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Acting Secretary
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Contents

Executive summary 3

Summary of Findings 5

Recommendations 6

Background Context 7

Initial observations and findings 10

Process issues - notifications 10

Lack of workload and workflow oversight 12

Lack of practice confidence and expertise 12

Vacancy of Community-Based Team Leader position 13

Bottlenecks at critical case transfer points 13

Issues receiving information from other professionals. 14

Staffing performance issues not managed effectively and consistently. 14

Lack of leadership response to staffing and workload issues. 14

Culture and workplace behaviours 15

Actions Taken in Response 16

Response Governance 16

Short Term Actions - Allocation of additional resources 16

Longer Term - System Improvement Strategies 16

Executive summary

During a data presentation to the CYS Executive Leadership Team (ELT) in the week beginning 27 July 2015, significant workload and workflow issues were identified as occurring in the North West Child Protection Intake team. The presentation on 30 July 2015 concluded that while in 2014-15 there had been a slight decrease in notifications and a lower client caseload per worked full time equivalent staff member on the North West (NW), there was a trend towards an intake "bottleneck" of notifications in active transition (that is, unallocated) that began with sharp "spikes" in November 2014 and February 2015, and significantly exceeded normal business fluctuations in June 2015.

Given this information, the CYS ELT requested a detailed breakdown of current notifications held at NW. The breakdown reported a total of 151 notifications in active transition held in two groups: 71 notifications on the team "active transition" list, and a further 80 notifications held by a Team Leader.

In response to that analysis, between CYS ELT put in place a two-pronged strategy to address the identified issue, consisting of immediate remedial action complemented by the development of a performance improvement strategy for the NW child protection program.

This report has been requested within a short timeframe due to the critical nature of the situation and need for;

- early identification of contributory factors;
- early identification of any need for further investigation; and,
- identification of any need for wider systemic change or remediation

As such, this report and its findings should be viewed without prejudice and with an acknowledgement that many issues require further consideration and testing.

In recognition of the requirements of natural justice, no staff member has been named or their position specifically identified in this report.

While this report has considered one specific system issue, there is a long history in Tasmania of reviews, reports and analysis of the child protection system, most of them pointing towards a requirement for systematic, structural reform. Unfortunately, Tasmania has not been able to achieve the level of reform required to dislodge the entrenched issues identified in the reports and which are stubbornly resistant to change today.

It is clear that previous reviews of Child Protection Services (CPS) have focused on putting the same components into a different type of 'box', whereas there is increasing evidence that the child protection system in Tasmania is not functioning effectively, meaning that despite the best efforts of all involved, the system faces potential collapse if comprehensive reform action is not taken, regardless of the level of any additional resources that are added to it.

Whilst the current reform projects in CYS are focussing on discrete elements of service development and design (e.g. OOHC, Signs of Safety) there remains the problem that, while they may deliver their specific reform objectives, there is no overarching plan to join up the individual elements up so as to maximise their intended outcomes.

In reviewing other jurisdictions nationally and internationally, it has also become clear that those child protection agencies which have demonstrated effectiveness in practice, and improved

outcomes for children, have a number of things in common – one of which is an agreed, adopted, implemented and "trained to" service delivery structure and practice approach.

With the immediate issues in the North West being comprehensively addressed, CPS Tasmania now has the opportunity to pursue a program of system redesign that will address the entrenched culture, processes and structures of the current CPS.

Summary of Findings

1. Contrary to standard practice in all other regions, the NW practice of administration staff receiving and creating notifications is contrary to the Intake procedures in the CYS Practice Manual and must cease.
2. The NW process of requiring the notification to be submitted to a Team Leader for approval creates an unnecessary step in the process and is to cease.
3. Child Protection staff will be accountable for creating and approving the notification so that an initial assessment can be created, allocated and initiated immediately.
4. Child Protection staff in NW Intake would benefit from professional development with regard to decision-making; commensurate with the type or degree of concern being raised.
5. Available reports and systems are not being routinely used by the North West to support work load management and supervision.
6. Additional professional supervision and practice support is required for the NW Intake Team.
7. The difficulties in recruiting a substantive Community Based Team Leader was a factor in the delays experienced at NW Intake.
8. The split location of Intake and Response is viewed as a critical element in a lack of cohesion and communication, and will be reviewed to ascertain whether, following consultation, the two teams can be co-located to encourage and require closer and more joined up work.
9. Workers have displayed a passive approach to requesting information from other professionals/services which has led to initial assessments being delayed.
10. Proactive, consistent and targeted performance management and risk management strategies have not been adopted within the team.
11. Despite awareness of, and attempts to locally resolve, the escalating issues within the NW Intake Team at an operational level, the urgency and critical nature of the situation was not adequately communicated and escalated to the CYS Executive Leadership group for resolution until July 2015.
12. Ongoing work needs to be undertaken to better understand and then manage and drive cultural change in the NW.

Recommendations

It is recommended that

1. NW Intake practice must align with CPS standard procedures, such that:

   a. Administration staff cease taking notifications and a system is put in place to allow all notifications to be referred and allocated to a Child Protection Intake Worker; and

   b. Child Protection Workers are required to create and approve notifications so as to allow the incident to be created and an initial assessment commenced without the need to submit to a Team Leader.

2. Team Leaders and Managers are required (and trained) to use available data reports through CPIS and Qlickview to support the monitoring and management of workflow and staff activities.

