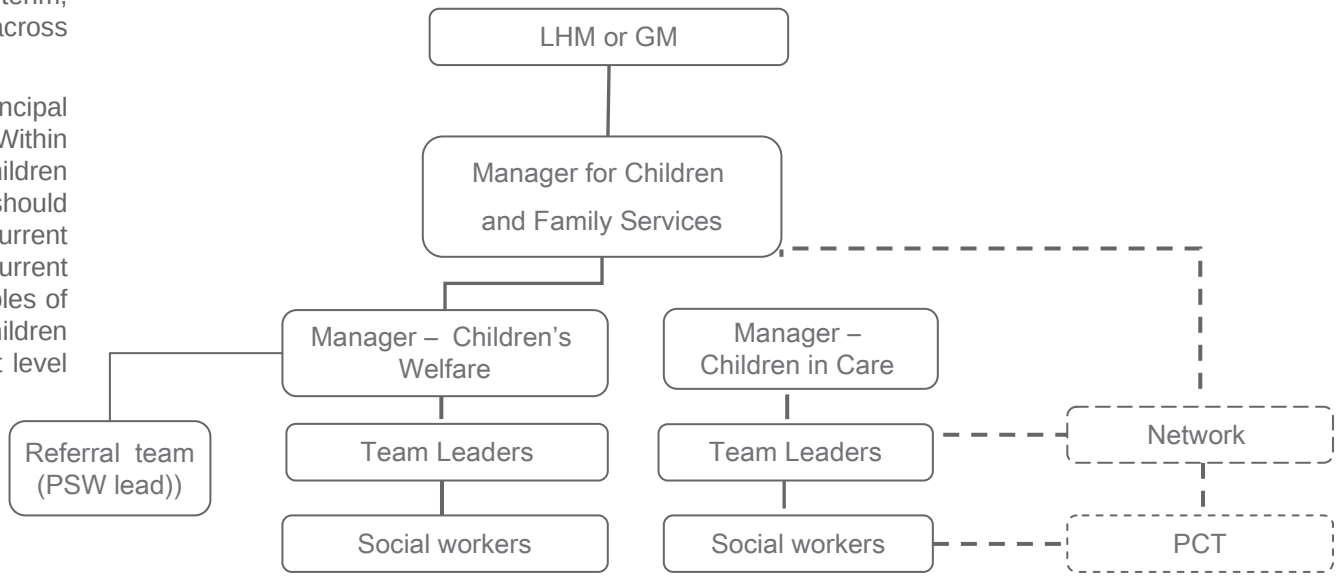


Option 2: LHO level view of recommended option: 'Integrated PCCC model'

Key enablers of integrationist option:

- This model is designed to ensure clear accountability and responsibility at LHO level through the allocation of responsibility for children's welfare and children in care with a separate referral team managed by a PSW. This structure would not however be viable for smaller LHOs. The model assumes that the number of LHOs will reduce as part of HSE re-structuring and that if necessary in the interim, Children and Family Services would be shared across smaller LHOs.
- The two legacy roles of Child Care Manager and Principal Social Worker will not be required within this model. Within this simplified structure, the role of Manager for Children and Family Services replaces both these roles. This should not generate an additional resource requirement. Current PSWs and Child Care managers will retain their current Terms and Conditions and will be allocated to new roles of Manager for Children's Welfare and Manager for Children in Care. Any new appointments at this management level will be at PSW grade or equivalent.
- The Manager for Children and Family Services reports to one management point within this structure. This will either be the LHM **or** GM of the LHO. We would recommend that the qualifications for this post should ideally include social work qualification and substantial experience in child protection.

Figure 10: LHO level view of Integrated Model



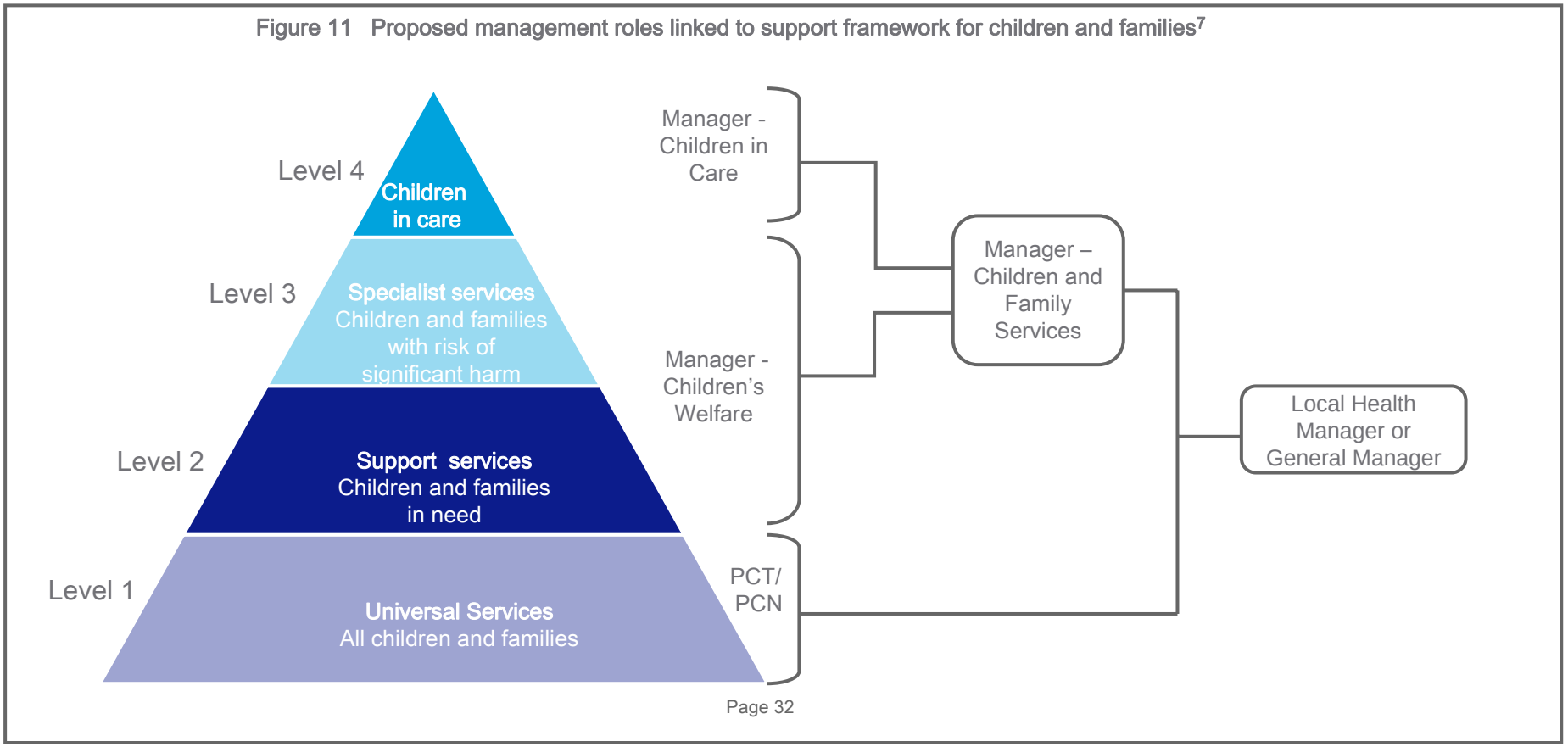
The principal strengths of the proposed management structure is that it:

- Is integrated with the emerging services models for PCCC and specialist services in the HSE. As PCTs and PCNs develop, this should correspondingly strengthen children and family services.
- Allocates a single point of accountability at local level for children and family services with clear responsibility for clinical and management leadership.
- Allocates responsibility for delivering key service elements locally i.e. Managers of Children in Care and Children's Welfare. This will help to drive delivery of new service model.

However, there are also a number of potential drawbacks:

- The PCCC structure and services are still not fully evolved at local/regional level. This brings an element of uncertainty to the model.
- The new role at GM level of Manager for Children's and Family Services carries important responsibility and accountability for clinical governance and management of the services. They will report to the LHM or GM but take guidance from the AND/CFS which potentially brings ambiguity and confusion to responsibility for operational delivery.

Figure 11 Proposed management roles linked to support framework for children and families[7]



AND for Children and Family Services

Under the HSE's current reconfiguration, this is a new and critical role in leading the HSE's delivery of children and family services in line with Government policy. In addition the new AND will be the key link to the Department of Health and Children in relation to children and family services.

The AND will be responsible for defining the delivery model at national model but will not have operational responsibility for delivering services at regional and local level. Their role will be critical in terms of providing national leadership but what will give them the authority to truly give the role 'clout' and exercise their remit? The risk is that the AND role will be become subsidiary to the operational needs of the regions and it will be difficult to find a meaningful way of engaging with services on the ground. The AND therefore needs the resources to give effect to its intended remit.

We recommend that the AND:

- Has a small Office staffed by all existing specialists with responsibility for key areas requiring attention e.g.
  - Development of strategy and service model at national level – an immediate priority
  - Development of learning culture through routine evaluation of services and in particular developing a framework of CPD and professional supervision
  - Development of 'intelligence' to guide system development. The current information officers are an important resource and should report directly to the Office while operating within the regions.
  - Facilitate development of local services by providing national framework of support e.g.
    - National Framework to assist local delivery in relation to critical issues e.g. separated children seeking asylum, inter-country adoption services, special care in high support, crisis intervention – interaction with the courts.
    - National framework for external providers with local management and targets
    - Resource allocation model to ensure that they are located where they are most needed.
  - Drive programme of change associated with implementing the recommendations of this review and also the Ryan Implementation Plan.
- Plays a central role in setting performance objectives for the service as a whole and its constituent elements. They would have overall responsibility for setting goals and KPIs through the National Service Plan.

Manager for Children and Family Services

This post will be at GM level and will provide both clinical and management leadership at local level. As such they will be the principal point of contact in relation to all children and family services at local level for the HSE and other agencies. They will:

- Provide leadership in setting and delivering local goals as agreed with the LHM and in line with national goals set by the AND.
- Be critical connector with other HSE services in particular overseeing linkages at local level with PCTs and PCNs – this will include development of pathways between level 1 and 2 services (see figure 10)
- Be principal point of contact for other agencies related to children and family services.
- Provide local coordination of HSE interaction with the Courts Service.
- Be responsible for resources and management of budgets at local level (budget holder)

The role of Manager for Children and Family Services is not an additional management post. It replaces the two legacy roles of Child Care Manager and Principal Social Worker. The Child Care Manager and Principal Social Worker roles will be allocated to either Children's Wellbeing or Children in Care.

- Oversee and report on performance including:
  - Service activity
  - Progress to goals
  - Resourcing
  - Serious cases.
- Have overall responsibility for quality assurance including professional supervision and CPD.

Manager - Children in Care

The key responsibility will be to oversee the provision of services for all children in care. They will:

- Ensure that there is a sufficient supply of fostering and residential services for children at risk
- Ensure that there are good quality care plans in place for children that are forward-looking and anticipate future transition events in children's lives.
- Monitor and assess the outcomes being delivered for children
- Oversee provision of services for children in care – both within the HSE and other agencies
- Match the needs of children to the services that are available.
- Ensure that there are sound consultation mechanisms in place to ensure that they listen to children's needs and concerns.
- Oversee the provision of aftercare services for children.
- Manage interaction with the Court services at a local level.

Referral Manager

A PSW will lead the intake team and will report directly to the Manager for Children's Welfare. While they could report directly to the Local Manager for Children's and Family Services, we are recommending that they report to the Manager for Children's Wellbeing in order to reduce the possible number of handover points for children. Their role will be to:

- Manage the initial referral to the service speedily and efficiently
- Interact with PCT and PCNs to identify potential referrals.
- Conduct initial screening in line with recommendations of the Task Force
- Conduct initial assessment in line with recommendations of the Task Force
- Review current referral and assessment processes to ensure that they make the referral process as simple as possible for people/agencies referring.

Cases will be managed on the basis of a quick turnaround. The PSW will have a small team comprising TL and social workers. The size of the team will vary according to the size of the LHO.

Manager - Children's Welfare

This role will provide professional leadership focused on supporting families and children in the first instance. The lead will ensure that support services and specialist services are in place for children (level 2 and 3 of the support framework) at risk. They will:

- Liaise with PCTs and PCNs in providing services for children and families
- Oversee the referral process
- Ensure that cases are allocated, risk assessed and service provided
- Oversee provision of care planning for children

- Liaise with PCTs and PCNs in providing services for children and families
- Oversee the referral process
- Ensure that cases are allocated, risk assessed and service provided
- Oversee provision of care planning for children
- Liaise with external providers of services to ensure that they are targeted on families and children that are most at risk.
- Provide professional supervision to all Team Leaders
- Identify CPD requirements of Team Leaders.

Team Leaders

They will continue to play a critical role in managing individual cases which will include:

- Allocating cases to social workers
- Monitoring individual caseloads
- Brokering services for children and their families
- Connecting with PCT and PCN
- Supervising staff including professional development

Some Team Leaders may be allocated specific responsibility to develop parts of the service model where there are identified gaps locally e.g. increase supply of fostering places, develop family services.

Senior Practitioner Role

This is a key resource for the HSE. Their role is essentially to:

- Manage particularly complex cases (level 3 of figure 6)
- Developing CPD within the LHO
- Developing professional supervision structures within the LHO and providing professional supervision for Team Leaders and social workers as appropriate.

4.3 Implementation constraints and challenges

We should not overestimate the scale of the implementation challenge particularly in the current service environment. The key constraints are likely to be:

- **Progress in reconfiguring the HSE at regional and local level is slower than anticipated due to current budgetary constraints**. The proposed management changes are linked to the overall PCCC reconfiguration programme. Any delays may also affect implementation of proposed recommendations. In this eventuality, we recommend that
  - in those areas where there is both a PSW and CCM, one is allocated as the single point of contact for children and family services in the LHO. This single change is the minimum required to bring clarity to the structure at local level.
  - Specialists in child protection are allocated to the AND for Children and Family Services.
- **There is resistance to the recommendations by people working in children and family services either at professional or management level**. Our sense is that most people will want to understand the personal impact of proposed changes for them. This is not unreasonable and means that the change programme must include a strong communications programme to sell the benefits of the change.
- **There is no appetite in the HSE to deliver the changes proposed.** Without leadership at all levels, the programme will not succeed. Our distinct sense is that there is commitment for a sensible change programme that will make the work of social work professionals and managers less stressful while delivering better outcomes for children. The new AND post for Children and Family Services will be a critical role. But they can't do it on their own and will need both the staffing resources and commitment from the most senior levels of the organisation to drive change. They will also need to identify key advocates for change at regional and local level.
- **The scale of the change is overwhelming.** In addition to this report, the HSE must also implement the Ryan Commission Implementation Plan.

