A REVIEW OF RESIDENTIAL CHILD CARE PROVISION WITHIN THE EASTERN HEALTH BOARD

A WORKING PAPER
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Appendix

1 Statement of Purpose - Content and Process
ACKNOWLEDGEMENTS

This review is the first of its kind to have been undertaken. It was not only a complex logistical exercise to undertake, but it also made particular demands upon residential managers and senior staff who had to compile a range of data in advance of my visit, allocate time to see me and in a number of cases respond to my subsequent request for further information. The fact that this exercise went so smoothly reflects the commitment and positive and open approach adopted by all the units.

The other crucial and fundamental factor was the administrative support that was made available to me from the Children and Families Programme. Suzanne Kenny co-ordinated review throughout and without her knowledge, understanding, skill and commitment to the task, it would have been nigh impossible to have completed the exercise.

Mike Laxton.
December 1999
INTRODUCTION

This review of the residential child care provision is part of a comprehensive appraisal of services for children being cared for by or on behalf of the Eastern Health Board. The report is sub-titled a working paper because it has been prepared as a contribution to the wider review.

Whilst the Board is required under Section 8 of the Child Care Act 1991 to review annually the adequacy of its child care services, it has recognised that a more substantive and comprehensive examination is necessary, because they have assumed greater direct responsibility for a wide range of residential provision over recent years which had hitherto been managed by the voluntary sector. More recently there has been a growth in residential care provision with the development of High Support Units, Family Group Homes and "temporary accommodation" for a small number of young people with special needs. The speed and size of this growth is best and simply illustrated by the fact that in 1993 the Health Board managed 1 residential centre. The total number of units included in this review was 54, of which 26 were managed by the Health Board and 28 by the voluntary sector. This is approximately twice that of the sum total of the other seven Health Boards which puts its significance in a national perspective.

The other important factor to acknowledge is the pending restructuring of the Health Board into three areas. This will have significant implications for the future management and distribution of residential child care as well as other child care services.

The pace of change and the increasing responsibilities placed upon the Health Boards over this decade cannot be underestimated. The withdrawal of the religious orders from residential child care, public enquiries, the introduction of the Child
Care Act 1991 and more latterly the Child Care (Standards in Children’s Residential Centres) Regulations 1996 have had a major impact on the Health Board. It inherited a range of provision with no commonly agreed standards and consequently variable practices, and no clearly defined role. This was occurring at a time when the Health Board was itself just beginning to assume responsibility for child care services in general.

The wide ranging nature of the recommendations from this review, reflects in part this lack of a clear organisational and practice framework within which to address the issues facing residential child care and to put its role into proper perspective. Recognition by the Health Board for the need to develop a comprehensive infrastructure to positively support residential child care which promotes the safe care for children and staff has prompted this review.

The review does not make a distinction between those units managed by the Board and those by the voluntary sector. It is necessary that all centres provide a level of care that is consistent with the needs and problems of the young people that are placed within any residential setting. This principle has particular importance for both the Health Board and the voluntary sector in terms of the expectations one will have of the other to ensure that the quality of care provided is of the highest standard. In this context the current discussions about contracts would seem to be both appropriate and timeous.

The review raises a range of questions because the issues effecting the quality of the residential child care services has implications for the whole organisation. Some of the necessary steps to improve the quality of service lie outwith the control of the Children and Families Programme and some of the recommendations may have cost implications beyond the scope of the Health Board.
Whilst the review is primarily from a residential care perspective, the consistency of the issues raised gives a significant measure of credence to the relevance and objectivity of them. They are also consistent with the outcomes of reviews of other residential child care services over the past decade, notably in England and Scotland. However, it should be noted that the Health Board in comparison to their counterparts in those countries has had only a fraction of the time to positively address these issues and within the context of a much more limited primary and secondary legislative framework.

The recommendations are themselves consistent with best practice and the standards and criteria for residential child care recently published by the Inspection and Registration Unit of the Eastern Health Board, which has responsibility for overseeing the voluntary sector. It is also anticipated that they will be consistent with the Department of Health and Children's standards to be published in due course, which will be applied to the residential centres managed by the Health Boards.

Given the significance of the role of residential child care, the importance of taking a comprehensive and integrated perspective cannot be overstated. It demands that residential care is given appropriate recognition, support, status and is seen as a placement of positive choice within the context of other child care provision and not as a last resort.

Account has been taken of child care practice in area teams, after care and the issues facing foster care from various reports and papers. Their ability to fulfill their respective roles has a major bearing on residential care practice and policy. These and other important related issues have been or are currently the subject of internal or national review and serve to underline the importance of taking a holistic view.
Whilst aspects of good practice were to be found in every centre it was not necessarily extensive or uniform. Collectively all the pieces of the jigsaw that go to make up the picture of high quality residential child care were to be found in the residential centres visited. The problem and the challenge is to ensure that all of the pieces are in each of the centres. In order to achieve this there needs to be in place a coherent framework of policy and practice principles and an organisational structure to support the development of the service. This review is concerned to identify the essential elements of that framework.

