REPORT ON THE MONITORING OF THE IMPLEMENTATION OF CHILDREN FIRST NATIONAL GUIDELINES FOR THE PROTECTION AND WELFARE OF CHILDREN

January, 2003

ADDRESS: Floor 3, 94 St. Stephens Green, Dublin 2
PHONE: 01-4180588 FAX: 01-4180829
WEB: www.issi.ie

1. Executive Summary

Children First, National Guidelines for the Protection and Welfare of Children, was launched in September 1999. The Social Services Inspectorate (SSI) was asked to monitor the implementation of the guidelines. The monitoring exercise took place over a two year period and an interim report was issued in October 2001.

The health boards agreed with the Department of Health and Children key objectives for the implementation of Children First as part of their service plans for 2000 and 2001. The monitoring exercise measured progress against these objectives. The inspector met with representatives of each of the health boards and others involved in the implementation process and the health boards provided written information on their implementation activities.

There was a national strategy for the implementation of Children First. A National Implementation Group, made up of representatives of each health board and one from the Department of Health and Children, was set up in late 1999 to support the implementation process. It was later renamed the National Implementation Advisory Group (NIAG) to underline its advisory and supportive as distinct from executive role. It facilitated a joint approach to common problems experienced by the boards. In 2000 the Health Board's Executive Agency (HeBE) set up a Children First Resource Team. The Team worked closely with and reported to the NIAG and developed solutions to difficulties thrown up by the process of implementing Children First. Three health boards devised and implemented joint Garda/ health board training on behalf of the ten health boards.

The national strategy must be judged a success. It allowed, for instance, for a national solution to a problem in relation to the Child Protection Notification System (CPNS) rather than ten individual ones which would have fragmented the child protection system and undermined the raison d'etre of national guidelines. The strategy provides a useful, workable model that could be applied to other policy initiatives. It represented economical use of resources, prevented disparate and fragmented approaches to problems and it made the process of implementation more open and transparent than it would have been otherwise as each board had access to information about the other nine. The strategy could have been improved. The HeBE Team should have commenced work at the same time as NIAG. Greater clarity was needed from the outset in relation to the role and function of each of them and their relationship to each other.

Not all of the targets set out in the service plans were reached. Some of the reasons for this had to do with the health boards and some related to the guidelines. The Department of Health and Children provided extra funding for the implementation process. New Children First Officer posts were created. However, boards found it difficult to recruit the extra staff required and for some boards this problem was particularly acute. Boards were also struggling to deal with a number of new policy initiatives at the same time. Some aspects of the guidelines caused confusion. Much time and effort went into developing guidance to the operation of the CPNS until it was eventually accepted, early in 2002, that this aspect of the guidelines could not be brought into operation without further clarification. By the middle of 2002 this clarification had been agreed with the Department of Health and Children. Boards

were then in a position to proceed with the introduction of the CPNS and this was due to happen in late 2002/ early 2003. The confusion over the role and function of the CPNS, and the delay in agreeing the need for further clarification, set back progress in the implementation of Children First.

Some boards made greater progress in implementing Children First than others. Indeed the record of some boards in relation to child protection training and information and advice given to voluntary and community groups is impressive. However, progress in relation to key areas such as Garda/ health board co-operation, child protection committees and planning for family support services has been slow and there is a need for more work at health board and at national level in order to implement these aspects of the guidelines. It is a matter of concern that both NIAG and the HeBE Resource Team are to be disbanded in early 2003, leaving no national infra-structure for the development of solutions to outstanding difficulties. SSI recommends that either current arrangements are allowed to continue for a time or that some alternative mechanism be put in place to further the implementation process and ensure a national response to outstanding issues. [1]

2. Background

2.1 Launch of Children First

Children First, National Guidelines for the Protection and Welfare of Children, was launched by the then Minister for State with special responsibility for children, Frank Fahey, on September, 21st 1999. The objectives of the guidelines are to:

- Improve the identification, reporting, assessment, treatment and management of child abuse.
- Clarify the responsibilities of various professionals and individuals within organisations.
- Maximise the capacity of staff and organisations to protect children effectively.
- Enhance communication and co-ordination of information between disciplines and organisations.

The government approved the guidelines and decided that all health boards, government departments and organisations providing services for children should apply them consistently. The Social Services Inspectorate (SSI) was asked to monitor the implementation of the guidelines.

[1] After this report was completed SSI was informed of the following statement: The chief executive officers of the health boards and the ERHA have established a 'Conjoint Programme of Action for Children' which will integrate work in the areas of child health, child welfare, child and adolescent psychiatry and other areas of services relating to children. This programme will have the responsibility for ensuring that the outstanding issues relating to Children First are addressed.