These constraints are potentially significant challenges. Managing them will require a rigour and discipline in following through the change management programme. The HSE can therefore not afford to take a piecemeal approach to implementation although it is clear that it cannot achieve everything at once.

In the following section we outline key elements of a draft implementation plan for discussion with the HSE. This sets out the key workstreams to implement recommendations and proposed timeframe. The Assistant National Director for Children and Family Services should be responsible for achieving the Implementation Plan.

4.4 Implementation plan (indicative)

	Recommendations		Work streams/ Deliverables	Project Scheduling
1	Develop a strategic and coherent service model	1.1	Develop a service model	Immediate
		1.2	Implementation of service model	Immediate
		1.3	Develop a response to the Agenda for Children's Services	Immediate
2	Deliver child centred services consistently	2.1	Implement recommendations from the task force to bring consistency to child protection processes	Immediate
		2.2	Develop future resource model that reflects need	Short-term
		2.3	Strengthen collaboration with other services in the HSE	Short term
		2.4	Strengthen collaboration with other external agencies	Medium term
		2.5	Strengthen professional supervision (See No. 6)	Immediate
		2.6	Strengthen continuing professional development and education (See No. 6)	Short term
		2.7	Stream line interface with the courts system	Medium term

3	Develop an intelligence lead system	**3.1**	Implement management information based on existing data	Immediate
		3.2	Develop outcome-based performance metrics	Short term
		3.3	Clarify budget and expenditure reporting	Short term
		3.4	Develop a workforce model for the service	Medium term
4	Develop a clear management structure	**4.1**	Implement integrated PCCC model	Short term
		4.2	Implement new roles within the PCCC model	Short term
5	Implement change of HSE Child protection services using a coordinated project management approach	**5.1**	Develop a project management office	Immediate
		5.2	Develop a comprehensive communications plan	Immediate
6	Professional supervision and CPD initiative	**6.1**	Develop a work stream to review professional supervision and CPD findings	Short term

References

1. Differential Response Model (DRM): This is a national pilot that is being implemented in Dublin North LHO based on a service model from Minnesota which puts the emphasis on child welfare in the first instance. The Minnesota experience has proven that a focus on children's welfare reduces the level of risk and potential abuse. Features of the model are that decisions are evidence-based, there is group supervision, social workers demonstrated leadership and feel strongly supported in working with children and families.The DRM requires a fundamental mind shift in how services are delivered and social workers are fully engaged in its implementation. There are variations of this model in a number of other LHOs.
2. The Implementation Plan of the Ryan Commission was published in July 2009 and sets out a far-reaching programme of change on children's welfare and protection. The HSE also set up a Task Force in 2008 to review current practices in delivery of child protection and bring more consistency to how they were applied. The work of the Task Force was broken down to 8 individual but inter-related tasks. The first was the Survey of Social Work and Family Supports which was published in April 2009. The remaining tasks covered different dimensions of core business processes and their governance. The report of the Task Force was subsequently validated by Helen Buckley, School of Social Work and Social Policy, TCD.
3. UK services were heavily influenced by a two year study in the 1970's entitled and be further studies in the 1980's. A team at York University have repeated a study conducted in the 1970s 'Children Who Wait' which developed a model of the care system and how long children are likely to remain in care. This work strongly influenced the development of UK services. Much depends on age of entry and the speed of action to either rehabilitate or find long-term alternatives. A child over the age of ten who is in care for a year is likely to be in care for the rest of their childhood. The recent York study demonstrates the vital importance of proactive planning and action. It found that:
   - 89% who entered care stayed for at least a week
   - If they stayed for a week, 90% would stay for 4 weeks
   - If they stayed for 4 weeks, 89% would stay 12 weeks
   - If they stayed for 12 weeks, 91% would stay for 26 weeks
   - If they stayed for 26 weeks, 83% would stay for 52 weeks
4. This has been demonstrated for instance by the work of the Family Futures Consortium in London over the last 12 years.
5. Report of the Task Force on the Public Service – Transforming Public Services; citizene centred performance focused, 2008.
6. Annual Review of Adequacy of Services for Children and Families. This report contains aggregate information on the service as a whole and the appendix includes detailed information for each LHO on performance.
7. Based on the Support Framework for children and families taken from the Implementation Plan prepared by the OMCYA in response to the Report of the Commission to Inquire into Child Abuse, 2009.

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Office of the Minister for Children (2007)The Agenda for Children's services: A policy handbook. Stationary office, Dublin

The Commission to Inquire into Child Abuse (2009) The report of the commission to inquire into child abuse. Stationary office, Dublin www.childabusecommission.ie

Stakeholders consulted

HSE:

Workshop with front line managers representing 7 LHOs and a cross-section of grades such as Principal Social Worker, Child Care Manager, Team Leaders,

Workshop with the National Steering Committee

Workshop with LHMs and GMs from five LHOs

Meetings with HSE senior management

Field visits to three LHOs

Consultation with HSE Departments who link in with Child protection e.g. Children and Adult Mental Health Services

External agencies:

Office of the Minister for Children and Youth Affairs

Department of Education and Science

HIQA/Social Services Inspectorate

National Education and Welfare Board

National Social Work Qualifications Board

Probation Service

An Garda Siochana

Barnardos

Extern

Children's Rights Alliance

Children's Ombudsman

Children's Acts Advisory board

Family Support Agency

Irish Association of Social Workers

Limerick Regeneration

Member of the Judiciary

Glossary

AND:	Assistant national director
CAAB:	Children's acts advisory board.
CCM:	Child care manager
CPD:	Continuing professional development
CSCs:	Children services committees
HIQA:	Health information and quality authority
HSE:	Health service executive
LHO:	The local Health Service Executive office, which health and social care in an area
LHM:	Local health manager
OMCYA:	Office of the Minister for Children and Youth Affairs
PSW:	Principle social worker
PCCC:	Primary, Community and Continuing Care (PCCC) delivers health and personal social services in the community and other settings including patient homes
PCN:	Primary care network
PCT:	Primary care team
PS:	Professional supervision
SW :	Social worker
TL:	Team leader

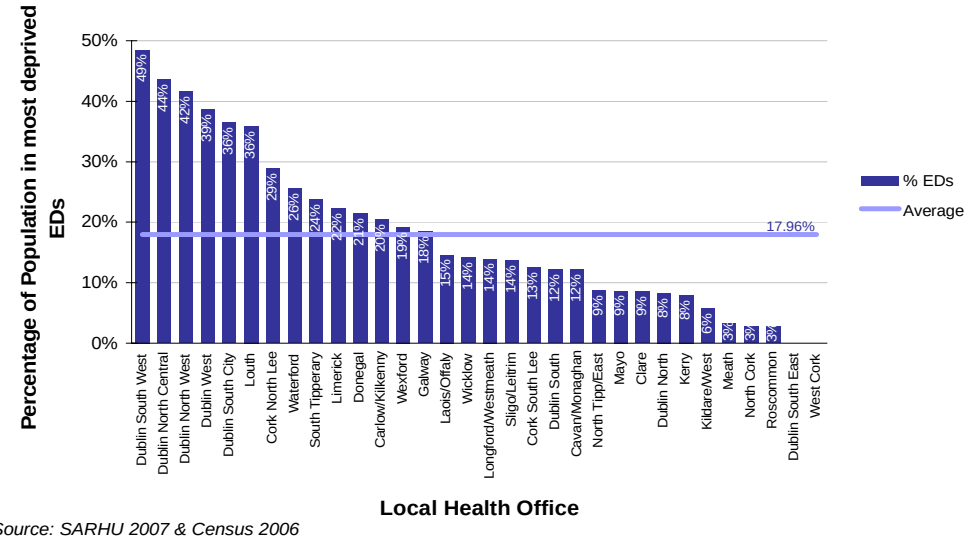
Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Appendices

A. Key data analysis
B. Overview of key processes in Child Protection (HSE Task Force)
C. Model of CPD and professional supervision
D. Sources of information
E. Overview of approach
F. Glossary of terms
G. References/footnotes

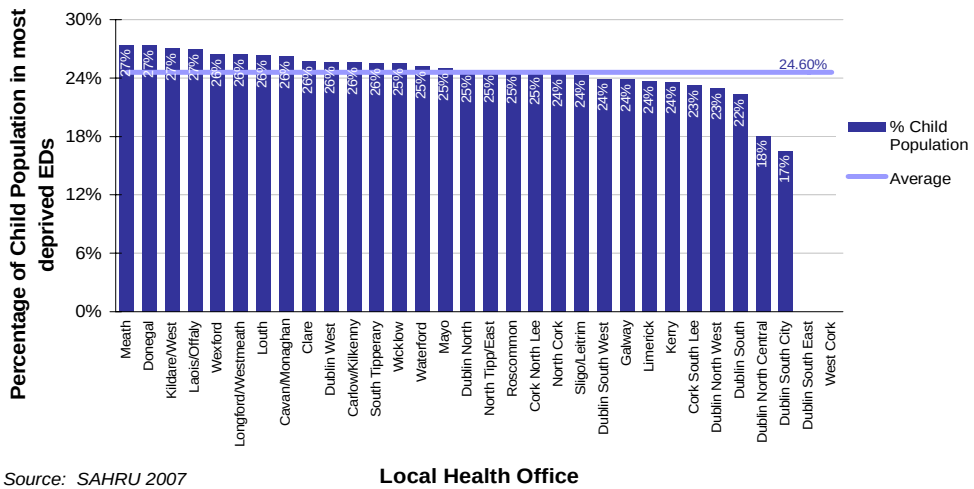
A. Indicators of Need

1. SAHRU: Percentage Population in most Deprived Electoral Divisions (Decile 10)



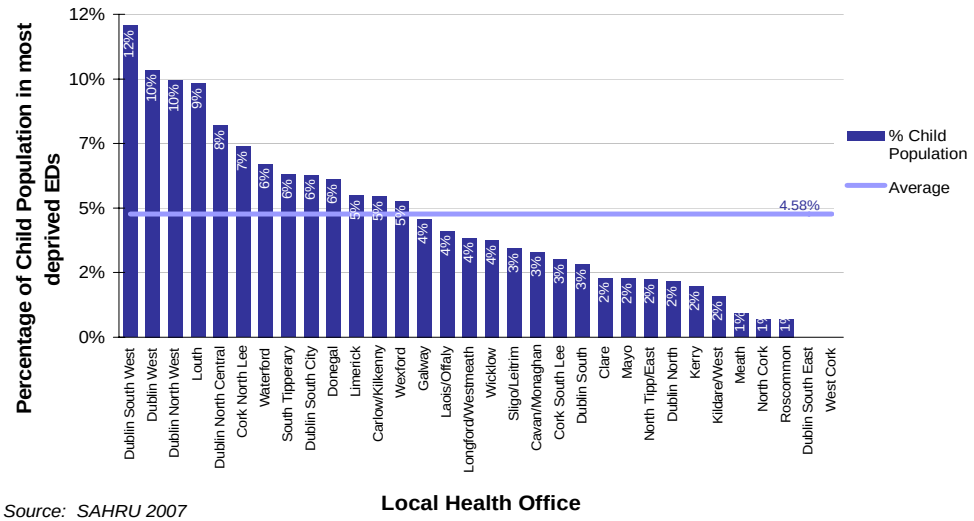
Source: SARHU 2007 & Census 2006

2. SAHRU: % Children contained in Population of most Deprived Electoral Divisions (Decile 10)



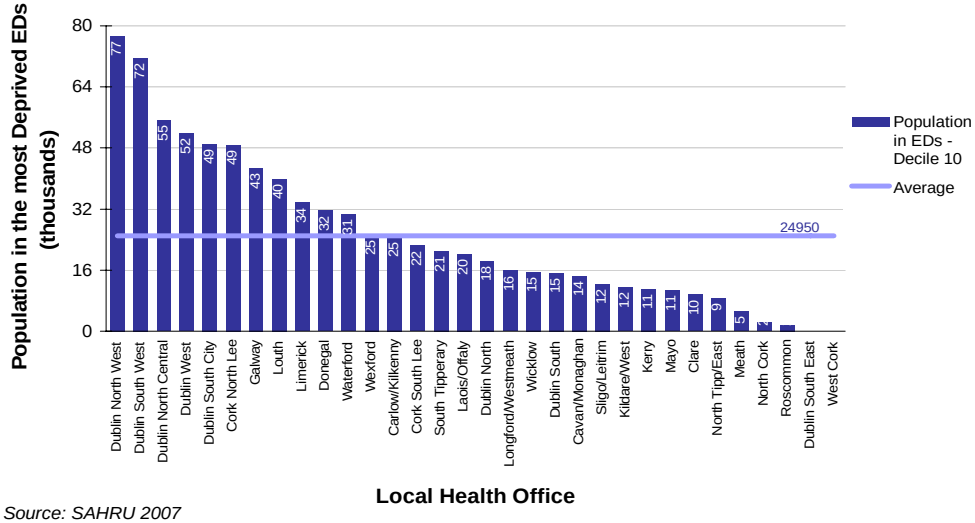
Source: SAHRU 2007

3. SAHRU: % Children contained in Total Population of most Deprived Electoral Divisions (Decile 10)



Source: SAHRU 2007

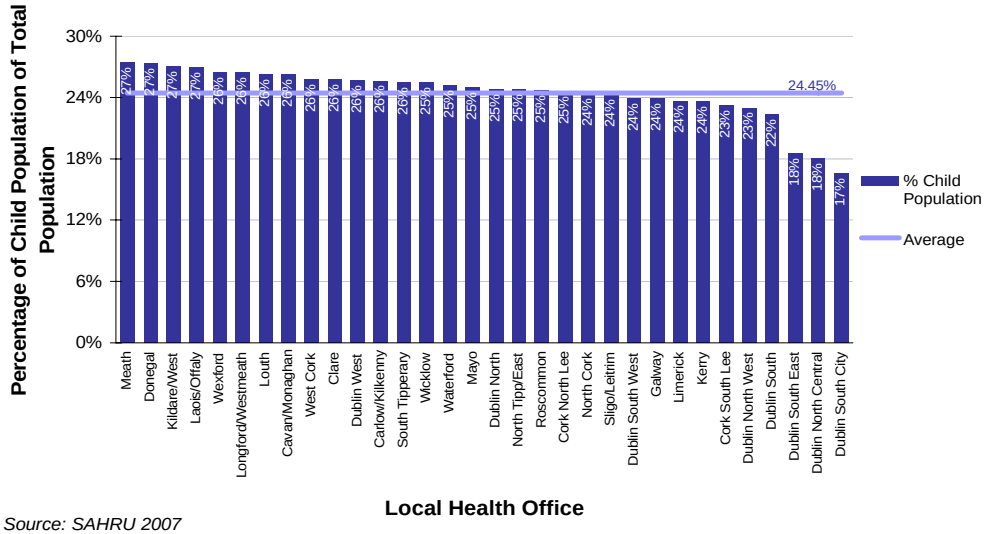
4. SAHRU: Population in the most Deprived Electoral Divisions (Decile 10)