The report is in five parts

1 methodology

2 some observations about the existing residential child care provision

3 the key issues arising from the review
   a policy and organisation
   b practice and service development
   c training
   d finance and
   e health & safety

4 action plan

5 summary and conclusions
1 METHODOLOGY

The review was based on visiting 54 residential centres providing a range of care for children and young people for whom the Eastern Health Board has responsibility.

The exercise was undertaken over a period of 13 weeks commencing 12 April 1999. The visits took on average between 2.5 and 3.5 hours. The length of the visit was determined in part by the size of the unit, the issues raised and where it fitted into the continuum of residential provision. The emphasis was on collecting some basic facts and gain an impression of the quality of practice and identify the key organisational and policy issues.

Prior to visiting each unit some basic information was sought. This covered the following areas;

(a) The current statement of Purpose and Function
(b) The staff in post, Residential Managers qualifications, vacancies as at 31 March 1999 and staff changes over the past two years.
(c) The characteristics of the young people placed in care over the past 2 years i.e, age, gender and care status.
(e) Average occupancy rates over the past two years up to 31 March 1999.
(f) A copy of all existing policies and procedures,

The visit to the residential centre focused on a range of practice and organisational issues. These covered the layout of case files, the quality of case
recording, the quality of care plans, the review process, the extent to which young people had access to their case files, the frequency of staff supervision, staff training needs, access to an external consultant, health and safety issues and whether the property was rented or owned.

The building was also subject to examination, both externally and internally and account taken of the structure, and the furnishings, fabric and decor. The number of single occupancy rooms was noted.

The discussion within the unit was with the residential manager and/or team leader and where neither were available with the senior member or members of staff on duty. The focus of the discussion centred on the above topics both seeking clarification and elaboration of the key issues for each unit. An opportunity was given for staff to identify their priorities both for the unit and residential care within the Eastern Health Board.

Assessing the cost per bed was the final factor to be taken into account. This has been calculated in two ways:

i. on a weekly basis, taking the grant allocation for last year and other costs such as rent and education where appropriate and dividing that by the average bed usage over the past two years;

ii. as above but calculating the cost on the stated number of beds provided.

The qualitative judgements are based on two primary sources, the DoH “Child Care

The analysis offered is a distillation of the essential findings since this report has been prepared as a working paper to enable the Children and Families Programme to develop a comprehensive Action Plan with specific targets and timescales.
SOME OBSERVATIONS ABOUT THE EXISTING RESIDENTIAL CHILD CARE PROVISION

This section is in two parts. The first part is concerned to set out a basic typology of residential child care services within the Eastern Health Board and map this out. The second part considers a range of questions that arise from this initial analysis.

At the time of the review there were 314 children/young people in care. 180 were placed on a voluntary basis, i.e. with parental agreement and 134 in statutory care, see table below.

There was a net bed vacancy of 54

The total bed capacity was 368 with 177 male and 137 female. The total bed capacity was 368 with a net bed vacancy of 54.

This section is in two parts. The first part is concerned to set out a basic typology of residential child care services within the Eastern Health Board and map this out.
single gender). There are **30 units** in this category with a **bed capacity of 216**.

(ii) Family group homes for under 1 year to 18 year olds whose needs and problems are wide ranging, (by definition mixed gender). There are **7 units** providing **38 beds**

(iii) Short-term care, including assessment and emergency provision for under 1 year of age to 14 years, wide ranging needs and problems including severe challenging behaviour and a significant level of emotional disturbance (mixed gender). There are **4 units** providing **29 beds** of which **3** are for emergency use.

(iv) Specialist short to medium term provision for young people aged between 10 and 18 years who are deemed severely disturbed, can be seriously challenging in their behaviour and maybe prone to self-harm (mixed gender). There are **3 units**, with **18 beds**

(v) After care including overnight emergency beds for 14 to 21 years old whose needs and problems are very wide ranging including severe challenging behaviour, self-harm and acute emotional and mental instability, (mixed and single gender). There are **10 centres** with **67 beds**, **16** of which are emergency

Since the location of the 54 centres has been determined as much by circumstance as identified need the distribution is inevitably very uneven. This is 9
illustrated on the map over leaf showing the location of units and the area/ areas they serve. There are 19 residential centres in Area 7, 9 in Area 1 and 6 in Area 5. The other 20 centres are spread over the other 7 community care areas.

There are a number of observations to make about this basic analysis.

a Most units are serving an Area or Areas other than where they are located. The majority however serve in theory the whole of the Eastern Health Board. Whilst this is clearly appropriate for specialist provision, this pragmatic amalgam of provision needs to re-assessed.

b There are two issues to be considered. Firstly the importance of each centre defining clearly its aims and objectives. Secondly for these statements to be put within the context of a strategic plan and for all non specialist provision to be allocated to areas. The policy and practice implications of that cannot be under-estimated, but the pending restructuring and decentralisation of the Health Board makes this an organisational imperative. A framework for developing an integrated strategic approach is outlined in Section 4, Action Plan

c In planning services in relation to need, it will underline what clearly emerges from this basic exercise, that there are short falls in some some types of provision, i.e. after care.

d There are four centres described as short-term, with two of those having an assessment function. It is axiomatic that the short-term role is dependent upon there being alternative positive placements or the possibility of returning home. The reality is, that it has proved very difficult to move
children on. One of the units, is about to embark on a pilot initiative to recruit "special foster carers" for some of their children.