2.2 The Implementation of Children First

In order to facilitate the implementation of the new guidelines a wide range of measures were taken across agencies and government departments. For the purposes of this report the most significant of these were the funding of Children First Officers by the Department of Health and Children to facilitate implementation within health boards, the setting up of the National Implementation Group (later renamed the National Implementation Advisory Group (NIAG)) to facilitate implementation across health boards and, some time later, the setting up of the Health Board Executive Agency (HeBE) Children First Resource Team, also to facilitate implementation within and across health boards. The roles of the HeBE Team and NIAG were advisory and supportive rather than operational. Responsibility for implementation rested with the health boards.

The Children First Officers were Implementation Officers, Training Officers and Information and Advice Officers. Implementation Officers took responsibility for distributing the guidelines and briefing health board and other professionals on their contents as well as other implementation activities such as developing local guidelines. Training Officers organised training in child protection. Information and Advice Officers liased with voluntary and community groups, helping them to understand their responsibilities in relation to child protection and to develop their own child protection procedures in accordance with Children First. The NIAG identified priority areas for implementation and advised the boards on a uniform implementation strategy. The HeBE Team worked closely with NIAG and reported to the chairperson of the group. Upon taking up post the members of the HeBE Team carried out an evaluation of the implementation of Children First throughout the ten health boards. The Team discovered widespread confusion in relation to the Child Protection Notification System as well as acute problems in relation to staff recruitment and retention. The Team subsequently worked on producing a clarification of the purpose and function of the CPNS and on a range of other issues such as the development of family support services, a framework for initial assessment and professional supervision.

2.3 Monitoring process

In the preparation of this report the inspector held meetings with:

- Several representatives of each health board.
- Members of the HeBE Children First Resource Team
- A representative of the Department of Health and Children.
- Members of NIAG, both individually and collectively.
- A member of the working group that drew up the guidelines.
- A group representing Implementation Officers.

In addition, a questionnaire was drawn up in 2001 in consultation with the stakeholders and each health board was asked to complete this and return it to SSI. All of the health boards did so. The questionnaires were returned between February and May of 2002. This report is based on the information gathered at the various meetings, the information provided by the health boards on the questionnaires and on the reports of the Department of Health and Children and the HeBE Team.

2.4 Scope of this report

This report outlines progress in the implementation of Children First. It focuses on the activities of the ten regional health boards as the agencies with primary responsibility for child protection. The detailed information in relation to each of the health boards set out in Appendix 2 covers the period to the end of December 2001. Some further national developments that took place in 2002 are reported on in the text.

It was agreed between the Department of Health and Children and the health boards that implementation of Children First would be phased over a number of years. This report focuses on progress in meeting a number of key objectives towards the implementation of Children First to which the health boards agreed with the Department of Health and Children in their services plans for 2000 and 2001. These are:

1. Distribution of the guidelines.
2. Development of an infra structure to support implementation.
3. Training of staff.
4. Introduction of a Garda/ Health Board protocol.
5. Bringing the Child Protection Notification System (CPNS) into operation.
6. Establishing local and regional Child Protection Committees (CPCs).
7. Developing a family support planning function.
8. Providing advice and support to voluntary agencies, especially those funded by the health board.

The report also considers observations and comments on the new guidelines and on the process of implementing them. The findings of the monitoring process are discussed, key learning points identified and the report concludes with an outline of progress in implementing Children First in each of the ten health boards.

This report does not purport to be an evaluation of Children First or of the child protection systems operated by health boards.

2.5 Acknowledgments

The inspector wishes to acknowledge the considerable co-operation and assistance provided by the Department of Health and Children, the health boards, HeBE and all those who contributed to the preparation of this report.

3. An overview of progress in implementing Children First

Detailed information in relation to each health board is contained in Appendix 2.

3.1 Distribution of Children First

The distribution of the guidelines was completed in seven of the ten health boards by the end of 2001. This means that all existing relevant staff had received a copy with arrangements in place to distribute them to newly appointed staff. The three other

health boards had distributed them to between half and over two thirds of relevant staff.

3.2 Development of infra structure to support implementation

The health boards experienced considerable difficulty in recruiting people to fill the Children First posts and not all had been filled at the end of 2001. These problems were particularly acute in, but were not confined to, boards operating in the greater Dublin area. One board, for instance, advertised the post of Implementation Officer three times before filling it. There were problems also with staff retention. One health board appointed an Implementation Officer in 2000 and another one the following year. Both had left by the end of 2001. Other boards experienced similar difficulties. These were part of the more general difficulties boards have experienced during recent periods of rapid economic expansion in relation to the recruitment and retention of staff.

Many boards had training officers in post before the new guidelines were published and had been training their staff in child welfare and protection. These training officers took on responsibilities in relation to Children First so that the appointment of the Children First Training Officers was an addition to what was already in place.

The implementation of Children First was adversely affected by recruitment and retention problems.