Source: SAHRU 2007

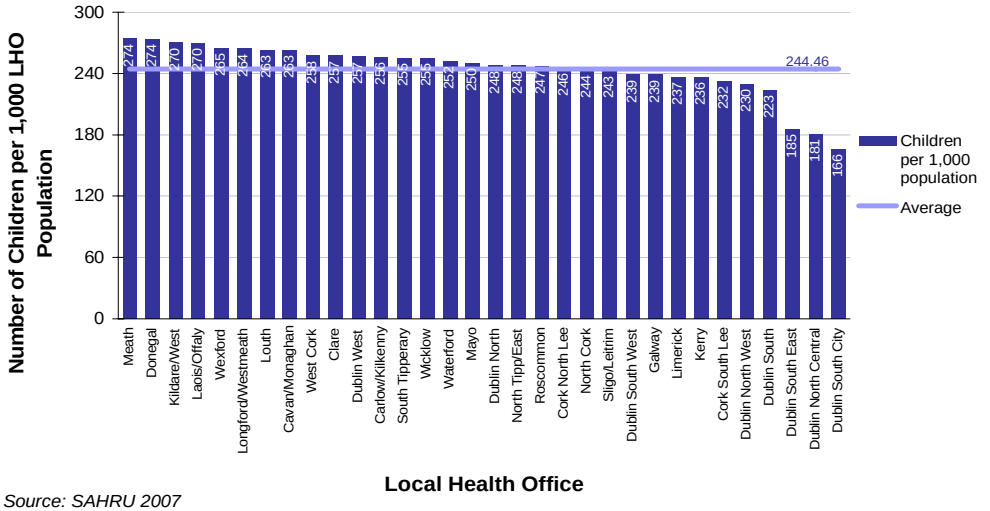
A. Indicators of Need

5. Percentage Child Population of LHO Population



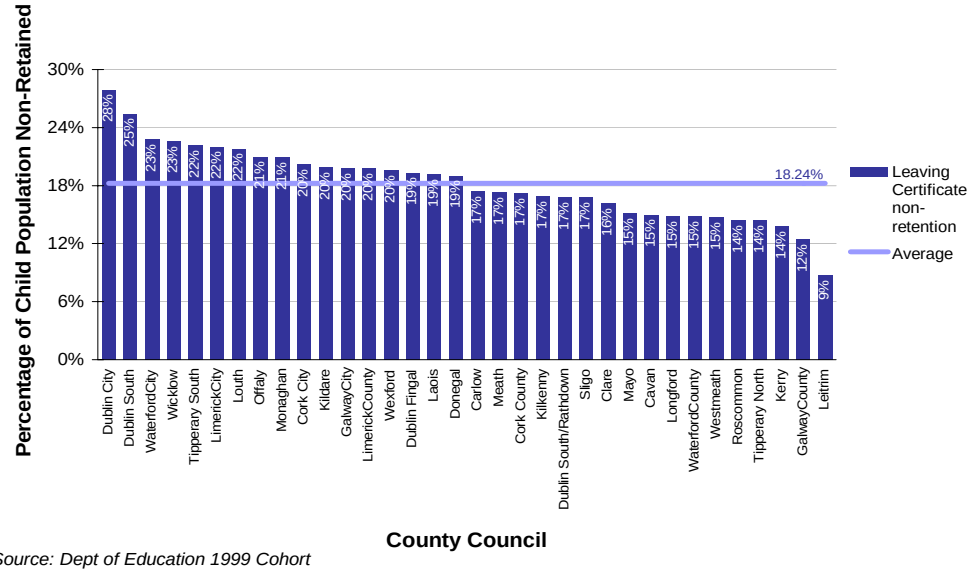
Source: SAHRU 2007

6. Number of Children per 1,000 LHO Population



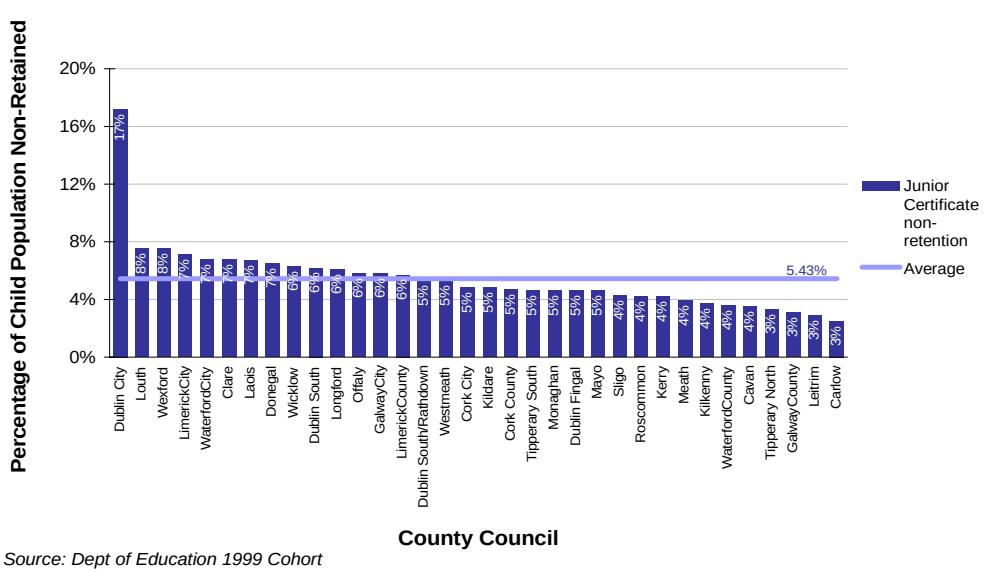
Source: SAHRU 2007

7 a) Leaving Certificate Non-Retention by County Council



Source: Dept of Education 1999 Cohort

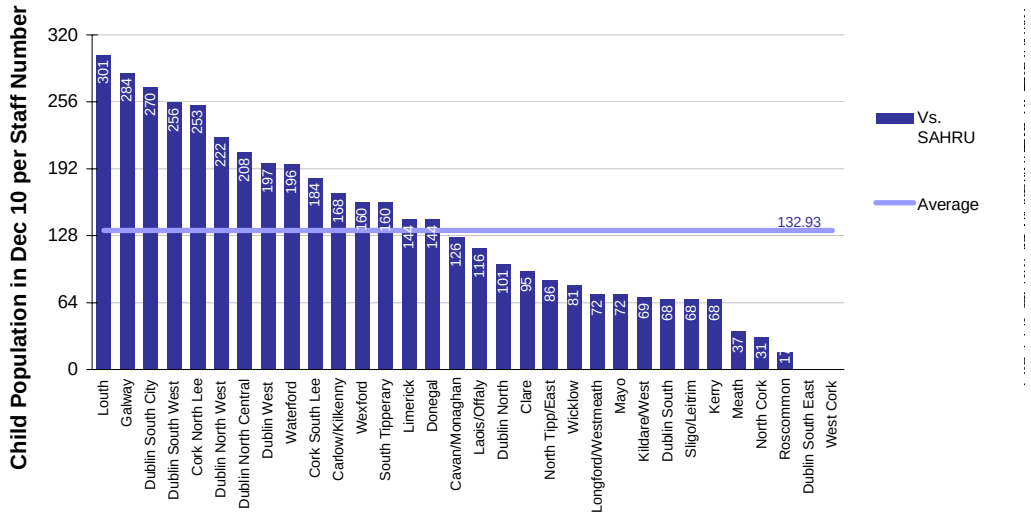
7 b) Junior Certificate Non-Retention by County Council



Source: Dept of Education 1999 Cohort

A. Indicators of Need

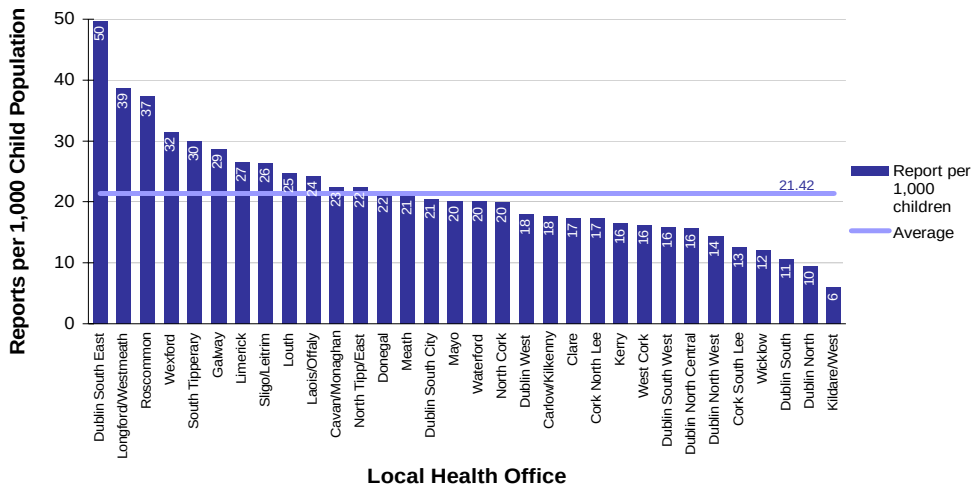
8. SAHRU: Estimated Child Population per Total Staff Number (Decile 10)



Source: SARHU 2007 & Census 2006

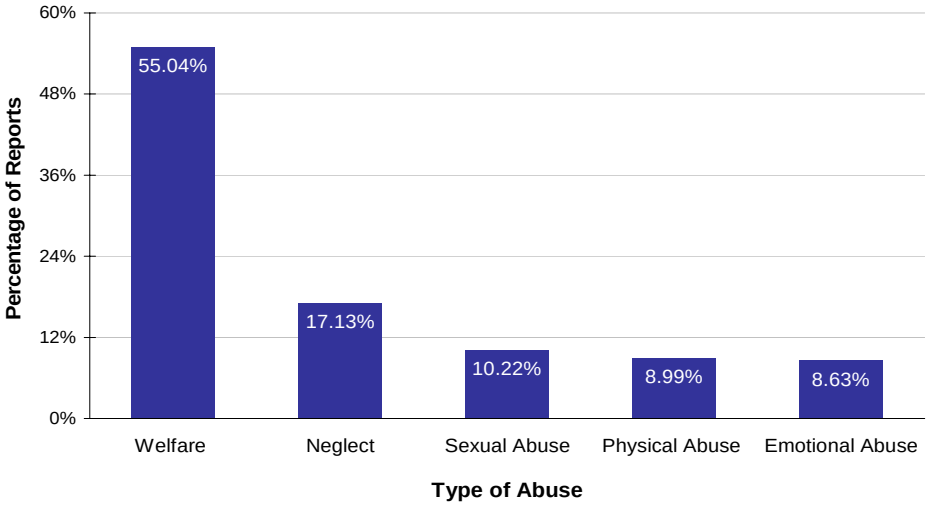
B. Demand

9. Volume of Reports by LHO per 1,000 child population



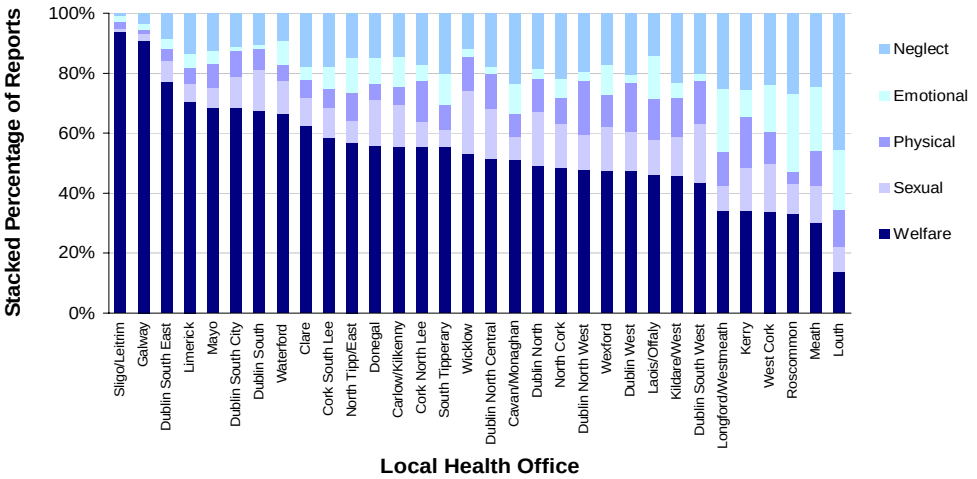
Source: CSO 2006, 2007;HSE IDS 2006 and 2007

10. Reason for Report



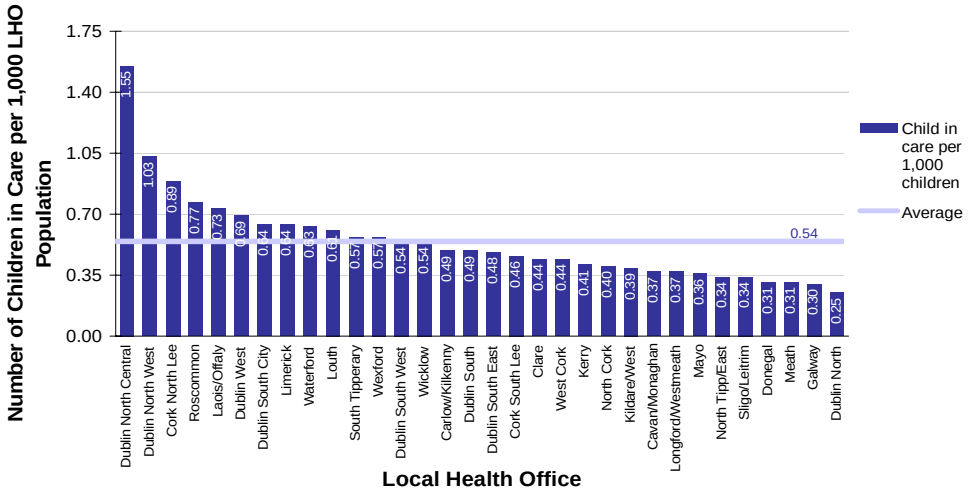
Source: Interim Dataset 2006 & Census 2006