That development has direct relevance to one of the other "short-term units" which is in fact providing long term care for six children under 9 years of age. There is general agreement that these care arrangements cannot be considered in their best long term interests.

The stated age range catered for by some residential centres, "0-18 years, 3-18 years, and 5-18 years," is questioned both in terms of policy and practice. Caring for such a wide age disparity, may have historical significance but best practice would now strongly indicate that this would not be in the interests of children/young people. This point will be highlighted with units needing to develop and refine their statement of purpose within the context of the Health Board developing a strategic plan. Both these crucially important issues are discussed later in this report.

The concept of the family group home needs to be re-examined on two counts. Firstly it is a misnomer in the sense that they are and will in the future be specifically governed by the same regulations and policies and procedures that apply to residential children centres. Secondly as vacancies occur in these units, non-related children are being placed in them. There are also some other questions around the necessity and viability for all the children to be together and if they do need to be, are there other potentially more appropriate care arrangements to be found?

There is a basic question to be addressed about what constitutes reasonable living space and legitimate privacy for young people. This
question is raised by two of the family group homes and five centres providing medium to long term care. There is a case for reducing the bed capacity in 7 of these units by 12 beds in total. In the case of one of the family group homes the degree of “overcrowding”, assuming the sibling group stay together, strongly indicates a larger house is required. It is worth noting that this issue will be raised when these units become subject to formal inspection and registration. Best practice would demand that action is taken before then.

i The number of single bedrooms currently available is 61.8% of the total bed capacity. The non-availability of single bedrooms is an important issue and raises questions about safe care practices. In general this demands that children/young people have physically separate sleeping arrangements.

j The total number of vacancies at the time of the review was 54. This represents 14.6% of the overall bed capacity. Whilst the movement of young people in and out of care inevitably means vacancies will occur in the short-term and sometimes changes in units may necessitate them working for a while below their bed capacity, it is important that the beds at the disposal of the Health Board are fully utilised.

k Of the 28 centres managed by the voluntary sector, 22 are supported by 11 different organisations. The remaining 6 are single service agencies. There is an important planning and co-ordination discussion to be had with these 28 centres. Such discussions are crucially important in developing a strategic child care plan, which by definition will increase and clarify the level
of accountability and expectations that the Health Board will have of the voluntary sector in the future.
3 THE KEY ISSUES ARISING FROM THE REVIEW

The issues raised are wide ranging, some of which cross departmental boundaries, but they are all regarded as having a direct bearing on the quality and viability of the residential care provision provided by the Eastern Health Board. What is significant is that many of the questions have been raised over the past three years, or are under consideration by, departmental working groups, research reports and national reviews.

What is important about this particular litany of questions and issues is that it is an attempt to put them in a more integrated and comprehensive context. The response to them therefore also needs to be holistic rather than piecemeal and pragmatic. This section of the report identifies the issues and questions raised by the review and the following chapter identifies the action that needs to be taken.

For the purposes of this discussion they are sub-divided into five areas.

(a) Policy and Organisation
(b) Practice and Service Development
(c) Finance
(d) Staff Training
(e) Health and Safety

(a) Policy and Organisation

Eight issues have been identified, they are:

(i) developing formal policies and procedures,
(ii) developing statements of purpose,
(iii) clarifying the role and status of residential managers,
(iv) developing the management structure and working arrangements in centres,
(v) establishing standard administrative support systems,
(vi) increasing the total number of single rooms,
(vii) improving maintenance and repairs.
(viii) developing three year contracts with the voluntary sector

(i) The lack of a coherent set of policies and procedures and practice guidance to underpin day to day residential child care practice is immediately evident. The lack of “official” guidance from the Health Board and the Department of Health and Children, (it is recognised and accepted that there is a joint responsibility in this matter), has led to individual units drafting working papers on a range of issues that they consider have a direct bearing on their day to day work.

The range of subjects covered and the quality of the content is inevitably very variable. The material has been generally gathered in an informal way. The voluntary sector may seem to have fared better in this respect, particularly where they are part of a larger organisation and a number of policies and procedures have already been put in place, but this was not always true. Some valuable and comprehensive documents have been produced by individual agencies. The difficulty with all of the extant papers however, is that they have no recognition or status beyond their own organisation.

The existence and quality of current policies and procedures is set out in the bar chart below. The categories are defined as follows:
Inadequate means that the subjects covered were limited and/or their content did not give adequate guidance and direction on the key issues.

Limited indicates that there were a number of useful and helpful papers but they did not cover all the areas.

Comprehensive means both the subjects covered and the content provided staff with a clear understanding of the policies and procedures governing day to day practice.

(ii) The importance of the statement of purpose which is intended to define the role of the residential centre is seen as essential from every perspective. The Standards and Criteria for the Inspection of Children's Residential Centres in its introduction to this subject, quotes both the Guide to Good Practice in
Children's Residential Centres, 1996 Part II, Section 1 and the Madonna House Inquiry recommendations about the issues to be covered in the Statement. The subsequent criteria emphasise the importance of regularly reviewing it and consulting key agencies and young people on its appropriateness and accuracy.