3.3 Training

In Children First training of staff is seen as a key to the development and the effective operation of the child protection system. The guidelines state that different levels of training are required for staff with different responsibilities within the child protection system. Basic level and advanced level training is described. Basic level training aims to equip people with knowledge of legislation, national and local policies, protocols and procedures, and with knowledge of local networks. Advanced level training aims to equip staff with knowledge, skills and critical perspectives in specific areas of policy and practice and ought to be relevant to the role of the particular professional, for instance, training for social workers in carrying out risk assessments. Children First places a major emphasis on providing training on an inter-disciplinary and inter-agency basis.

A national Trainers Group agreed the content and format of basic level training in consultation with a member of NIAG. However, it was not possible to agree on advanced level training as boards were at different stages in the development of their training programmes.

Children First envisages formal liaison structures between An Garda Siochana and the health boards. To facilitate this joint training was organised. A ‘train the trainers’ programme was designed and implemented by the training officers of three health boards. They undertook responsibility for this training on behalf of all ten health boards. The training was delivered in three locations covering all ten health boards and their corresponding Garda districts. The people who completed this training

assumed responsibility for providing joint Garda / health board training in their local areas.

The area of training demonstrates clearly that some boards invested greater resources to implementing Children First than others. While all of the boards trained their staff in child protection during the period in question some boards offered a greater variety of courses than others and some trained a far greater number of people than others. The trainers in the boards that organised the 'train the trainers' courses for Garda and health board personnel also provided significant amounts of training within their own boards. One of these boards delivered 40 courses to over 1,500 people during this period. Two other boards each delivered child protection training to over 1,000 people through a variety of training courses.

As was pointed out earlier some boards had training officers in post prior to the introduction of Children First and they were already training their staff in child protection. Boards that had to recruit training officers for the first time were starting at a disadvantage. The boards with training officers already in post must be commended for their foresight and commitment to training generally.

3.4 Garda/ health board co-operation

Children First proposes that a social work team leader from the health board and a Garda inspector or sergeant from the corresponding district form a liaison management team to:

- Consider notifications
- Assign personnel and supervise investigations
- Review progress in cases.

Only one health board reported that liaison management teams had been established in each of its community care areas by the end of 2001. One board had a team in one area and was setting one up in another and in another board some progress had been made in establishing teams in all of its three community care areas. However, that left no liaison management teams in seven health boards.

Children First states that a member of An Garda Siochana should attend strategy meetings. These are primarily professional networking meetings called to pool information and consider whether immediate action is required to protect a child about whose safety there is a concern. In eight health boards Gardai attended at least some strategy meetings. Five health boards had other arrangements in place for some form of inter-agency discussion and co-operation at a senior level.

It is important to note that the data refers to formal arrangements only. Health boards or community care areas with few formal arrangements for co-operation with An Garda Siochana may, nonetheless, have very good informal co-operation 'on the ground'. However, such arrangements tend to depend on personal contacts, which can be lost when staff change and, in any case, are not what are envisaged in Children First. Given that one of the objectives of Children First is to enhance communication and co-ordination of information between disciplines and organizations, the lack of progress in putting formal structures in place for co-operation between An Garda Siochana and health boards is a cause for concern.

3.5 The child protection notification system (CPNS).

Children First (8.15.1) describes the child protection notification system as "a health board record of every child about whom, following a preliminary assessment, there is a child protection concern. A child's name is placed on the child protection notification system by the child care manager/ designate following completion of a preliminary assessment. Notifications to the child care manager/ designate must be on the standard notification form". (This form is referred to as CPN1).

There are different aspects to the operation of the CPNS and this makes it difficult to state in simple terms whether it operates in a particular situation. This report follows the lead of, and is indebted to, the HeBE Children First Resource Team in breaking the matter down into four separate issues.

(i) Notification to the child care manager of child protection concerns.

Six boards reported that child protection concerns were notified to the child care manager. One of these reported that this was the case in two of its four community care areas.

(ii) Use of form CPN 1

Six boards reported that form CPN 1 was in use in some or all of its community care areas.

(iii) Establishment of child protection notification management team

In all but one community care area of one health board, there was some form of inter-disciplinary team established to consider child protection notifications.

(iv) Facility for placing a child's name on the CPNS

Three boards were operating the notification system envisaged in Children First. Five boards were operating other notification systems some that had been developed before Children First.

One board did not provide information under these four headings. It reported that systems were in place to facilitate the introduction of the CPNS but that it was awaiting clarification of its purpose and function before bringing it into operation.

The principle that inter-disciplinary teams should have some input into the management of the child protection system was well established by the end of 2001. Many boards were merely continuing a practice that was already in place in their boards prior to the introduction of Child First. Notifications to the child care manager and use of CPN 1 were established in at least half of the health boards.