11. Percentages of Reported Abuse Types by LHO



Source: HSE National Social Work Survey

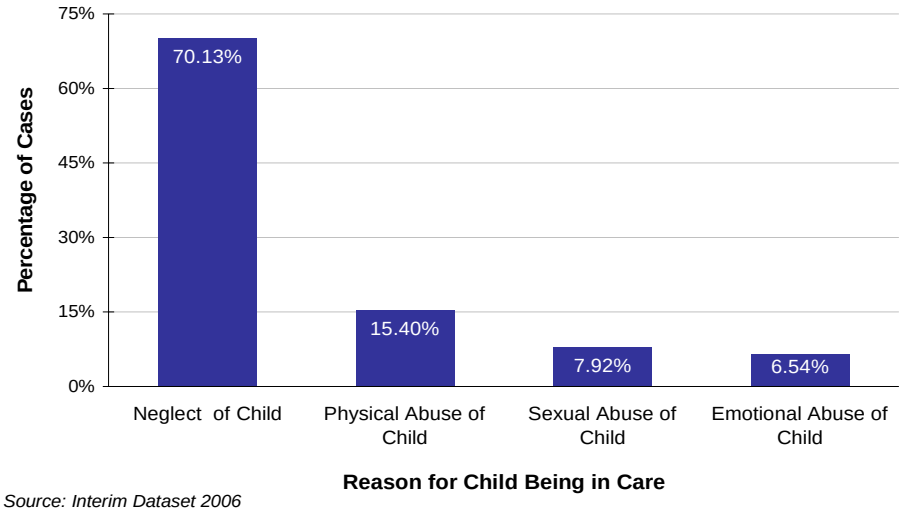
12. Children in Care per 1,000 Children population by LHO



Source: CSO 2006, 2007;HSE IDS 2006 and 2007

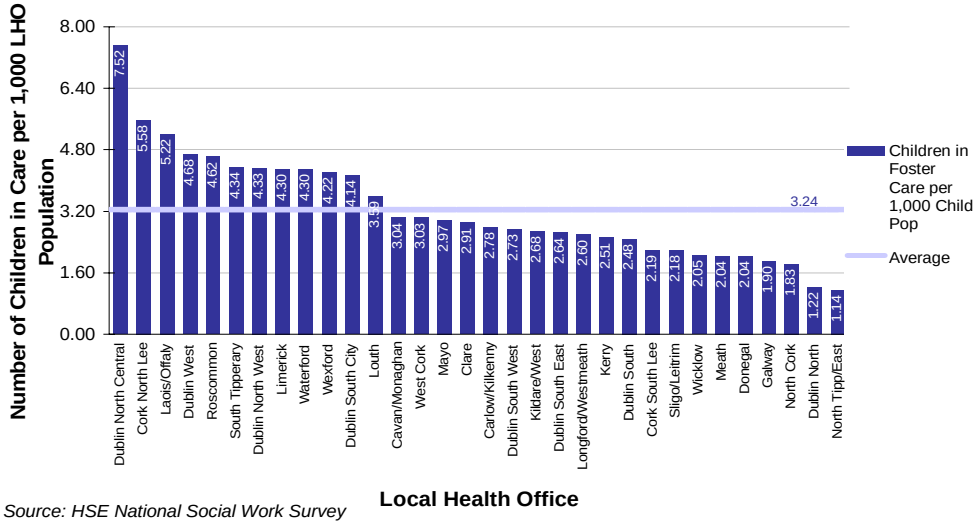
B. Demand

13. Primary Reason for Children being in Care



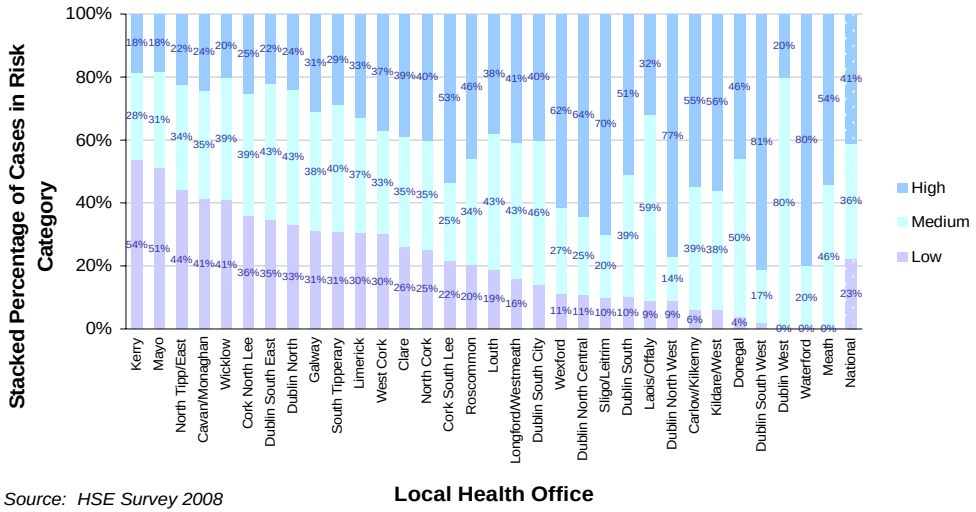
Source: Interim Dataset 2006

14. Children in Foster Care per 1,000 Child Population by LHO



Source: HSE National Social Work Survey

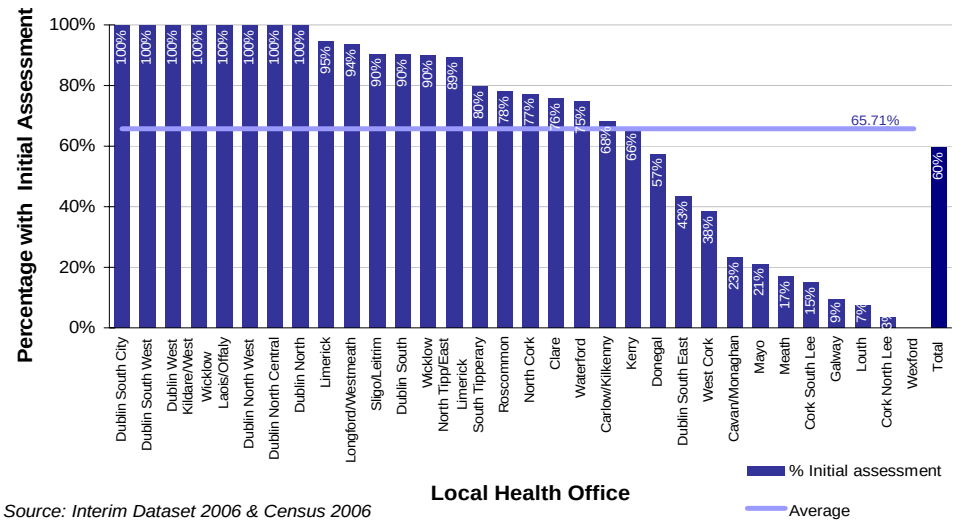
15. Risk Assessment of Total Cases by LHO



Source: HSE Survey 2008

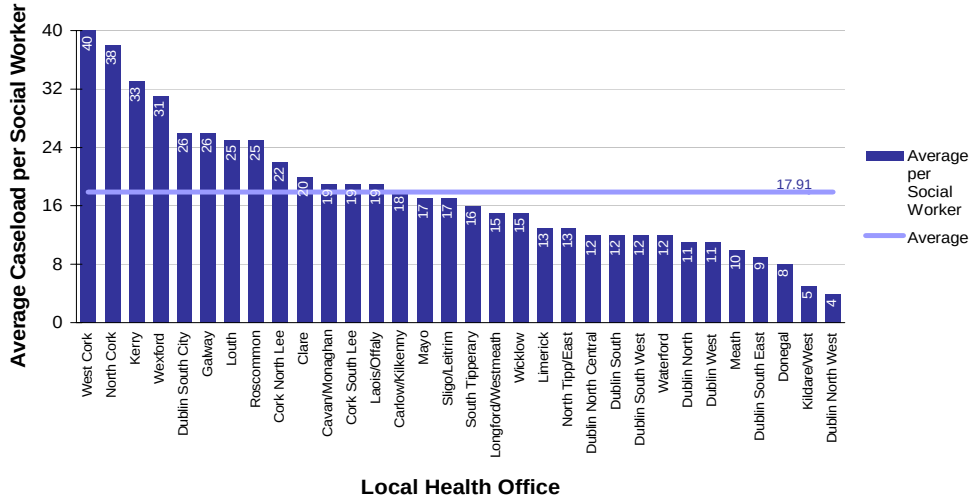
C. Activity

16. Proportion of Reports with Initial Assessment



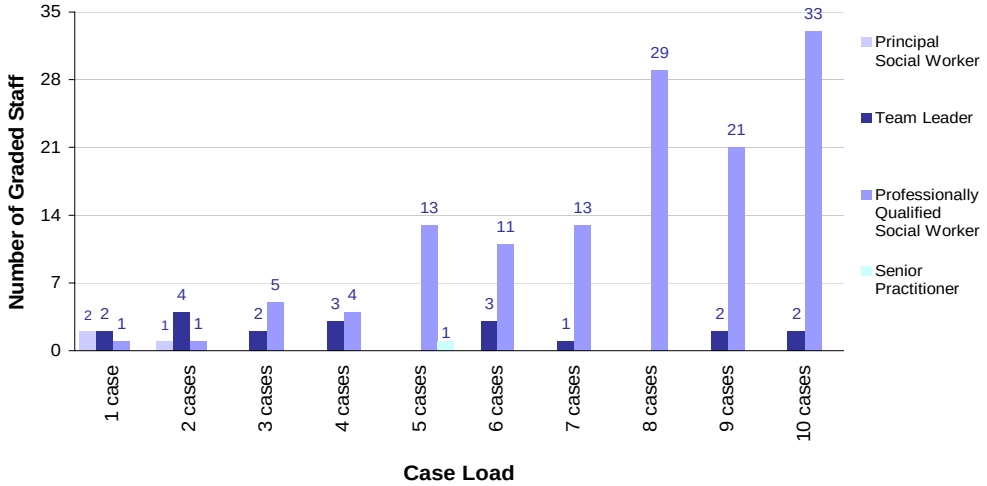
Source: Interim Dataset 2006 & Census 2006