This was the base from which current Statements were judged. The reality of current practice as the table below shows, leaves room for significant improvement. Staff clearly need guidance and training to help them fulfil this task more effectively. Appendix 1 provides an initial reference about the process and content of a statement of purpose.

(iii) The role and status of the residential manager, particularly those employed by the Health Board, has emerged as a pivotal organisational issue. It was described by one manager, "as a title with no meaning beyond the unit." This question is important on two levels. Firstly the very limited organisational authority of the Manager in relation to day to day expenditure, a point considered later under "Finance". Secondly the external influence
the Residential Manager may have with the Area Management Team. This lack of clarity of role can lead to idiosyncratic decisions being made based upon personal working relationships rather than appropriately defined structures, roles and organisational authority. The need to define clearly the Residential Manager's role in relation to the Area Management Team and the development of an integrated child care service for example, whilst self evident, is essential.

(iv) Within the unit, (again this point would seem to apply particularly to Health Boards but not the High Support Units), the flat organisational structure with no formal senior post to cover for the Residential Manager raises some important basic questions about staff roles, proper delegation of responsibilities and opportunities for promotion and professional development. It is noted that these matters are currently the subject of national discussion.

(v) The administrative tasks and responsibilities within units make increasing demands upon staff and there is a question about how this might more effectively be met. Whilst some units have PC's and/or secretarial and administrative support it is not the norm. What is required is the establishment of a minimum standard of administrative support which applies to all non-specialist provision.

(vi) The number of single bedrooms currently available is 61.8% of the total bed capacity, this is regarded as a significant shortfall. Put the other way just under 40% of all children in residential care have to share a bedroom sometimes with two other children. The non-availability of a single bedrooms can and does effect decisions about admission and directly linked to that is
the ability of units to ensure safe care.

(vii) The maintenance and repairs of units is a major issue directly affecting the physical quality of care in Residential Units managed by the Health Board. Since the voluntary organisations make their own private arrangements with local tradesmen this is much less an issue. The overall physical state of units is considered inadequate. The issue under consideration here is essentially, an organisational and policy one. In short, the time it takes for significant repairs, both internally and externally to be done. The reported delays ran on occasions into months and whilst safety repairs were given immediate priority others such as damage to walls, doors, external guttering and drain pipes, etc could seemingly be left indefinitely. Properly maintaining the living environment of children being cared for by the Health Board is regarded as a fundamental objective and central to its stated values and principles. The gap between the principles and the reality and how that might be resolved is essentially a management and organisational issue.

(viii) The development of contracts and formalising the partnership with the voluntary sector is considered a basic prerequisite to begin making the most effective use of the key child care resources and give substance to a regional strategic plan. Contracts also give the voluntary agency recognition and financial security, as well as making them more formally accountable for the service they provide within the context of a strategic plan.

b Practice and Service Development

There are six issues to be considered under this heading:

(ix) improving the quality of the fabric and furnishings;
(ix) The overall assessment of the physical environment in which children were being cared for, was considered fair to poor, see bar chart below. The standard of both the decor and furnishings of 16 centres (29.6%) was considered satisfactory and they provide an important marker for the other 38 units. Of those 16, only 1 was managed by the Health Board. The poorest units were characterised by broken or badly worn furniture, stained and damaged floor covering, badly damaged doors and walls and poor decoration. In some units there could be a room or rooms that were considered satisfactory but others that were poor. The delay in repairs and maintenance of the Health Board centres only served to exacerbate the problems.
There were some very good examples of written referrals by social workers, to be found in the case files, setting out the child's needs and problems, why residential care was the preferred option and what they thought the particular centre could offer. This however was not the norm but clearly needs to be.

It was noted that some units in the voluntary sector had or had had an admissions panel which involved a key member of staff from the Area Team. Whether a formal admissions panel is necessarily the appropriate mechanism to consider referrals is open to question. However the crucial importance of trying to match the needs of the child with what the residential centre can offer or be helped to offer cannot be questioned. There was widespread acceptance that neither "cherry picking" referrals nor trying to push "square pegs into round holes" were consistent with good practice and the concept of planned care. Consistent and open communication between residential care staff and child care social workers is considered the basic antidote to such tendencies.

The standard of case files, care plans and reviews was again variable, but the best examples had a number of the facets associated with sound practice. Case files were well layed out, the material easily accessible and up to date. The care plan was comprehensive with identifiable objectives that had been agreed with the young person and prepared by the keyworker and discussed with the social worker. The case notes were linked to the care plan showing what progress was being made.

Reviews were held on time and as often as the situation demanded the young person attended all the meeting with their parent and the minute of
the meeting was sent by the Area social worker to the unit within a fortnight of the meeting.

The wider reality showed a high level of variability, see chart below. Both the case records and care plans were assessed as satisfactory in 12 units, i.e. the case recording was demonstrably linked to the care plan, the one informing the other. In 19 other units the care plans were considered satisfactory but the case records were not of the same standard. The total number of units with satisfactory care plans was 31, (57.4%).