Boards reported considerable confusion in relation to the purpose and function of the CPNS. Six stated on the forms returned to SSI that they were awaiting clarification, at national level, of these issues before proceeding further with the introduction of the CPNS. The HeBE Team, in their evaluation of the implementation of Children First,

found that 56% of principal social workers and child care managers saw the CPNS as a record of all children about whom there is or has been a child protection concern. However, 28% saw it as a record of children about whom there is a current or ongoing concern. A further 16% saw it as something other than these two. Among other professionals the level of confusion was even greater.

A group, made up of two members of the HeBE Team and three health board representatives drew up a document that addressed these issues. This document favoured a narrow or restricted use of the CPNS as a record of every child about whom there are ongoing or unresolved child protection concerns. This was submitted first to the chief executive officers of the health boards and then, with their approval, to the Department of Health and Children. This clarification was accepted in the spring of 2002 and is now the nationally agreed definition of the purpose and function of CPNS. This has removed a considerable obstacle to implementation. The HeBE Team prepared guidance notes for the use of the CPNS. It is anticipated that the CPNS will be in operation in all boards in early 2003.

The clarification prepared by the HeBE Team includes threshold criteria for the notification of children. The Team developed a framework for initial assessment of child welfare and protection referrals and guidance notes for its use. These were published together as a practice handbook in December 2002.

3.6 Child Protection Committees

Children First advocates the setting up of local (community care level) and regional (health board level) Child Protection Committees. These should involve representatives from social work, public health nursing, the probation and welfare service, An Garda Siochana, medical practitioners, teachers, other professionals, agencies and government departments. Their purpose is to monitor and review progress on arrangements to prevent child abuse, promote the development of inter agency co-operation and raise public awareness of the issue of child abuse. Regional committees have a further responsibility to initiate research on the prevention and treatment of child abuse and to develop a strategy for the provision of therapeutic services to perpetrators of abuse.

By the end of 2001 local committees had been set up in eight health boards, though one of these had yet to set up committees in all of its community care areas. Three boards had set up regional committees. The HeBE Team, which updated the data in August 2002, reported that no new local committees had been set up but that one additional regional committee had been established.

A notable feature of the operation of the Child Protection Committees was the lack of participation by the Department of Social, Community and Family Affairs and the Probation and Welfare Service in the local committees. Of the local committees established, two health boards reported that the probation and welfare service was represented on their committees while one reported the involvement of a representative of the Department of Social, Community and Family Affairs.

There were some difficulties in the setting up and running of these committees. Some boards, especially the more rural boards, reported ‘committee fatigue’, the problem of

asking often the same people to serve on many different committees. Some committees have overlapping responsibilities such as the Child Care Advisory Committees, the County and City Child Care Committees and the Youth Homelessness Forums. This has led to a lack of clarity in relation to the particular role of Child Protection Committees. This, together with the fact that they do not meet very frequently, has made it difficult for some to achieve and sustain a focus to their activities.

There has been a particular difficulty in relation to representation from education and from the medical profession. Schools and general practitioners operate independently of each other, so, though teachers and doctors participate in the child protection committees, they cannot act as representatives of professional colleagues in the area in question.

Progress in relation to the implementation of this aspect of the guidelines has been slow and certain issues need to be resolved to move the process forward. These are the issues of representation and attendance of government departments and agencies on the committees and the role and function of the committees, particularly in relation to functions that overlap with other committees such as the Child Care Advisory Committees. It is recommended that these issues be addressed at a national level.

3.7 Planning of family support services

Children First emphasises the importance of family support. Many children who are not being abused are, nonetheless, at risk as their needs for care and protection are not adequately met through exposure to adverse social circumstances. Health board must, under the Child Care Act 1991, provide family support services to promote the welfare of children in such circumstances. Children First states that "each community care area should have a family support service plan" (7.2.3).

Two boards had family support service plans in place for each of their community care areas by the end of 2001. Two other boards had produced draft family support policies. Other boards reported that family support services were part of their general service plans.

The HeBE Team published a 'Family Support Discussion Document' in May 2002 to assist the health boards to develop their thinking and approach to the provision of family support services. In addition, many boards have had family support services in place and have grant aided voluntary organizations to provide other family support services over many years.

While all boards were including family support in their overall service plans, planning in relation to family support services at community care level remained underdeveloped in most health boards at the end of 2001.

3.8 Advice and support to voluntary agencies and community groups

Children First states that all organisations providing services to children must have child protection procedures in place. The Department of Health and Children funded the employment by health boards of Information and Advice Officers to provide

information and advice to help voluntary and community groups in this matter. The department also funded the publication a document entitled 'Our Duty to Care'. This was produced by a sub group of NIAG to help voluntary and community groups to develop safe care and child protection policies and practices. The Department also funded accredited training for Information and Advice Officers.

The level of advice and assistance provided to voluntary and community groups varied widely between health boards. One health board had not provided any such advice or assistance as it was unable to recruit an Information and Advice Officer. By contrast another board had made contact with approximately 270 grant aided groups.