17. Caseload per Social Worker across LHOs



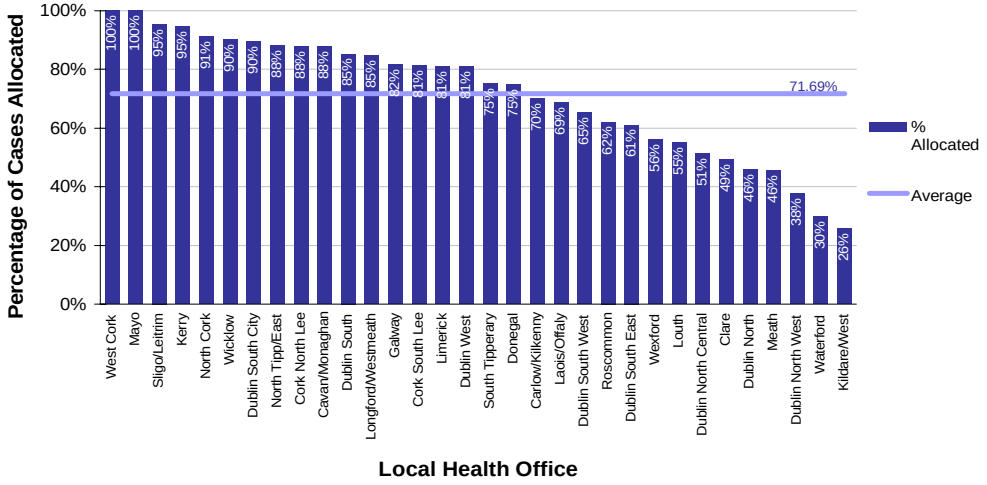
Source: HSE National Social Work Survey

18. Case Load by Grade (up to 10 cases)



Source: HSE Survey, December 2008

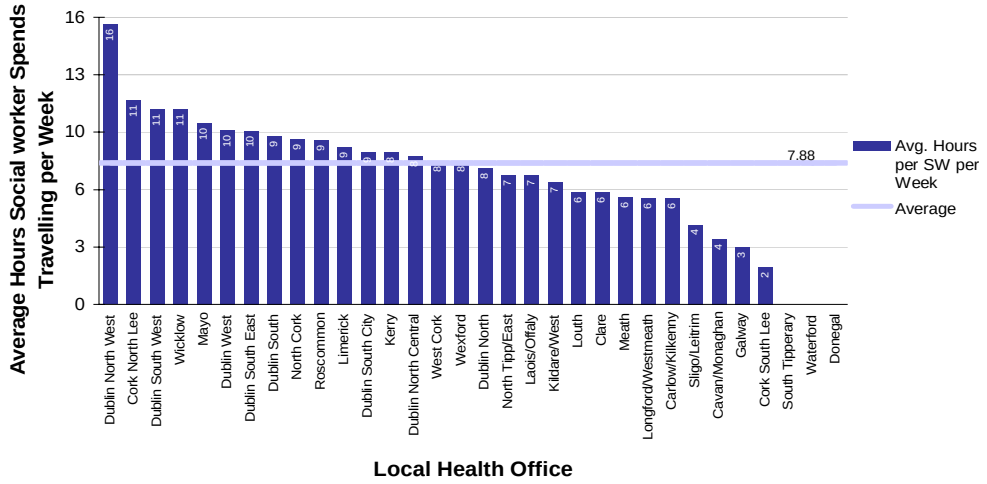
19. Allocated Cases by LHO



Source: HSE National Social Work Survey

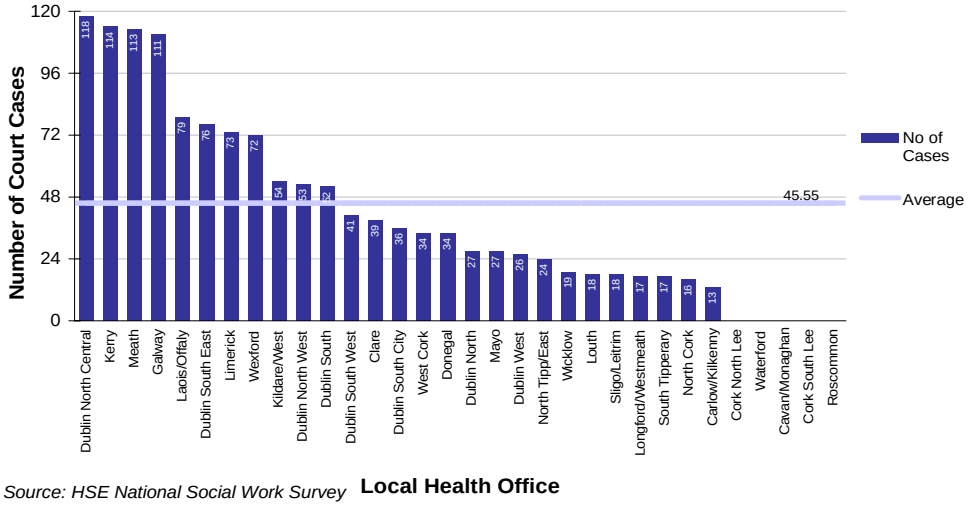
C. Activity

20. Average Hours Social worker Spends Travelling per Week by LHO



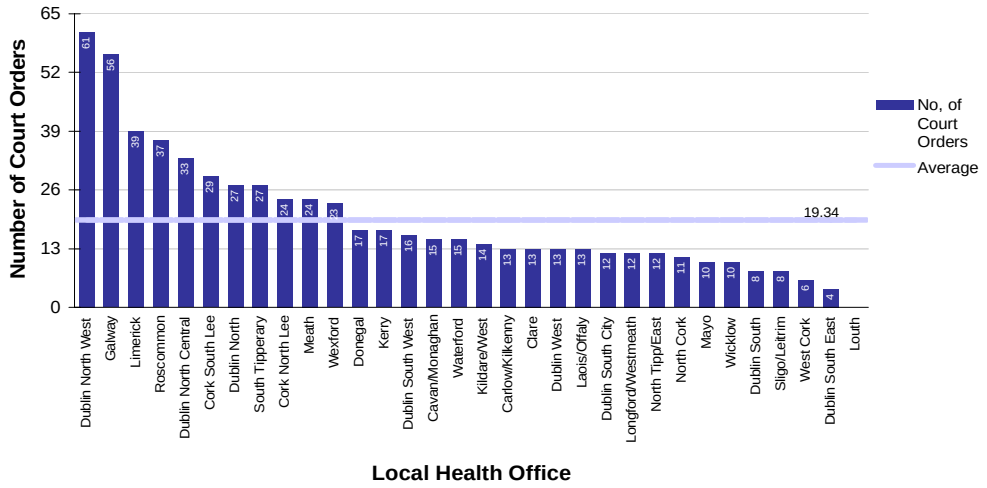
Source: HSE National Social Work Survey

21. Number of Court Cases by LHO



Source: HSE National Social Work Survey

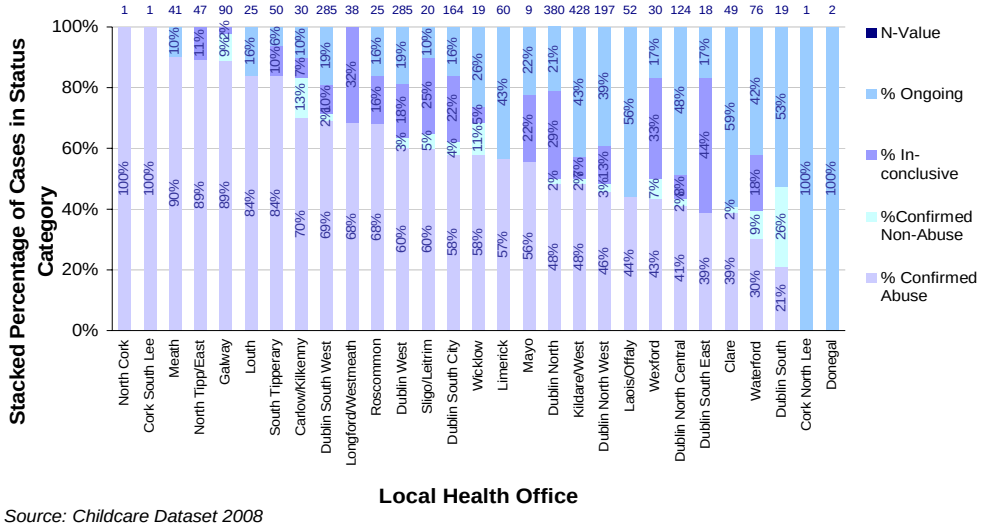
22. Number of Court Orders by LHO



Source: Childcare Dataset 2008

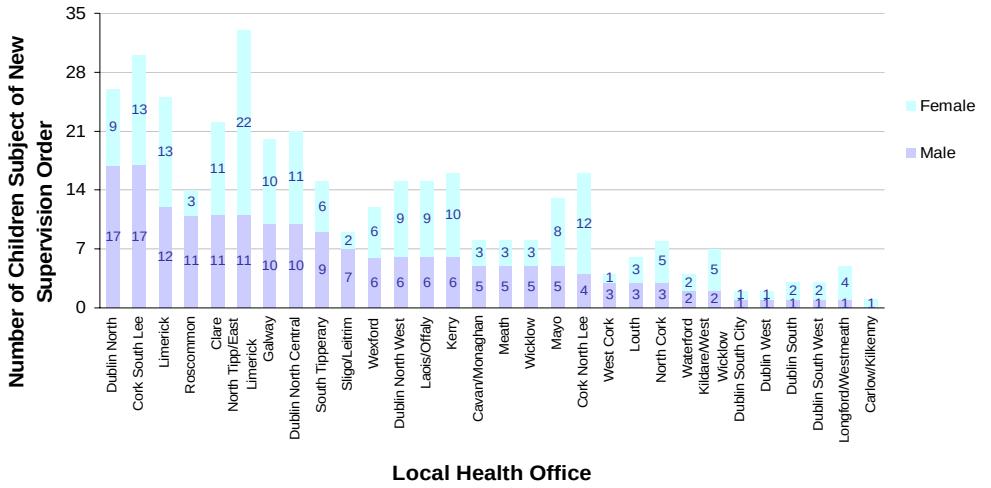
E. Outcomes

23. Confirmation of Abuse/Non-Abuse



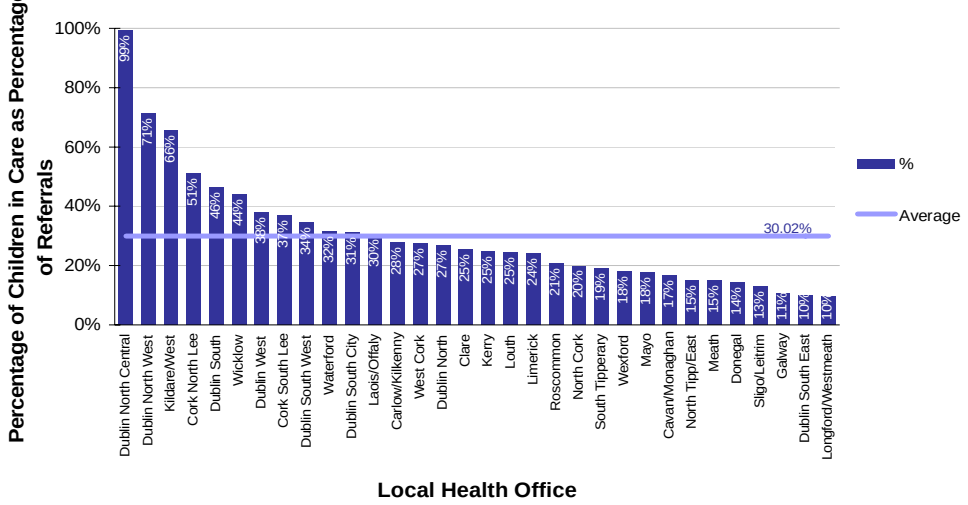
Source: Childcare Dataset 2008

24. Children Subject of New Supervision Order by LHO



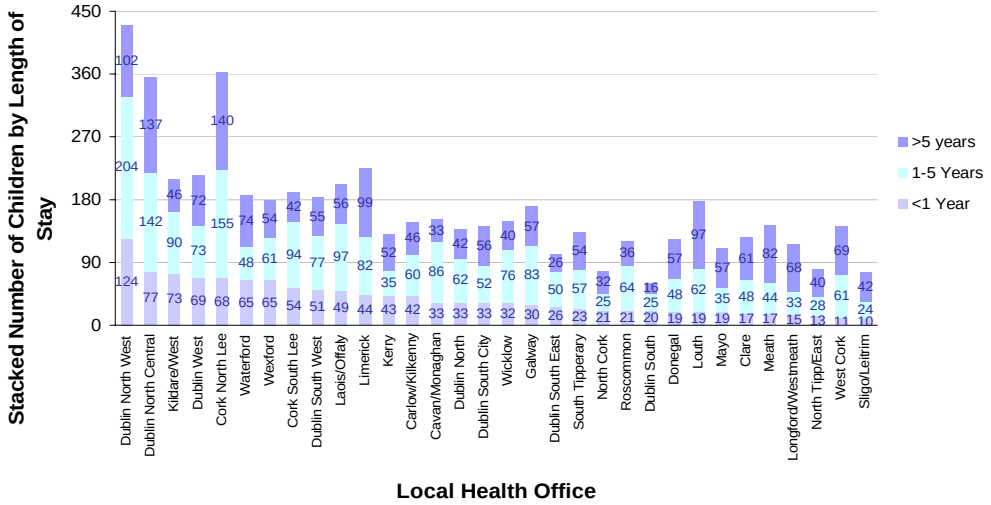
Source: Childcare Dataset 2008

25. Children in Care as % of Referrals



Source: HSE National Social Work Survey

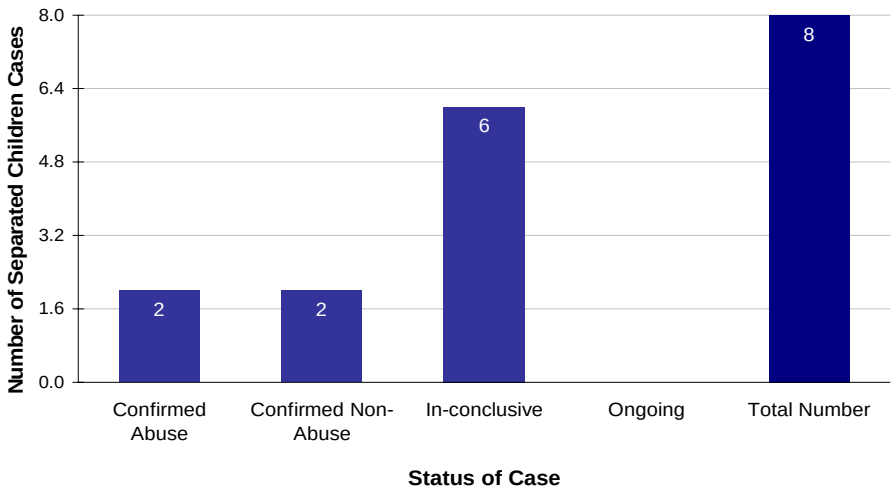
26. Length of Stay in Care



Source: Childcare Dataset 2008