However a less than satisfactory aspect was the review process. Unit's saw themselves more often than not taking the initiative in setting up the review but they were still not always held on time. Because minutes of the meeting were not always sent out, units increasingly assumed responsibility for writing their own.
Whilst it is important to note the examples given of positive working relationships between social workers and care staff with a sense of a real partnership, this was not perceived as the norm by residential staff.

The case files gave few indications of conjoint work. The establishment of positive working relationships between care staff and social workers is one of the keys to developing comprehensive child care plans and the consistent review of the jointly set objectives. The evidence would suggest that current practice is some way from this.

(xii) Associated with the above practice is attendance of the young person at reviews and access to their case files. Whilst there were no examples of a young person not being invited to a review, variation was reported on what stage in the process they were invited to attend. In principle it is suggested that they should attend all of it. In relation to case files, 39 units (73.5%) reported that the young person had access to all records written in the unit by the care staff. The units that did not make the case files available were linked with concerns about freedom of information legislation and the implications for the type of records kept.

(xiii) The use of consultants by residential units is significant, i.e.(37%). There are three basic questions to be considered: (i) To whom are they accountable? (ii) How is their role determined? (iii) Are they being used to best effect? The impression gained is that the development of the consultative role has been rather ad hoc and consequently the answers to these questions is unclear. The assumption is that the consultants are potentially an important resource for the Eastern Health Board to take forward some of the practice agenda arising from this review. However for that to be realised some
redeployment may be necessary within a clearer framework of role, purpose and accountability.

(xiv) There are two specific areas of service development identified by this review. They are foster care and after care/on-going care.

The case for long term foster care is evidenced by the number of children 11 years old or under who are currently in residential care, i.e. 36. This figure excludes children in family group homes. The other significant figure is the number of children reported to be in residential care because of the breakdown of their foster care placement. The figure is 25.

The current national review of foster care will have a direct bearing on the future viability and development of the service. Mainstream foster care has a vital role to play in providing long term and respite care for children under 11 years of age. Whatever other observations it may make, it is anticipated that the national review will underline the findings of various other studies that appropriate support, training and recognition of foster carers is fundamental and social workers and care workers have an important part to play in these three areas.

The case for a wider range of after care accommodation was argued by many Residential Managers who cannot find appropriate semi-independent or supported accommodation, particularly for girls. There would appear to be broadly two groups of young people requiring support, those in care and needing to move on and those who are homeless and are now wanting to find a more permanent base. The limitations of the existing situation are described in the recent study by Focus Ireland, “Out on Their Own”
adolescents and the need to develop guidelines on a range of issues, such as after care, care plans and reviews." The report concludes, "there is no overall strategic plan for young people in care. All the issues outlined need to be addressed in a comprehensive strategic plan "

That perspective echoes the basis of this review and underlines the importance of developing an action plan that includes the needs of young people up to the age of 21.

(c) **Finance**

There are two issues to be considered under this important and potentially complex heading. The first is about the financial management of the Health Board residential centres and the second are questions around the variation of cost of similar types of residential units.

The day to day funding of the units managed by the Health Board and the compilation of their annual budget is linked to the role and organisational authority of the residential manager considered earlier. The problem can be simply expressed. The residential managers do not know what is in their budget at the beginning of the year because they are not involved in setting it, nor do they receive a regular print out of expenditure. Accessing monies for basic essential day to day items, costing between £R30 and £R500 appears to be idiosyncratic and can be time consuming. The organisational relationship between the residential manager and the Area Administrator is central to this issue. It is noted that this problem is not an issue for managers of the three High Support Units who can access money more immediately through their line manager.
These differential organisational relationships need to be clarified which means re-examining the residential managers level of authority and discretion and relationship to Area Management.

It is noted that these complexities do not generally exist in the voluntary sector, where the residential manager and the management committee are more closely involved in all these matters. This is not simply an issue of organisational size.

The second issue concerns the variation of cost of similar types of care. The cost of units providing medium to long term care, (30), family group homes (7) and High Support Units (3) were examined. The method for calculating these costs were described earlier in the report. The first set of figures are based on the average occupancy rate over the past two years and show the average weekly costs and the range. The second set show the cost and range based on the actual bed establishment. All the calculations are based from the grants approved for last year.

<table>
<thead>
<tr>
<th>Units Providing Medium to Long-term Care</th>
<th>Average Bed Usage</th>
<th>Actual Bed Establishment</th>
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<tbody>
<tr>
<td><strong>Average Weekly Cost</strong></td>
<td>£1005</td>
<td>£892</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>£696 to £1457</td>
<td>£696 to £993</td>
</tr>
<tr>
<td><strong>Family Group Homes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Average Weekly Cost</strong></td>
<td>£1127</td>
<td>£1127</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>£801 to £1442</td>
<td>£801 to £1442</td>
</tr>
<tr>
<td><strong>High Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Average Weekly Cost</strong></td>
<td>£2151</td>
<td>£2151</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>£1538 to £2995</td>
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The striking point about the figures is the variation of cost associated with each of the three types of provision.