The service health boards provided consisted of briefings on the new guidelines and advice to groups in developing their own policies and procedures. In addition, five boards provided training for members of voluntary or community groups. This was done either by boards providing courses specifically for such groups or by offering places to members of the voluntary and community groups on multi-disciplinary courses being provided for health board staff.

Significant progress was achieved in this area. However, difficulties in recruiting staff, referred to earlier, had a major impact on the capacity of some boards to meet their service plan commitments.

4. Discussion of findings

The implementation of Children First differed from most other such initiatives in that a national strategy was put in place. The ten boards came together to share their experience and expertise. While the responsibility for implementation rested with the boards, the NIAG and the HeBE Resource Team played a key role in the implementation process. The fact that the boards were coming together in the advisory group also led to a sharing of information about the progress of implementation. The boards knew of each other's progress and the information was available to the Department of Health and Children. The process was more transparent than it might have been if each board had proceeded unilaterally.

The national strategy must be judged a success. It allowed, for instance, for a national solution to a problem in relation to the CPNS rather than ten individual ones which would have fragmented the child protection system and undermined the raison d'etre of national guidelines.

Health boards, compared to similar authorities in other countries, are small. Their capacity to implement new policy initiatives is limited by virtue of the fact that the same small group of people may have to drive several new initiatives. The co-operation that was apparent in relation to the implementation of Children First suggests a way of overcoming this difficulty. There are several aspects of this co-operation that are noteworthy.

Three boards, on behalf of the other ten, took responsibility for the 'train the trainers' joint Garda/ health board training. This placed a considerable burden on the training

officers in the boards in question but it was certainly a more efficient use of resources than expecting each health board to do this. Indeed, given the difficulty some boards had with staff recruitment and retention it is doubtful whether the training would have been done in all parts of the country had it not been done in this manner.

The setting up of NIAG facilitated the taking of a common approach by boards and the sharing of experience and expertise in relation to issues such as the CPNS, the setting up of the local and regional child protection committees and other issues.

Finally, the setting up of the HeBE Resource Team furthered this process. The difficulty for the training officers of the three boards and for the members of the NIAG was that they were heavily committed to their other duties. The HeBE Team were dedicated to supporting the implementation process. They had the time to meet with the key stakeholders and their intervention in relation to the role and function of the CPNS was decisive, as discussed earlier. Their approach to the difficulties they encountered was another key factor. It was a pragmatic one, one that responded to the difficulties encountered by practitioners on the ground. Given the history and culture of health boards that have no tradition of doing things in a uniform way, the Team's approach of trying to develop agreement on principles while allowing for variations in practice was the appropriate one. For instance, while each community care area will have its own Child Protection Notification Management Team, the approach of the HeBE Team allows for variation in how these operate. Given the very different approaches to this issue between, and often within, boards, this is a sensible and pragmatic position.

The implementation of Children First is, at the time of writing this report, not complete. Eight objectives were identified in section 2.4 of this report:

1. Distribution of the guidelines.
2. Development of an infra structure to support implementation.
3. Training of staff.
4. Introduction of a Garda/ health board protocol.
5. Bringing the Child Protection Notification System (CPNS) into operation.
6. Establishing local and regional Child Protection Committees (CPCs).
7. Developing a family support planning function.
8. Providing advice and support to voluntary agencies, especially those funded by the health board.

Section 3 of this report outlined the progress achieved under each of these headings. While major progress was achieved in a number of areas such as distribution of the guidelines, training, and advice and support to voluntary agencies, less was achieved in relation to areas such Garda / health board co-operation, child protection committees and planning of family support services at community care level.

Enough progress has been made to conclude that the model of a national implementation strategy is one that could be applied to other similar policy initiatives. However, some things could have been done better and ought to act as learning points for the application of the model to other initiatives. In particular, the role of the NIAG should have been more clearly defined and understood and the HeBE Resource Team should have started their work at an earlier point in the process.

There was a sense at the outset of the implementation process that the NIAG, then known as the National Implementation Group, was responsible for implementing Children First, rather than the health boards. This was recognised and corrective action taken during the life of the Group, underlined by the name change. However, clarity about the role and function of the Group from the outset might have helped the implementation process to develop a momentum within boards at an earlier stage.

NIAG was established in late 1999 and the HeBE Resource Team 15 months later. This led to a certain duplication of work, for instance, in relation to the CPNS. It also led to a certain early confusion in relation to the role of the Team and its relationship with NIAG and with the health boards, as evidenced by the criticism of the Team's role outlined later in this report (Appendix 1, Section A.2). It would have been preferable for NIAG and the Resource Team to be set up simultaneously. As with NIAG, greater clarity about the Team's role would have been helpful.