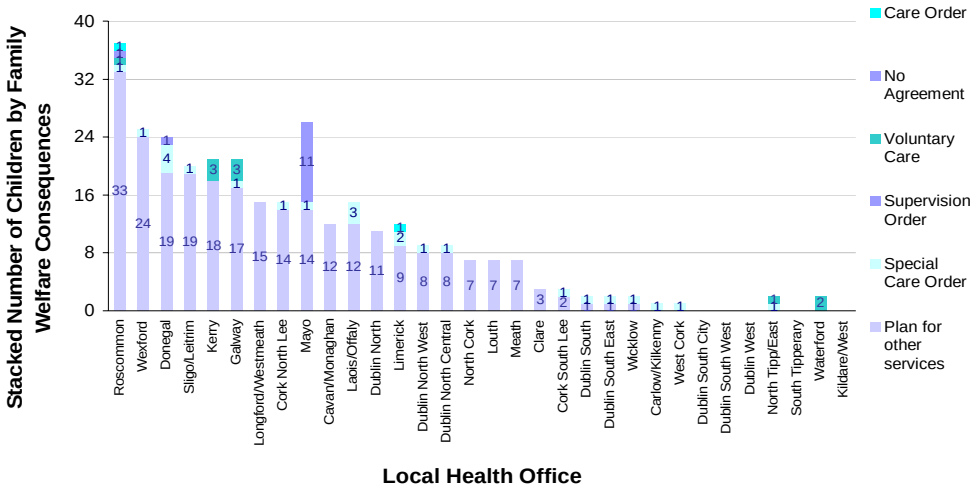
E. Outcomes

27. Outcomes for Separated Children



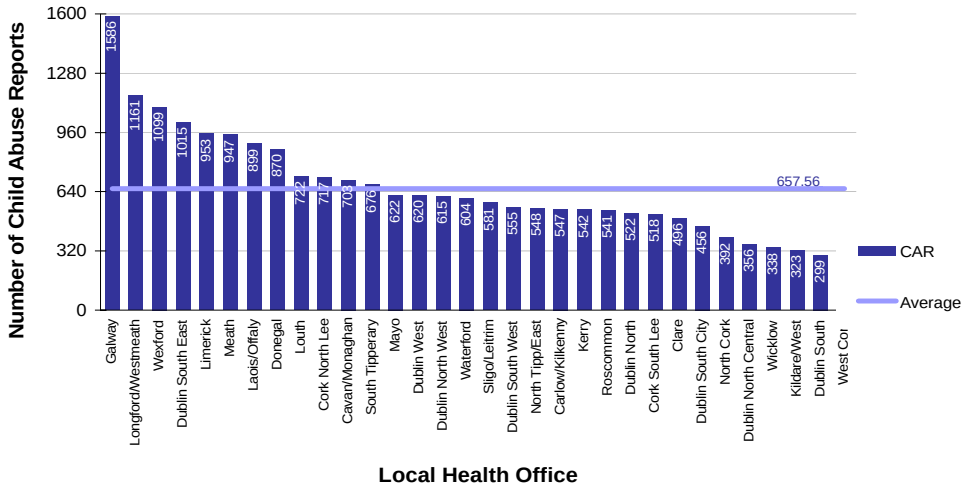
Source: Childcare Dataset 2008

28. Outcomes of Family Welfare Consequences



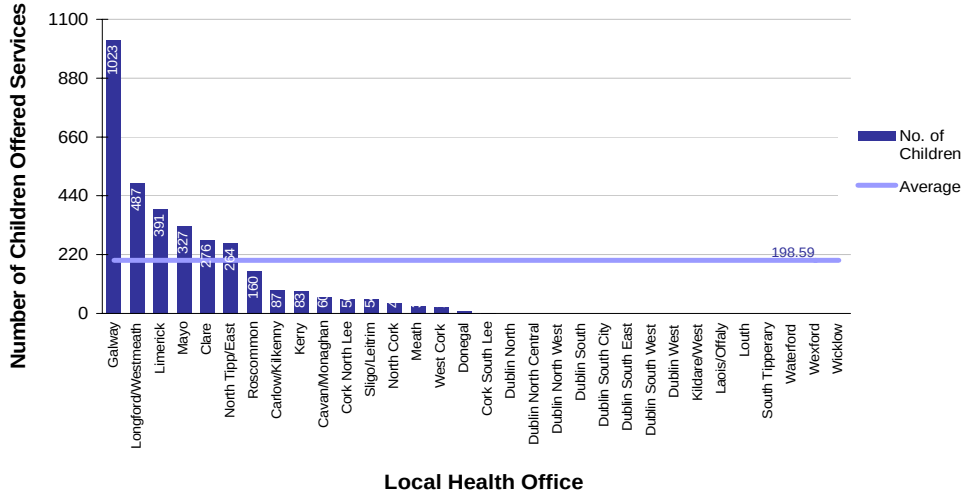
Source: Childcare Dataset 2008

29. Child Abuse Reports by LHO



Source: HSE National Social Work Survey

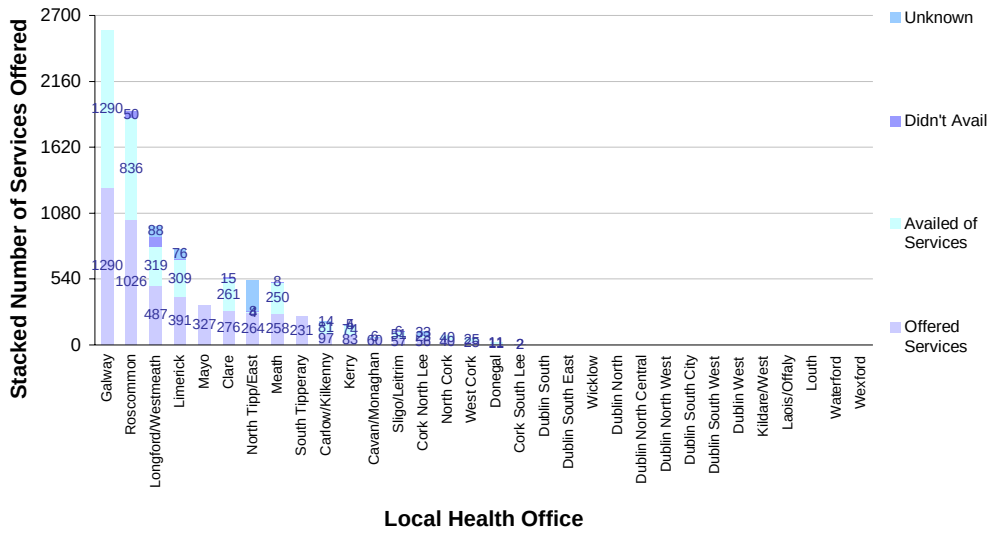
30. Number of Children Offered Services by LHO



Source: Childcare Dataset 2008

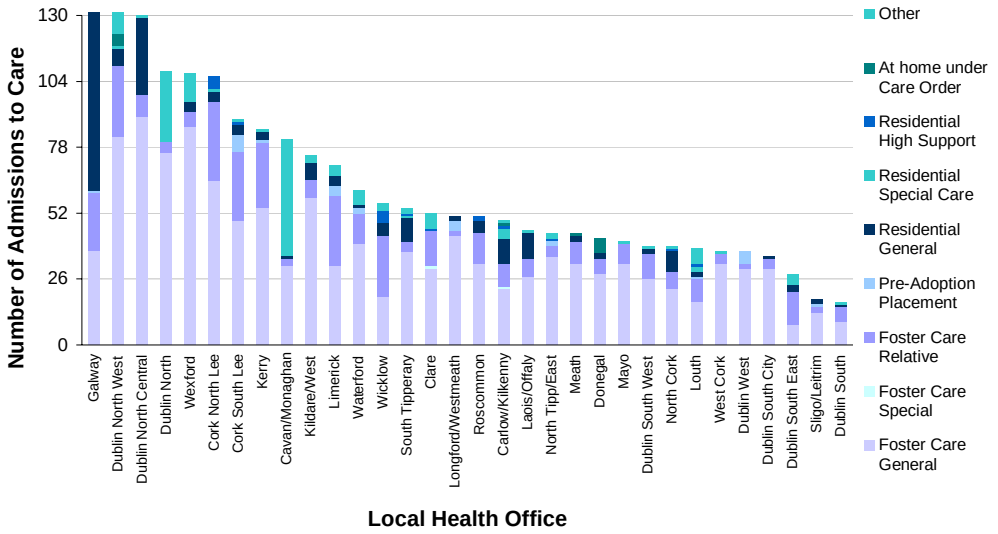
E. Outcomes

31. Stacked Number of Services Offered



Source: Childcare Dataset 2008

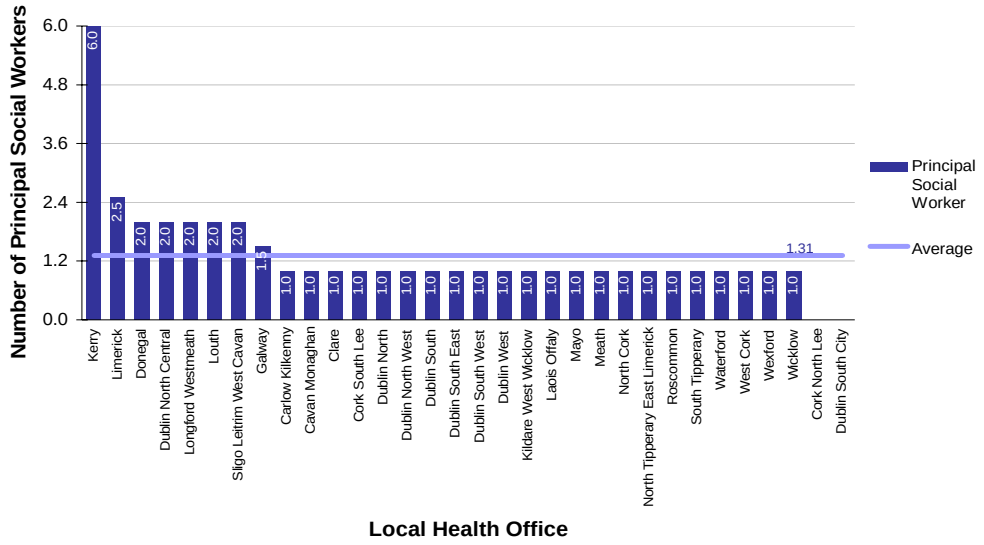
32. Stacked outcome of Admissions to care by LHO



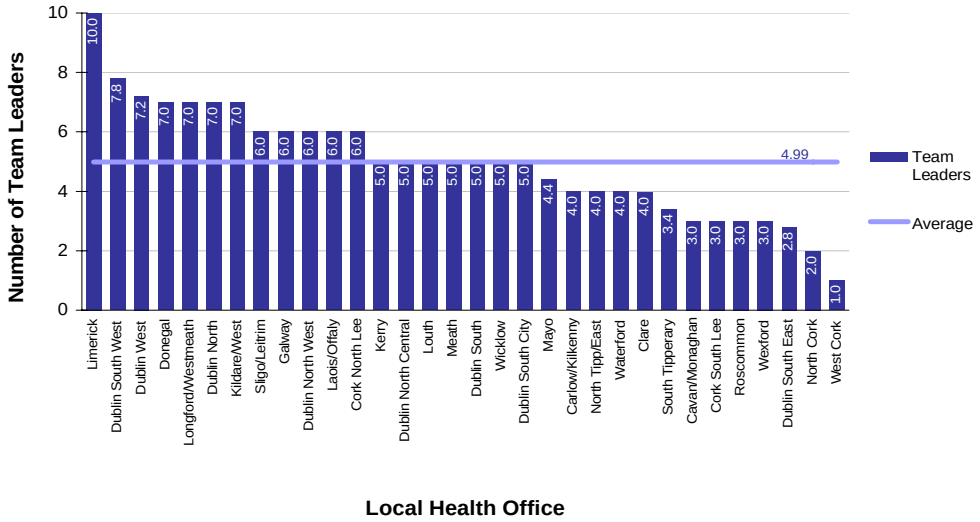
Source: Childcare Dataset 2008

F. Workforce

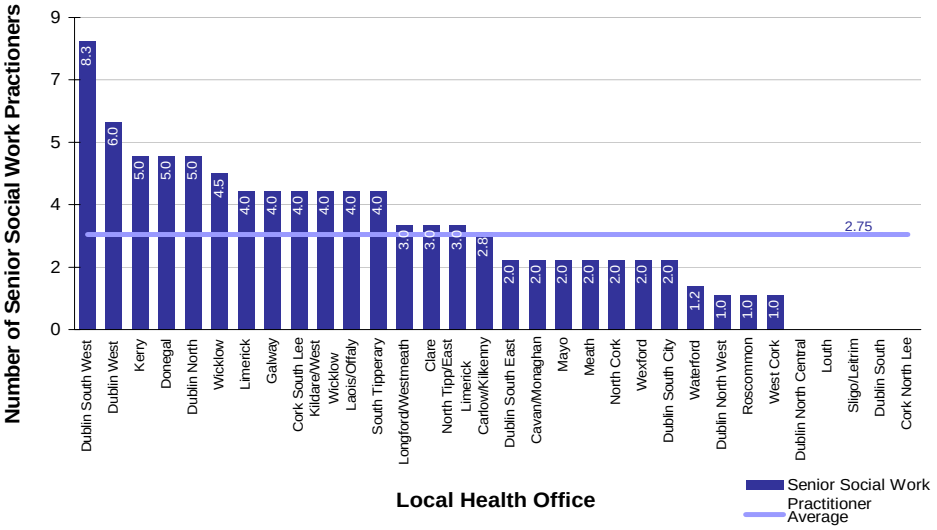
33. Principal Social Workers by LHO



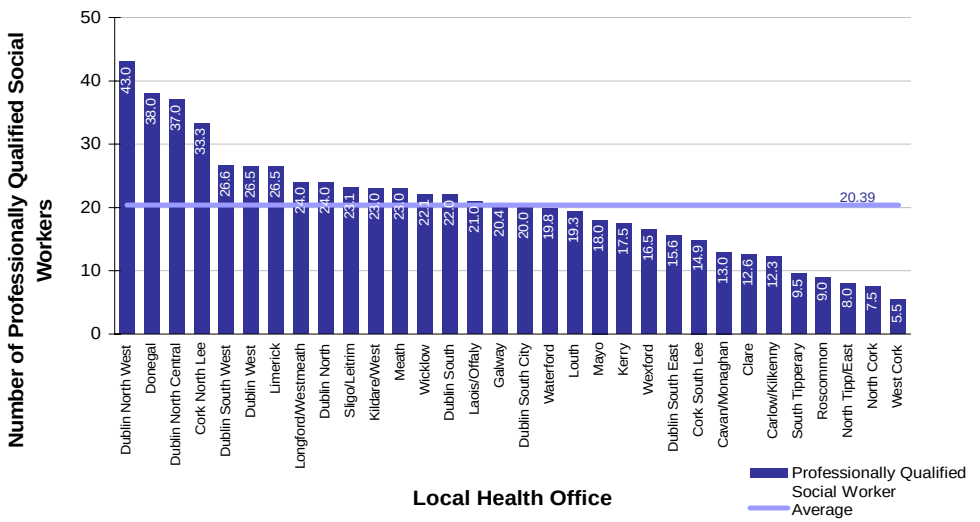
34. Team Leaders by LHO



35. Senior Social Work Practitioners by LHO

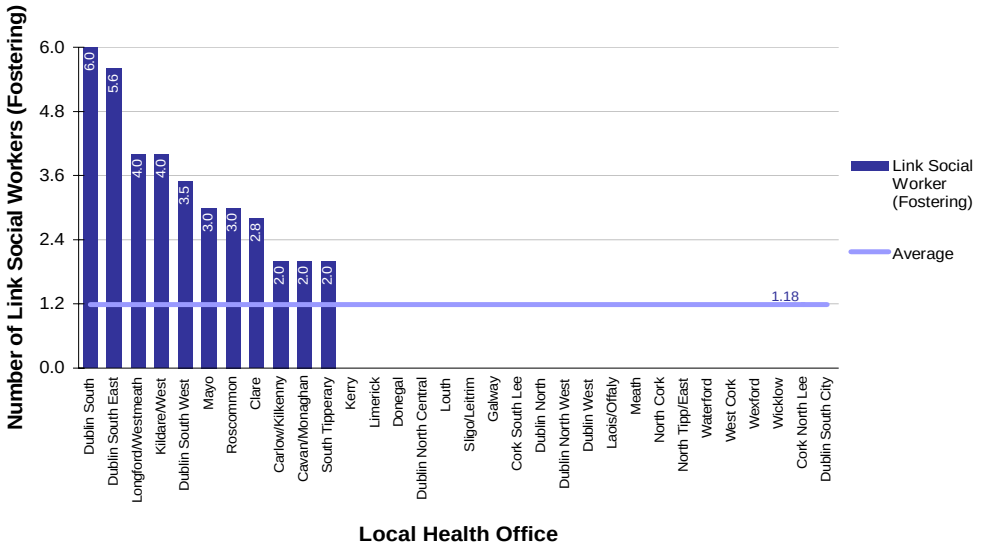


36. Professionally Qualified Social Workers by LHO

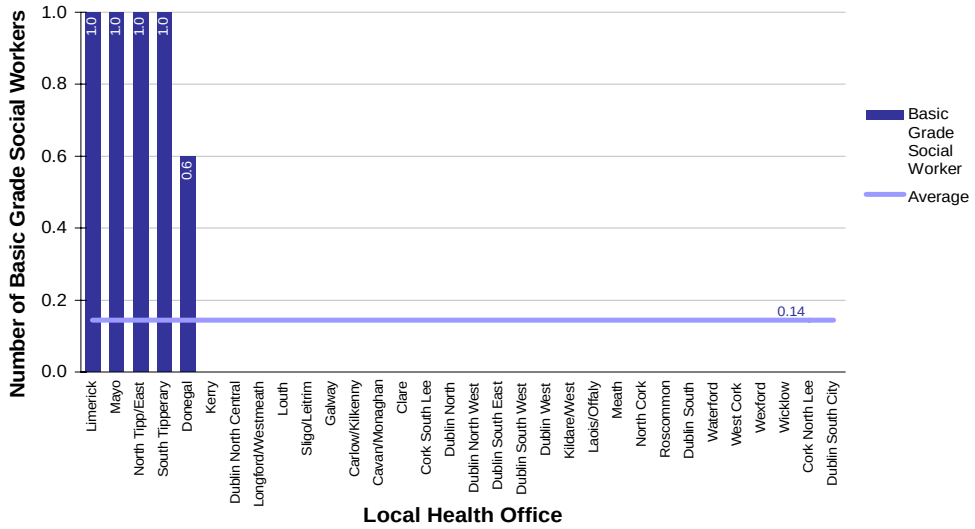


F. Workforce

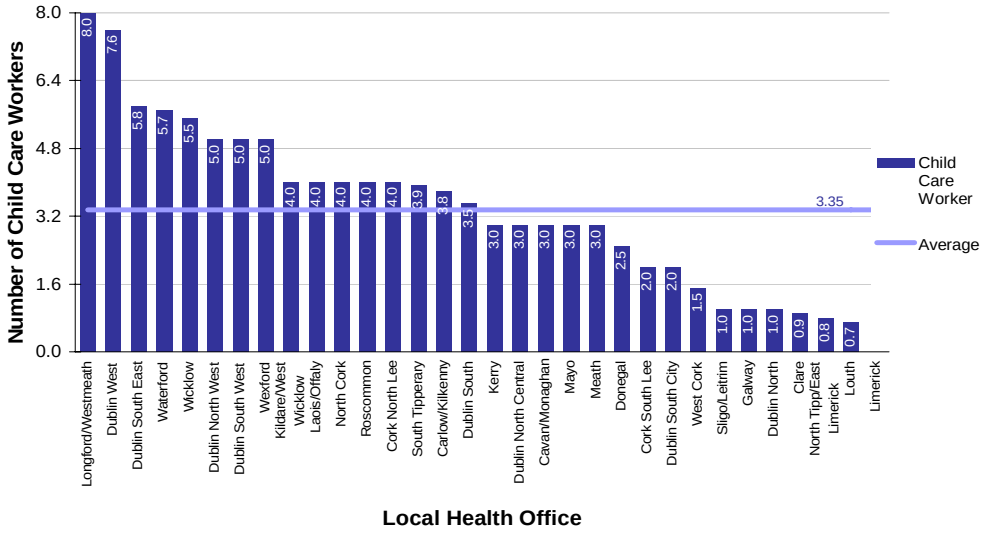
37. Link Social Workers (Fostering) by LHO