The weekly cost based on the average bed occupancy for units providing medium to long term care shows a cost differential between the highest and lowest figure of IR£761. Calculating the variation of weekly cost based on the bed establishment, the differential is IR£297.

The variation of the cost of Family Group Homes shows a differential of IR£641 per week. The variation in the High Support costs is IR£1457.

Whilst some of these differences can in part be accounted for by rent and vacancies for example, it is difficult to easily reconcile the larger discrepancies. The cost of residential care requires a more detailed and separate analysis beyond the scope of this review. It is however clear that there are no basic cost models because there are no explicitly agreed standards, e.g. staff/child ratios, staff grades and the cost of running a unit. The issues raised by this initial analysis argue for a clear cost formulation which may have implications for the future level of grant for some units.

Whilst these organisational and technical arguments need to be carefully analysed there is no escaping the fundamental fact that the provision of high quality residential care has a justifiably high price associated with it. The aim is to provide cost effective services which means ensuring that they are appropriately funded to offer the level of care that is necessary to consistently meet the needs and problems of each child/young person.
Being cost effective and child centred are regarded as synonymous and not contradictory concepts.

(d) Staff Training

(xvi) The focus of enquiry was on two levels, the qualifications and experience of Residential Managers and the training needs identified by staff and emerging from the practice issues raised by the review. The question of the qualification levels of managers is not considered as significant, particularly given the wide range of qualifications that are recognised as acceptable. However they do have specific training needs as do care staff. The emphasis of this review is on the development of an extensive in-service training programme for both managers and care staff. This would automatically involve staff in all residential children’s centres including the voluntary sector. This would probably amount to a two year programme.

The core subjects for both managers and care staff are set out in the next section. However particular attention is drawn to staff supervision. Whilst supervision was seen by the majority of residential managers as an important part of their role many did not feel confident about doing it and perhaps to some extent this is reflected in the variable quality of the practice examined.

There is an important wider issue concerning the opportunity for care staff to gain a recognised professional qualification. Whilst the ratio of qualified staff to unqualified staff in some units is relatively high in general there is a significant shortfall and this will need to be more formally addressed by the Health Board in relation to its own units.
(e) **Health and Safety**

(xvii) The review had sight of twenty Health and Safety Inspection Reports of which 13 covered Units managed by the Health Board, the other 7 were in the voluntary sector. It is not clear whether these are the only inspections that have been undertaken, but the reports were seen as as helpful and important documents, particularly the risk assessment analysis. It seems probable that not all the units have been inspected and there appears to be no follow up procedures.

An issue and requirement that is clearly stated is fire drills in all residential child care establishments. Whilst most centres had met this requirement, 11 had not done so and a further 11 said they were neither consistently carried out nor necessarily recorded. This failure directly contravenes the regulations and must be addressed immediately.
ACTION PLAN

Given the nature of the agenda it will be necessary to work on a number of the items simultaneously but by definition setting different completion date targets within the context of a 2 year programme. The point was made earlier and has become readily apparent throughout this report that the issues raised are wide ranging and the focus therefore is about putting in place a fundamental organisational, policy and practice framework, building and developing on the existing structures and where necessary putting in new foundations.

What is also clear is that the Children and Families Programme Senior Management Team need to create the capacity to take forward this agenda in a consistent and focussed manner. Given existing pressures on the SMT, there is a case for an additional post, at the very least, to work on the action plan. This post(s) will need to pitched at an appropriate level within the organisational structure. It will be important that it is given the necessary status and authority to co-ordinate, drive and monitor the action plan.

It was beyond the scope of this exercise to offer detailed costings on each aspect of the plan, but broad estimates are given on two of the major items, refurbishment of units and in-service training. Some of the other recommendations will have relatively minor cost implications and others could possibly be absorbed or are currently taken account of in existing budgets, but nonetheless new money will be required over the next three years to make this plan a reality.

The working agenda set out below is not in order of priority, but such is its
fundamental nature there is a degree of urgency associated with all of them.

From the perspective of this review, point (i) is as important as point (xii). What is beyond doubt is that they all need to be positively addressed. They are as follows:

(i) **Issuing formally approved policies and procedures covering all residential care provision**, thus providing a common framework for Residential Managers, Care Staff, the Area Management Team and Social Workers to work within. There is a range of very useful material that has been produced by a number of units that could appropriately form the basis of such policies and procedures. Some of this work is currently being undertaken and it would be important for this to be completed and formally issued by the time the Health Board's new decentralised structure is in place. *(Target date March 2000).*

(ii) Alongside the publication of these policies and procedures there will need to be drafted some comprehensive practice guidance which in turn must be complimented by an extensive in-service training programme. The wide range of current practice requires a number of measures to support and develop the skill and knowledge base of all residential staff, practice guidance is considered an important element of this. The first package of material should include,

* Individual Case Recording, including layout and content of case files, monthly summaries and cross referencing with care plans*
* Making an Assessment

* Writing a Care Plan

* Drafting a Statement of Purpose and Function

* The Role and Content of Residential Child Care

(Target Date June 2000)

(III) A recurring theme directly and indirectly throughout this report has been the importance of residential units having a comprehensive statement of purpose, being clear about their role, the care they provide and where they relate to the other child care services. The potential value of this exercise to the individual unit and the Health Board is readily apparent. This exercise assumes greater relevance in the context of regional child care planning and the establishment of a contract orientated culture.