No health board met all of the service plan objectives for the implementation of Children First agreed with the Department of Health and Children for 2000 and 2001.

There were a number of reasons why targets were not reached. Some of these had to do with the difficulties the health boards experienced. Problems in relation to staff recruitment and retention have been mentioned already in this report. Health boards were trying to implement new child protection guidelines at the same time as attempting to respond to other policy initiatives such as the Youth Homelessness Strategy and the Report of the Working Group on Foster Care. Even with the extra funding available to employ Children First Officers, the implementation of Children First depended on the commitment and effort of key management staff who had to divide their time between competing priorities.

Some of the obstacles to implementation were to do with difficulties with the new guidelines. The health boards referred repeatedly to confusion in relation to the role and function of the CPNS. This difficulty was identified to the inspector at the very outset of the monitoring process in the middle of 2000. Yet it took nearly a year before this difficulty was accepted and a clarification agreed by the Department of Health and Children. During this time NIAG produced CPNS guidance notes in various versions with each succeeding version serving to increase confusion among managers and practitioners. These notes were then set aside, despite a great deal of work having gone into them.

The intervention of the HeBE Team was decisive. The members of the Team went around the country meeting health board personnel from each community care area. They issued a report that highlighted the confusion and the different understandings of the role and purpose of the CPNS. It became apparent that the guidelines could not be implemented without further clarification.

Some boards came nearer to meeting their targets than others. This report has highlighted the significant amounts of training undertaken by some boards. The information, advice and training provided by some boards to voluntary and community groups was also very impressive. While the availability of staff was a key factor, the boards themselves identified other factors that facilitated implementation such as a commitment to change, good internal communication and

co-operation within boards. The boards highlighted not just the availability of the Children First officers but the quality of the personnel employed, their expertise and commitment to the process.

By the end of 2002 significant progress had been made in the implementation of the new guidelines. A significant obstacle to further progress has been removed with the clarification of the role of the CPNS. The CPNS is central to the new system as it introduces for the first time a standardised system for notifying and recording the names of children about whom there is a child protection concern. However, more work needs to be done at both health board and national level at implementing other key aspects of the new guidelines such as the child protection committees, the development of family support services and Garda/ health board cooperation. In response to a draft version of this report some boards expressed concern about the planned disbandment of both NIAG and the HeBE Resource Team in early 2003, given that a number of issues in relation to the implementation of Children First remain to be resolved. SSI recommends that either current arrangements are allowed to continue for a time or that some alternative mechanism be put in place to further the implementation process and ensure a national response to outstanding issues.

5. Key learning points

There are a number of lessons from the experience of the implementation of Children First that could be applied in relation to similar policy initiatives in the future.

5.1 The model of a dedicated resource team that reports to a group comprised of a representative of each health board and the Department of Health and Children is one that should be replicated. Both the resource team and the group to which the team reports should be set up simultaneously and their roles in relation to each other and in relation to each health board's own managers and/ or dedicated implementation staff should be clarified from the outset.

5.2 The resource team should work closely with and take account of any difficulties experienced by those practitioners attempted to implement proposed changes.

5.3 Implementation strategies must take account of the different starting points of the various health boards and community care areas. Solutions to identified difficulties should be pragmatic and flexible. A national strategy should allow for some variation in practice at local level, provided there is agreement on basic principles.

5.4 There must be a strong expectation that the advice offered by a resource team reporting to a national implementation advisory group will be followed by each health board. A truly national approach to policy implementation can only be achieved if each health board relinquishes its discretion to do things in its own way.

5.5 The health boards should share resources and expertise as happened with the Children First 'train the trainers' programme.

Appendix 1. Feedback on the implementation process

A.1 The implementation process as experienced by the health boards.

Table A.1 (1)
Factors facilitating the implementation of the new guidelines as identified by health boards

The contribution of the Children First officers	5 boards
Training	4 boards
Good internal co-ordination within the health board	4 boards
Children First is not a completely new system	3 boards
Setting up of inter-disciplinary groups	2 boards

'Good internal co-ordination' within health boards refers to a number of factors identified by health boards such as the commitment of managers to change, good communication and positive working relationships within health boards.

Table A.1 (2)
Factors impeding the implementation of the new guidelines as identified by health boards

Confusion concerning the purpose and function of the CPNS	7 boards
Staff shortages	5 boards
Problems with other aspects of the guidelines	4 boards
Staff resistance	3 boards
Difficulties in relation to developing information systems to support implementation.	3 boards

Staff shortages refers both to the difficulties some boards had in recruiting enough staff, particularly social workers and Children First officers, to introduce and operate the new system and to the difficulty some boards experienced in having members of staff teams released to attend briefings and to participate in training.

Staff resistance covers a number of factors referred to by boards such as anxiety on the part of social workers in relation to the new system, fear of being overloaded with responsibilities and confusion in relation to aspects of the system such as the CPNS.