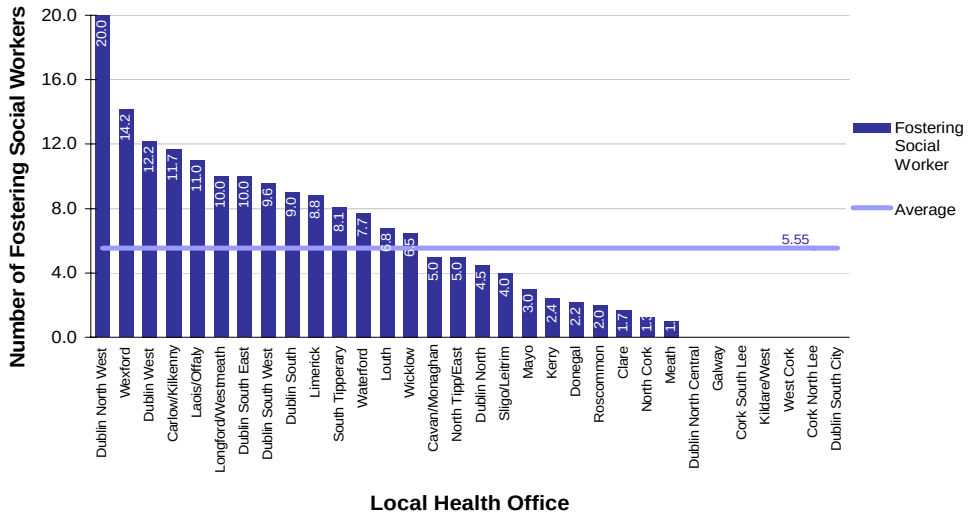
38. Basic Grade Social Workers by LHO



39. Child Care Workers by LHO

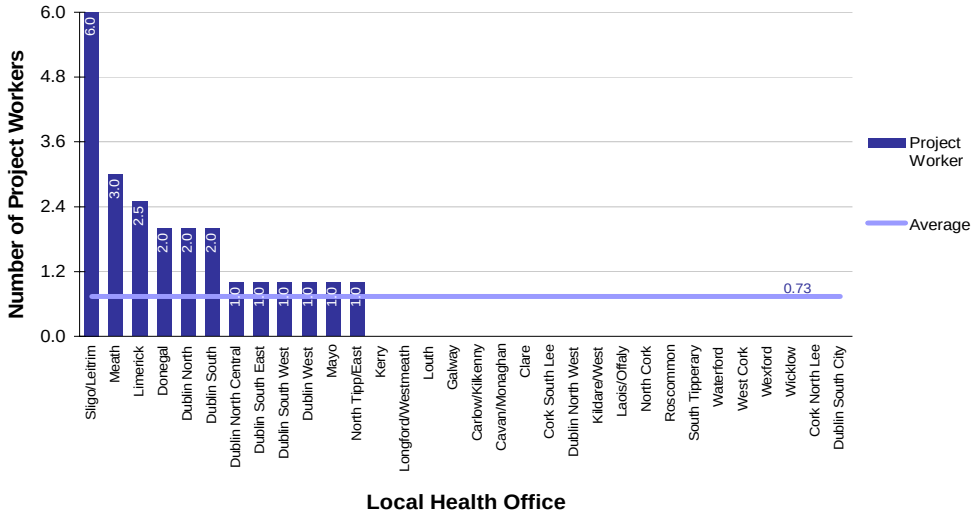


40. Fostering Social Workers by LHO

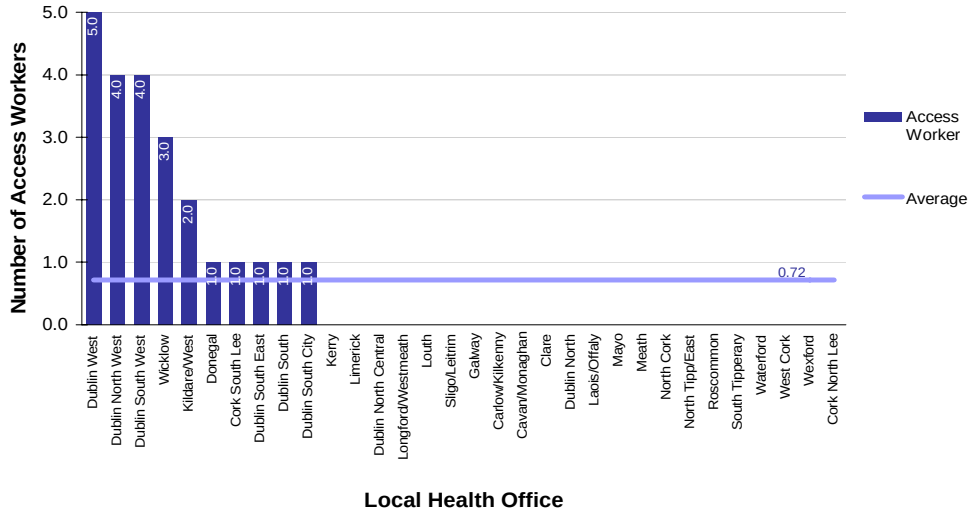


F. Workforce

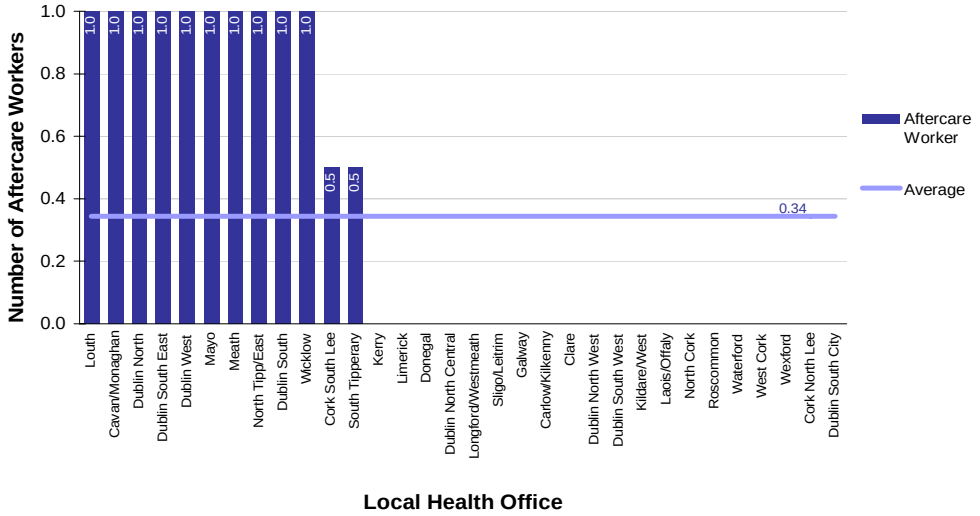
41. Project Workers by LHO



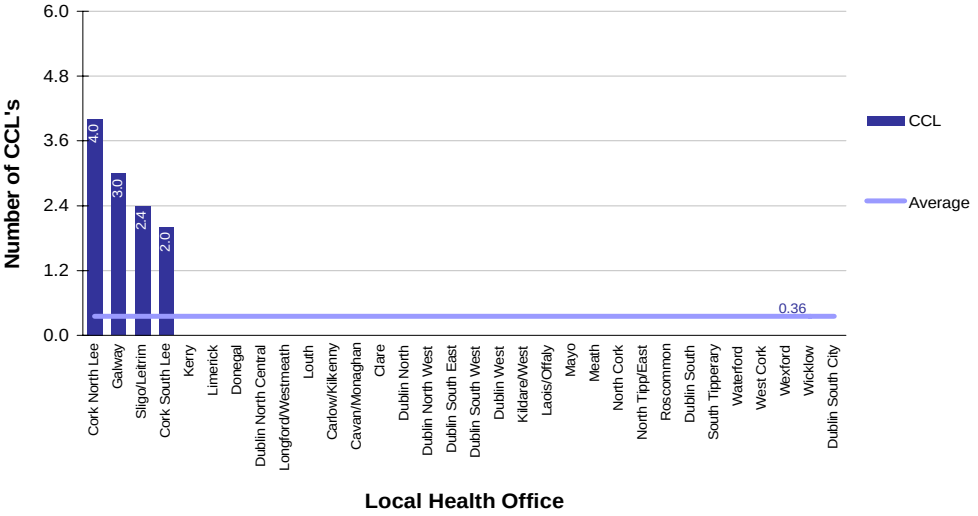
42. Access Workers by LHO



43. Aftercare Workers by LHO

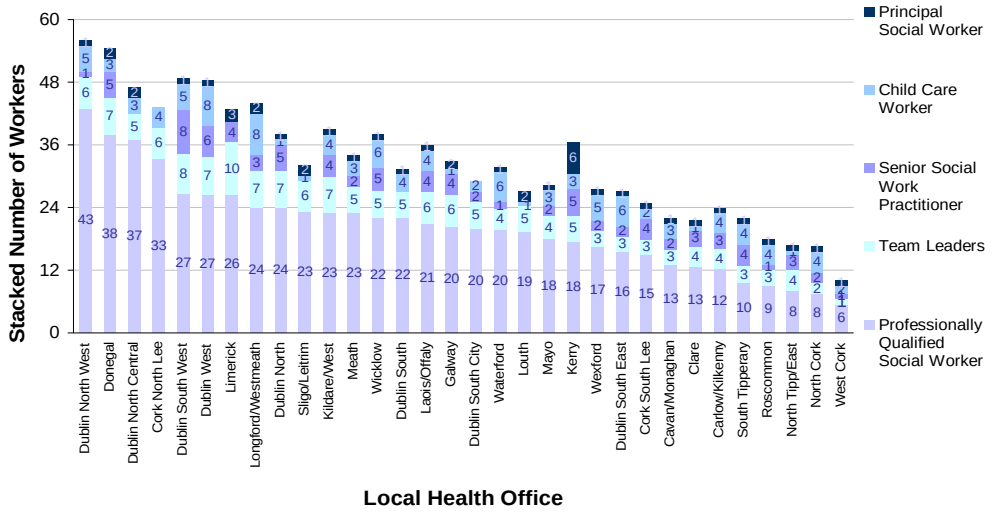


44. CCL's by LHO

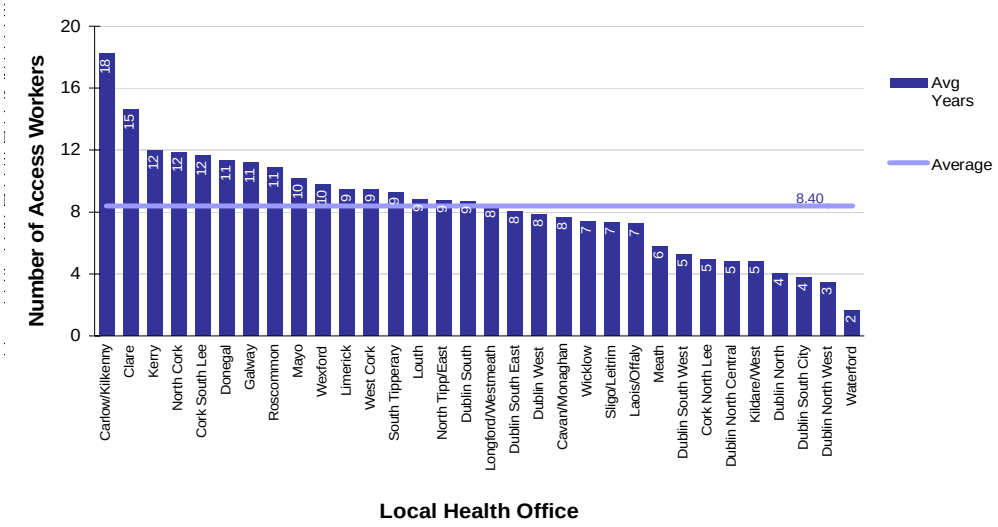


F. Workforce

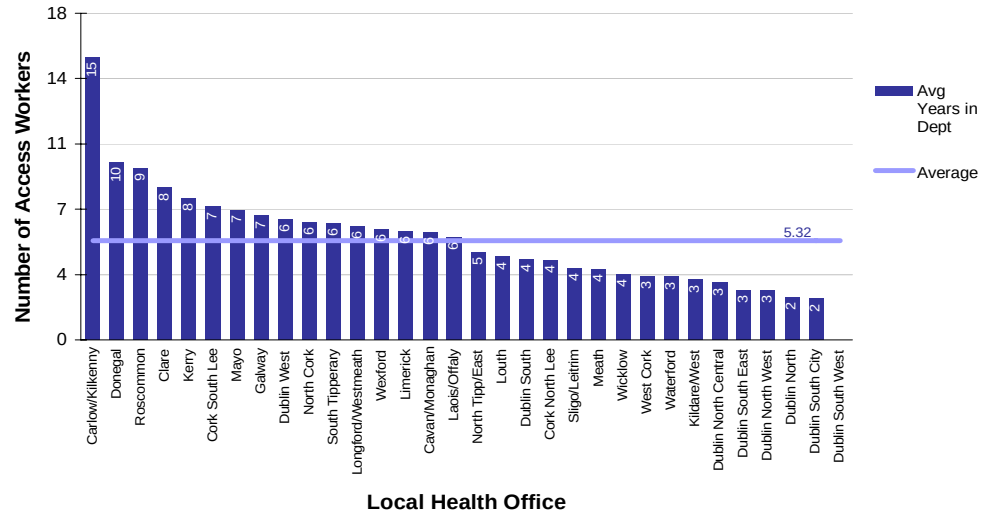
45.Stacked Numbers of Key Workforce by LHO