The suggested approach in taking this forward, is on three fronts, the issuing of practice guidance referred to earlier, making it a priority subject on the proposed in-service training programme, (see below) and where consultants are available using them to think through some of the issues. The aim should be for every unit to have drafted as comprehensive statement as possible, which means amongst other things having consulted fully with key agencies/stakeholders. (Target for every unit to have completed a first working draft by June 2000).

(iv) There are a number of key management and administrative issues relating to the units and whilst some may not apply so
specifically to the voluntary sector they do have some relevance. It is important that the Residential Managers particularly within the Health Board are seen to be exercising their organisational authority and discretion consistent with their job description. The formal establishment of Deputy Managers and appropriate administrative support are all regarded as fundamental to the effective running of units. Whilst there is a cost implication associated with some of these recommendations clarifying and reinforcing the Residential Manager’s delegated authority and responsibilities is about process and training. The planning and pace of these developments will require further detailed consideration but the implementation could be achieved quite quickly. *(Target December 2000)*

(v) **The high proportion of shared bedrooms must be reduced significantly.** To achieve this it will require reducing the bed capacity of a number of centres, ie planning not to fill vacancies and making modifications to rooms turning a large double room into two singles. *(Target to increase the number of single rooms by between 40 and 60 over two years)*

(vi) The need to embark on a **major refurbishment of the residential centres**, at least two thirds of them. Refurbishment in the context of this discussion means both the fabric of the buildings and decoration and the furnishings. The aim must be to achieve a level of improvement in the living environment of the least satisfactory to match the best centres. On the basis of this review there were a number of units where the fabric of the building and in some cases the surrounds were considered to be in an unacceptable or poor state.
In the remainder of buildings assessed as poor or fair, some repairs, an improvement to the surrounds, significant re-decoration and major re-furnishing would have an important and positive effect on the living environment for the children/young people and staff living and working there.

The essential requirement is capital funds, which is estimated to be not less than £1R2m. Whilst the timetable will be dependent upon available funds a detailed plan needs to be put in place with a starting date before the end of the year. (Completion Target September 2001)

(vii) Linked to the above issue is the issue of maintenance and repairs. This is essentially a Health Board problem. The matter requires to be urgently reviewed. The question is, does the Maintenance Department have the potential capacity to meet the demands made upon it by the residential child care sector.? The evidence given during the course of this review would suggest that they do not. The use of private contractors, which is how the voluntary sector operate, would seem to be an obvious possibility. (Target review existing and possible alternative arrangements put in place March 2000)

(viii) Health and safety reviews do not appear to be carried out systematically From the perspective of this review, the centres should be inspected at least every two to three years. They should automatically involve the voluntary organisations providing care on behalf of the Eastern Health Board. The reports themselves need to be made available within 6-8 weeks and followed up within 3 months. These basic recommendations require detailed discussions with the Health and Safety Officer. (Target for a policy to be formulated and agreed by January 2000)
The training agenda has grown throughout this review and that was to be expected. The intention here is to simply identify some of the key subjects that are of relevance and importance to Residential Managers (RM) and Care Staff (CS). The essential subjects are as follows:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drafting a Statement of Purpose and Objectives</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Assessment of Needs and Problems</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Child Care Plans</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Residential Care as an integral part of Child Care Provision - Working Within and Across Boundaries</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Working Directly with Children and Young People</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Normal Human Growth and Development</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Care Reviews</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Individual Case recording, (including layout, content of case files, monthly summaries and cross referencing with care plans)</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Working with Abused and Abusing Children</td>
<td>RM &amp; CS</td>
</tr>
<tr>
<td>Staff Supervision</td>
<td>RM</td>
</tr>
<tr>
<td>Managing a Residential Centre</td>
<td>RM</td>
</tr>
</tbody>
</table>
The Role of Keyworker  RM & CS

Making Best Use of a Computer  RM & CS

Children’s Rights - involving young people in their care  RM & CS.

It is assumed that this programme would be refined and developed by the Training Staff Development Unit, Child Care and Family Support Service and where possible be integrated with the community care social work training programme.

Given the range of training needs it is recommended that the Child Care Training Manager undertakes a specific training audit identifying those care staff that would want to undertake a recognised professional training course.

In context of this review the importance of the in-service training programme cannot be over emphasised. It is the vehicle for addressing a number of key practice issues. The development of this programme will however have major organisational and cost implications since it will involve in total around 600 staff comprising, Residential Managers, Care Staff and Relief Staff working for the EHB and the voluntary sector.

Based on an average of 25 staff attending each course, the daily cost for one member of staff to attend is calculated at £122. This figure comprises, rented venue, external trainer, teaching materials, handouts, lunch etc, staff cover and travel, (one third of this cost is associated with putting on the event and two thirds with staff cover and travel). One day’s training for 600 staff would cost, $600 \times \£122 = \£73,200$ per annum. If each member of staff
were to receive a minimum of 6 in-service training days per year this would amount to $6 \times £122 \times 600 = £439,200$.