Apart from confusion over the role and function of the CPNS, other aspects of the guidelines caused difficulties for health boards such as how underage pregnancies ought to be dealt with under the new guidelines.

A.2 Support for the boards in implementing the new system

The boards were generally positive about the role of the Department of Health and Children in the implementation process. Some felt that the Department could have

done more and others criticised the Department for failing to offer clarification of aspects of the guidelines.

Many boards commented favourably on the contribution of the NIAG though a number of these highlighted the heavy workload of the members of this group. One was critical of the group and another referred to difficulties experienced by the group.

A majority of boards were also positive about the role of the HeBE Team. One of these, however, stated that there was a need for clarity in relation to the role of the Team vis a vis NIAG. This was echoed by another board which was critical of the role of the Team and referred to the Team 'going over the heads' of health board managers and circulating documents and pro-formas to front line staff.

Six of the questionnaires returned by health boards were completed by members of the NIAG. All of these people were centrally involved in the implementation process and devoted considerable time and energy to the task. There was a tendency for those questionnaires completed by others to be less positive about the support offered to health boards in implementing Children First. In addition, at a meeting with Implementation Officers, the inspector learned of difficulties within boards in relation to a lack of clarity on the role of Implementation Officers and a sense among some of them of not being kept informed of developments at a national level. The NIAG was aware of communication difficulties and a newsletter was produced to give regular updates on progress in implementing Children First. Taken together with the comments on the role of the HeBE Team, these suggest that not all parts of the implementation machinery were as well co-ordinated as they might have been, at least at certain points in the process.

A.3 Changes to the Child Protection System

Table A.3 (1)
Improvements in the child protection system brought about by the introduction of Children First as identified by health boards

Standardisation of approach	5 boards
Better co-operation between Garda and social workers	3 boards
Puts emphasis on assessment	3 boards
Greater awareness of child abuse among professionals and agencies	3 boards
Improved record keeping systems	2 boards

Table A.3 (2)
Aspects of the child protection system that have not been improved by the introduction of Children First as identified by health boards

Confusion/ lack of clarity of guidelines	4 boards
Too early to judge/ no comment	3 boards
Waiting lists	2 boards
Overemphasis on role of social workers in child protection	2 boards
Inadequate resources	2 boards

In contrast to those who stated that Children First had increased the awareness of other professionals and agencies in relation to their child protection responsibilities, two boards stated that Children First did not go far enough in this regard. Their view was that Children First overemphasised the role of social workers to the neglect of the role of other professionals.

All of the health boards stated that Children First needs to be reviewed.

TableA.3 (3)
Aspects of the new guidelines that need to be reviewed as identified by health boards

Purpose and function of CPNS	9 boards
Concept of significant harm	3 boards
Document as a whole	2 boards
Forms	2 boards
Taking children's names off CPNS	2 boards

There are a number of points to note in relation to the review of Children First. In the first instance, a review has been agreed and was promised at the time of the launch of the guidelines in 1999. The second is that, as noted, the role and purpose of the CPNS was clarified in 2002. The clarification document includes threshold criteria for notification of children that do not refer to the concept of significant harm. The HeBE Team have also done some work on the forms used as part of the new system and clarified their function. Therefore, some, though not all, of the issues that led the boards to want a review of Children First have been addressed and resolved. Despite this, a number of health boards, in responding to a draft version of this report, identified a need for a further review and, indeed, revision of the guidelines.

Appendix 2. Progress on implementation by health board

(to end of September 2001)

	East Coast Area Health Board
Distribution of Guidelines	Completed
Children First Officers	Implementation Officer, Training Officer and Information and Advice Officer appointed
Training	Basic and advanced level training delivered to approximately 500 professionals
Garda / health board cooperation	Liaison management teams not established. Gardai attend strategy meetings.
CPNS	Inter-disciplinary team meetings consider notifications. Other components of system not in operation
Child protection committees	Local committees established but not regional one
Family support services plan	Child care strategy completed in 2001
Service to voluntary and community groups	None

	Midland Health Board
Distribution of Guidelines	50% complete
Children First Officers	Implementation Officer, Training Officer and Information and Advice Officer appointed
Training	Basic and advanced level training delivered to 1433 professionals (69 courses in total)
Garda / health board cooperation	Liaison management teams not established. Gardai attend some strategy meetings in one of the two community care areas.
CPNS	System in operation in both community care areas.
Child protection committees	Neither local committees nor regional one established
Family support services plan	Forms part of general service plan
Service to voluntary and community groups	Information and/or advice and/ or briefing sessions and/or training delivered to 46 groups.