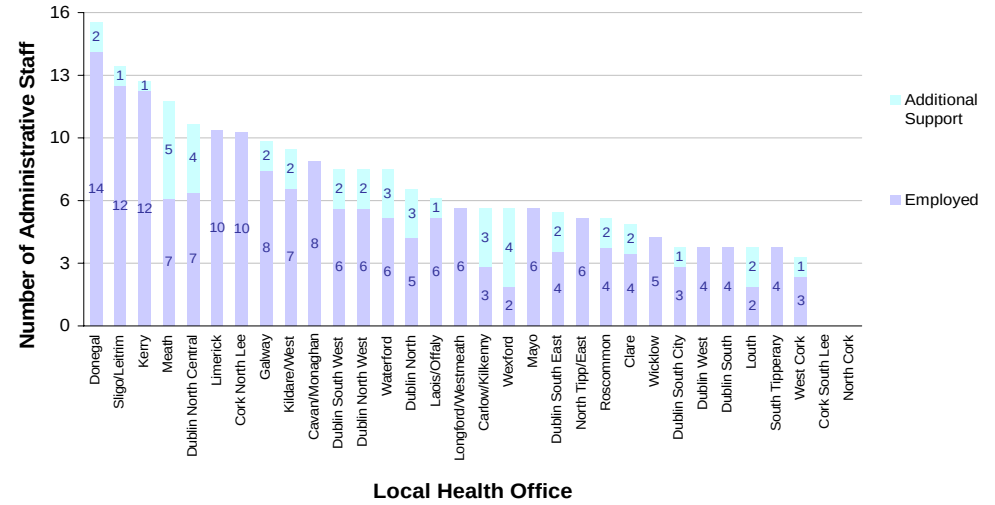
46 a) Average Experience of Staff by LHO



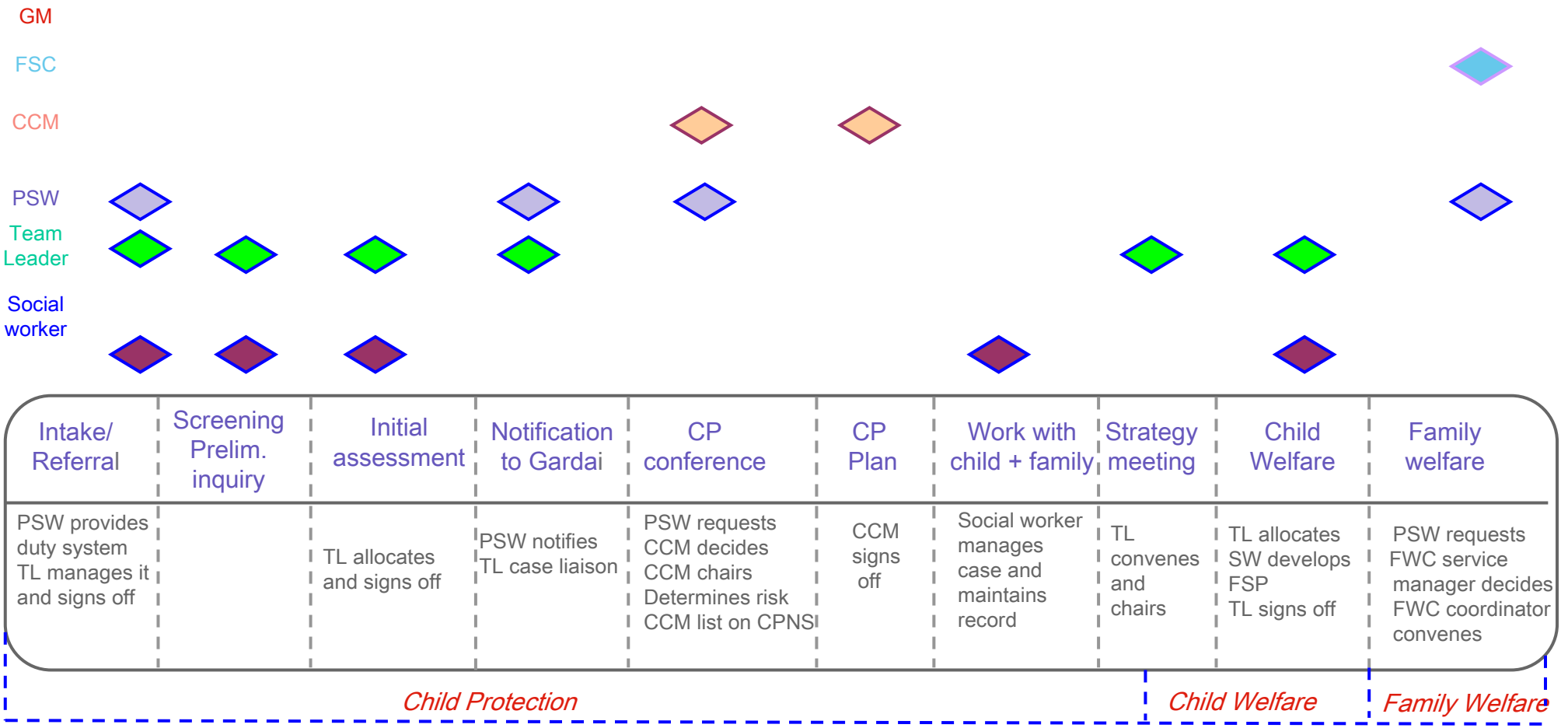
46 b) Average Experience of Staff in Department by LHO



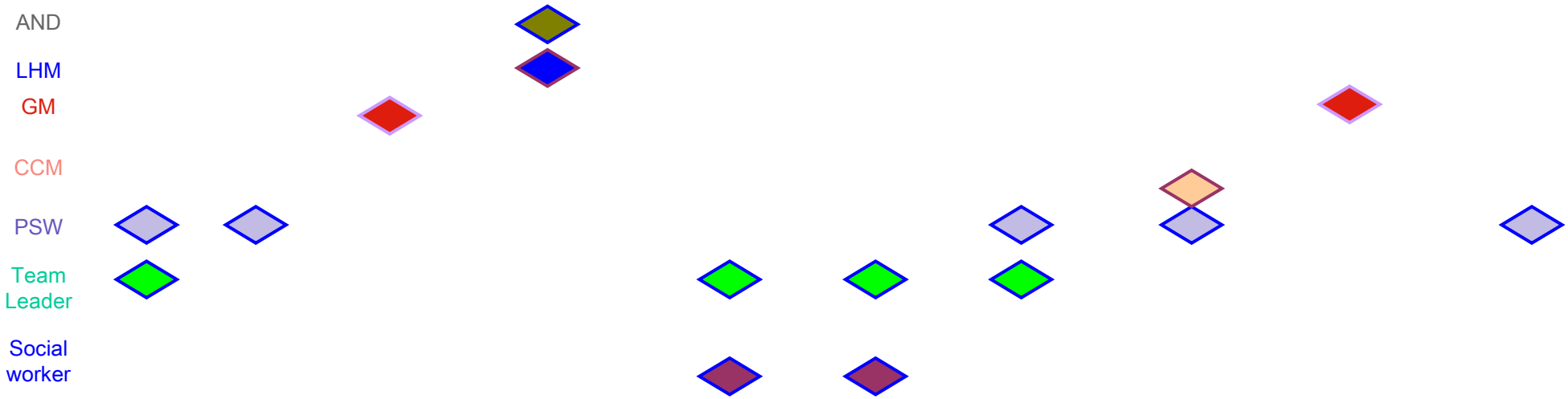
47. Administrative Staff by LHO



Source: HSE National Social Work Survey


GM
FSC
CCM
PSW
Team Leader
Social worker
Intake/ Referral
Screening Prelim. inquiry
Initial assessment
Notification to Gardai
CP conference
CP Plan
Work with child + family
Strategy meeting
Child Welfare
Family welfare
PSW provides duty system TL manages it and signs off
TL allocates and signs off
PSW notifies TL case liaison
PSW requests CCM decides CCM chairs Determines risk CCM list on CPNS
CCM signs off
Social worker manages case and maintains record
TL convenes and chairs
TL allocates SW develops FSP TL signs off
PSW requests FWC service manager decides FWC coordinator convenes
Child Protection
Child Welfare
Family Welfare
Increased level of risk and/or Unmet need

(2) Children in Care, Closure, Case Transfer, Aftercare, Homeless children



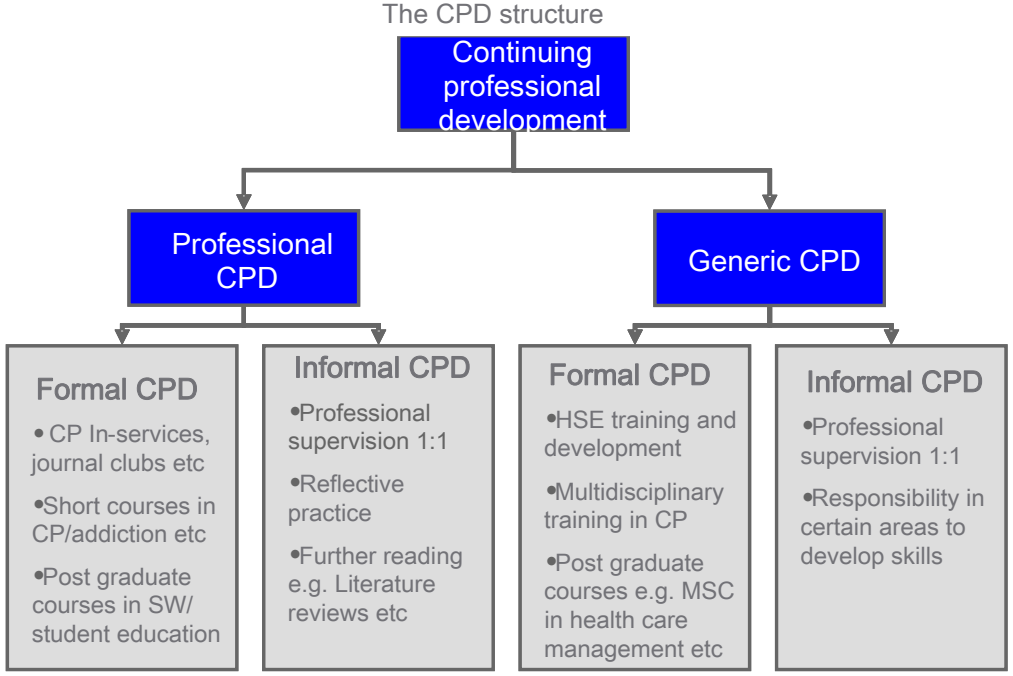
Referral	Decision to place in care	Supervision order	Application to SCADC	Care Plan	Child care review, discharge, transfer	Case closure	Case transfer	Aftercare services	Homeless children
TL refers to foster, residential, relative PSW signs off exceptional care	PSW - Voluntary, emergency, interim care	GM initiates care or supervision order	AND - Special Care Admission Discharge Committee LHM signs off application for SAP	SW draws up TL signs off	TL signs of on review PSW signs off on discharge TL signs off on transfer	PSW signoff on child protection TL signoff on child welfare	PSW authorises CCM on CPNS	GM signs off	Decision to provide accommodation

Increased level of risk and/or Unmet need

Professional supervision and CPD are the key elements in creating a professional and competency driven service, and could impact on future professional registration. However the findings point to a lack of clarity and a wide variation in its provision.

Professional development refers to a process whereby individual professionals increase their level of knowledge and refine or learn new skills to apply in their professional practice and workplace. CPD is the ongoing process of developing and updating the knowledge and skills necessary to ensure competent practice. It works in a 'top down' manner where the development needs of the relevant social work department are planned for as well as 'bottom up' where the individual social workers professional needs. It has both formal and informal dimension as illustrated below.

The CPD structure



The Health and Social Care Professional Council- registration for Social work: Social work is one of 12 professional groups that will require statutory registration. This will require a more structured approach to supervision and CPD at HSE and individual level. Ultimately the responsibility for CPD rests with individual professionals. However, given the gap between what currently exists and what is required, a corporate approach is also needed.

The key features of CPD should include:

- **Acknowledgement of the importance of providing for CPD and the respective responsibilities of HSE corporately and individual professionals.** This commitment needs to be reflected in budgets and protected time allocation to CPD as well.
- **A CPD strategy and implementation plan:** Training and development should be planned both at a national level (core skills and competencies necessary to roll out the business processes etc, legislative and statutory requirements, multidisciplinary training, management competences) and be supported at a regional and LHO level. Each LHO must also devise a CPD plan to reflect current and future service needs, the individual social worker needs as well as leveraging the national CPD strategy. (This could be done using the HSE Departmental and individual CPD planning tools available on HSE Land)
- **Individuals with responsibility for roll out of the CPD strategy**: Key social workers identified in each LHO to organise and coordinate CPD in line with the national and departmental CPD programme. This would ensure that front line professionals are involved in the on going development of courses.
- **Universities and social work courses:** The role of universities in the area of CPD could be strengthened. Social work departments support universities by providing practice placements to social work students. Quality placements can only be provided if the university reciprocates and provides CPD to the departments to develop their practice education skills. Skills which add value to the day to day social work role. A connection with the universities also links research and the work setting and supports evidence based practice
- **Multidisciplinary CPD training**: During the review some good examples of multidisciplinary training emerged which had fostered multidisciplinary working. This should be a key element of the CPD programme.

HSE's requirement:

The purpose of the review is to assess the existing management organisational child protection arrangements including structures, management and governance arrangements and consider if they:

- ❑ Are fit for purpose in achieving safe and high quality child protection services, consistent with statutory obligations
- ❑ Ensure and support best practice in clinical and professional effectiveness
- ❑ Facilitate public accountability and public confidence
- ❑ Support effective interdisciplinary and interagency relationships
- ❑ Are consistent with international best practice regarding Child Protection, assessment and Intervention