It is estimated that the training programme set out above would require nearer 12 days per year if it were to be covered over a two-year period. The annual budget based on this cost model would therefore be in the region of £880,000 per annum.

The purpose of setting out this model is to illustrate the nature of the task and the potential organisational and cost implications. In short, staff training/development at this level becomes a major and integral facet of the Children and Families Programme and such a development is consistent with best management practice. *(Target, agree on a training strategy and commence the programme March 2000, completion date February 2002)*

With the emergence of a strategic plan for the development of residential child care services within the EHB, it will be necessary and appropriate to establish more formal working relationships with the voluntary sector through contracts. The voluntary sector will remain a significant provider of residential child care provision and it is essential that their role is clarified and defined in relation to the needs and problems identified by the strategic plan. This approach will place new demands on some agencies and it is therefore important that they are equipped and confident to respond to them. This may require specific in-service training packages for individual units which the Health Board should provide as part of its new working relationship with the voluntary sector. *(Target to have in place contracts by December 2000)*
(xi) In order to make the best use of project consultants it is recommended that the Health Board undertake a review of their optimum role and how best to link them more firmly to organisation’s policy and practice development objectives. *(Target to be completed February 2000)*

(xii) Underlying implicitly much of the discussion on practice issues is that of children’s rights. Apart from ensuring that this is given appropriate emphasis in the recommended policy, procedural and practice guidance to be drafted, consideration should be given to the appointment of a Children’s Rights Officer. Their role is essentially about promoting children’s rights, good practice in residential child care and dealing directly with individual complaints and concerns of young people in care. *(Target consideration of the post February 2000)*
SUMMARY AND CONCLUSIONS

The issue and the principle underpinning this report is that all residential child care provision within the Eastern Health Board needs to attain and maintain the highest standards demanded by best practice. This working paper has been concerned to take stock of some of the essential elements that contribute to this optimum care model.

This model goes beyond the specific issues directly related to the actual quality of residential care and includes planned conjoint work with social workers and Area Managers, foster care and aftercare. The relationship of these factors to one another is regarded as self-evident but that is not to underestimate the complexity of developing an integrated organisational perspective with commonly agreed and understood priorities. At the same time dealing with these matters in a piecemeal manner will only serve to undermine and limit the development of a comprehensive child care service and some of the central recommendations of this review.

It is also important to see this review within the context of the development of child care services in Ireland over the last decade. The changes have been significant and rapid. The difficulty is that it is not possible nor necessarily appropriate to leap frog to a point, that has taken other countries, notably Scotland and England 40 years to reach. However whilst it may be useful to draw and learn from some of those experiences it is far more important to build on the valuable examples of best practice within the Health Board identified in this review.

Progress on some of the wider issues, i.e. capital investment, the
establishment of a major staff training and development programme and some aspects of national policy and practice guidance, fall outwith the authority and maybe the capacity of the Health Board and will require the Department of Health and Children to tangibly support those recommendations.

The agenda is inevitably wide ranging, covering management, policy, practice and organisational issues. The Action Plan recognises that work is already in progress on a number of them and therefore the two year timescale is not considered unrealistic. What is important is to maximise the opportunities that presently exist to develop child care services in Ireland.
Appendix 1

Statement of Purpose - Content and Process

The optimum Statement of Purpose should include details of the essential policies and practices of the residential centre and cover the following areas:

* defining the role of the unit, what it is attempting to offer and how it offers it.
* defining the child's rights and responsibilities;
* identifying the nature of the relationship between children/young people and staff;
* safeguarding the physical care of children;
* ensuring appropriate education and health care;
* assisting each child/young person to develop their potential;
* involving children/young people and where appropriate their parents in all key decisions about their future;
* reviewing and evaluating each child's progress in a comprehensive manner;
* defining sanctions and measures of control;
* protecting children;
* dealing with unauthorised absences;
* involving children/young people in decisions about daily living;
* working and living in the community;
* dealing with complaints;
* keeping case records, content and purpose;
* recruiting, supervising and training staff, including reference to probationary period;
checking fire precautions and fire drill procedures;
* meeting health and safety requirements;
* providing aftercare;
* consulting children/young people, parents and staff in preparing a Statement of Purpose;
* identifying the role of the external manager in the process.

It can be argued that the process of preparing such a statement is as important as the actual content. The emphasis is on involving key people living and working in the Unit as well as though with an external involvement and professional interest. It is essentially an inclusive exercise and will need to be subject to regular review to ensure that the actual practice remains consistent with the statement and the statement itself is still relevant. Overleaf is the process in diagrammatic form. This is taken from “Action Guide for Developing and Using Statements of Purpose in Residential Care’ Lyn Cook and Harry Zutshi 1993.
DEVELOPING, IMPLEMENTING AND REVIEWING A STATEMENT OF PURPOSE

1. TAKING STOCK

2. INVOLVING OTHERS

3. USING FORUMS

4. DRAFTING

5. CONSULTING

6. REDRAFTING

7. APPROVING

8. IMPLEMENTING

9. MONITORING

10. REVIEWING