	Mid Western Health Board
Distribution of Guidelines	Complete
Children First Officers	Implementation Officer, two Training Officers and three Information and Advice Officers appointed
Training	Basic and advanced level training delivered to 1028 professionals
Garda / health board cooperation	Liaison management teams not established Gardai attend some strategy meetings
CPNS	Three of the four components of the system in operation
Child protection committees	Regional and local committees established
Family support services plan	Board has produced a draft child welfare and family support strategy
Service to voluntary and community groups	Information and/ or advice and/ or briefing sessions and/or training delivered to 52 groups.

	Northern Area Health Board
Distribution of Guidelines	Complete
Children First Officers	Implementation Officer, three Training Officers and an Information and Advice Officer appointed
Training	Programme of basic level training developed.
Garda / health board cooperation	Liaison management teams not established
CPNS	Two of the four components of the system in operation
Child protection committees	Regional committee established. Local committee established in one community care area (of three)
Family support services plan	Board has a family support policy
Service to voluntary and community groups	48 briefing sessions, involving nearly 1000 people, delivered to personnel from 52 grant aided voluntary organisations and hospitals

	North Eastern Health Board
Distribution of Guidelines	Complete
Children First Officers	Implementation Officer appointed. Two Training Officer posts approved and one half post filled. Three Information and Advice Officer posts approved and one filled.
Training	Basic and advanced level training delivered to 1,505 professionals (40 courses in total)
Garda / health board cooperation	Liaison management teams established in one community care area (of three)
CPNS	Three of the four elements of the system in place
Child protection committees	Local committees established but not regional one
Family support services plan	Each community care area has a family support service plan
Service to voluntary and community groups	Advice and/ or briefing sessions and/or training delivered to 34 groups. Contact made with over 200 individuals, groups and agencies.

	North Western Health Board
Distribution of Guidelines	70% complete
Children First Officers	Two Implementation Officers, two Training Officers and an Information and Advice Officer appointed
Training	Basic and advanced level training delivered to 618 professionals
Garda / health board cooperation	Liaison management teams not established Gardai attend strategy meetings
CPNS	Three of the four components of the system in operation in one of the two community care areas. One component in operation in the other community care area
Child protection committees	Neither local committees nor regional one established
Family support services plan	Board developing a regional family support policy and strategy
Service to voluntary and community groups	Briefings and advice delivered to 37 groups.

	Southern Health Board
Distribution of Guidelines	65% complete
Children First Officers	Two Implementation Officers, two Training Officers and two Information and Advice Officer appointed
Training	Basic level training delivered to 755 professionals
Garda / health board cooperation	Liaison management teams not established Gardai attend strategy meetings
CPNS	Board reported that all systems were in place to operate CPNS once its purpose is clarified
Child protection committees	Local committees established but not regional one
Family support services plan	Forms part of overall service plan.
Service to voluntary and community groups	Contact made with 270 groups who have been offered briefings and/ or training and/ or advice.

	South Eastern Health Board
Distribution of Guidelines	Complete
Children First Officers	Implementation Officer, three Training Officers and an Information and Advice Officer appointed
Training	Basic and advanced level training delivered to over 550 professionals
Garda / health board cooperation	Liaison management teams established in each community care area Gardai attend strategy meetings
CPNS	All components of system in operation in one community care area Three of the four components in operation in two community care areas Two components of the system in operation in one community care area
Child protection committees	Local committees established in three community care areas (of four). Regional committee not established.
Family support services plan	A draft family support policy document has been prepared.
Service to voluntary and community groups	Advice given to seven agencies and groups, briefings delivered to a further four.

	South Western Area Health Board
Distribution of Guidelines	Complete
Children First Officers	Two Implementation Officers, one Training Officer and an Information and Advice Officer appointed
Training	Garda – health board training completed. Board placed emphasis on briefing its own staff and those of other agencies on the new guidelines.
Garda / health board cooperation	Liaison management teams not established Gardai frequently attend strategy meetings
CPNS	One component of the system in operation in three of the four community care areas
Child protection committees	Local committees established but not regional one
Family support services plan	Family support services are included in board's provider plan
Service to voluntary and community groups	Briefings and advice given to pre-schools and grant aided agencies

	Western Health Board
Distribution of Guidelines	Complete
Children First Officers	One Implementation Officer appointed. One Training Officer appointed and two other posts approved. Two Information and Advice Officers appointed. Two Project Leaders appointed and a further post approved. Project Leaders combine the functions of Implementation and Training Officers.
Training	21 people from various agencies and disciplines were trained to train others. They delivered basic level training to 632 people (a total of 35 courses). Advanced level training delivered to 212 social workers, psychologists, child care workers, Gardai and others.
Garda / health board cooperation	Liaison management teams identified but not established
CPNS	Three of the four components of the system in operation in all three community care areas
Child protection committees	Local committees established but not regional one
Family support services plan	Family support plan for each community care area
Service to voluntary and community groups	Information and/ or advice and/ or briefing sessions and/or training delivered to all disability agencies, all health board funded pre-schools and 14 other agencies and groups