3. The NW Senior Quality and Practice Advisor undertake practice development work with the Intake team to build confidence and capacity in risk assessment and decision making.

4. All Intake staff undertake the Risk Assessment and Safety Planning training in the first instance with the view to further, more targeted, training being delivered if required.

5. There is an urgent review of the current supervision arrangements in place for Intake staff (in relation to the split of task and professional supervision) to ensure this is adequate and appropriate.

6. The appointment of the Community Based Team Leader is maintained and alternative arrangements are put in place if/when the CBTL is absent – so as to ensure that delays do not occur when Intake are referring matters to Gateway.

7. Engagement with internal and external services who have been noted to not be responsive to information requests by CPS should occur at a senior management level to ensure that expectations/agreements/processes are identified and confirmed – so as to ensure that Intake are able to receive and action external information as part of their risk assessment process

8. Clear processes and expectations are developed to allow for the efficient and timely transfer of notifications from Intake to Response, and Response to Case Management.

9. The split location of Intake and Response is reviewed to ascertain whether the two teams can be co-located, following consultation, to encourage and require closer and more joined up work.

10. Further assessment of the level and type of support offered to manage poor performance is required.

11. Arrangements be put in place to monitor progress on the implementation of these recommendations.

It should be noted that recommendations 1-6 have been fully implemented, while recommendations 7-10 and currently being implemented. A suggested response to recommendation 11 appears at the end of this report under the heading "Longer Term – System Improvement Strategies"

Background Context

Structural Change

- CYS completed a review of its senior leadership structure in early 2015, with an independent review completed by Mr Terry Murphy. The findings of that review were released to CYS ELT on the 20th April 2015.

- In terms of context for the matters under consideration in the North West, the review identified that the then structure of regional arrangements, and lack of operational "sight" by the Deputy Secretary, was deeply problematic. The reviewer specifically noted:

  1. *The removal of an additional single point of executive responsibility between these directors and the deputy secretary position for the core business of CYS, creates the best opportunity for the exercise of prompt and appropriate reporting and action, management and accountability to support good practice in the respective programs and the avoidance of bottlenecks*

  2. *The deputy secretary role as the chief executive of the CYS division of DHHS has to have responsibility and the capacity to exercise leadership over both service delivery and the strategic context in which it occurs.*

  3. *The reviewer's opinion is that the first tier leader (Deputy Secretary) of the organisation must be close to its core business, the reason that the agency exists, to be able to lead it effectively. The separation of operational and strategic management is considered to be artificial and in fact deleterious to the leadership and management of the organization. The notion of executive leadership being responsible for the review of service performance but not directly for its delivery misrepresents the role of quality assurance within an agency as opposed to that of external oversight bodies.*

  4. *The recommended changes to the structure of CYS are considered to warrant the costs of making the transition. First, this is because the program areas, particularly youth justice and ChaPS do not currently have the executive leadership focus they need. Child protection has by default had the greatest share of executive attention as it is the most contentious area of service and imbued with risk. Second, the current portfolio responsibility for the areas is widely regarded as ineffective. Third, there are communication and leadership bottlenecks and impasses that are both inherent to the one-on-one structure of first and second tier executive leadership for service delivery.*

- Arising from this review, CYS leadership was completely restructured, commencing on the 1st July 2015. This included the expansion of the Executive Leadership Team to include the full suite of Directors across CYS.

- The positions of Director, Children and Families (CPS) and Director, Services for youth, have been advertised and positions closed 21 August. It is anticipated that the interviews and selection process will be completed in September 2015. These Director roles will bring a statewide program perspective to each portfolio, addressing the current regionality approach to service delivery which was correctly identified as a fundamental flaw in the governance of CYS by the aforementioned report.

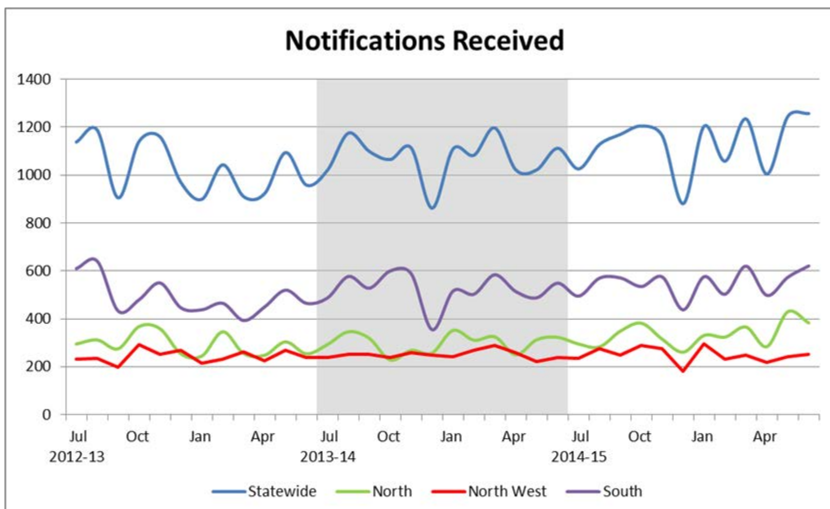
- The reviewer noted, in seeking to "correct CYS" that

> *It is considered that each of the directors should assume full responsibility for the operations of their program areas. The directors can more effectively assume the functions that the director of operations performed in their areas because each would be responsible for a single area, and also be closer to day-to-day operations.*

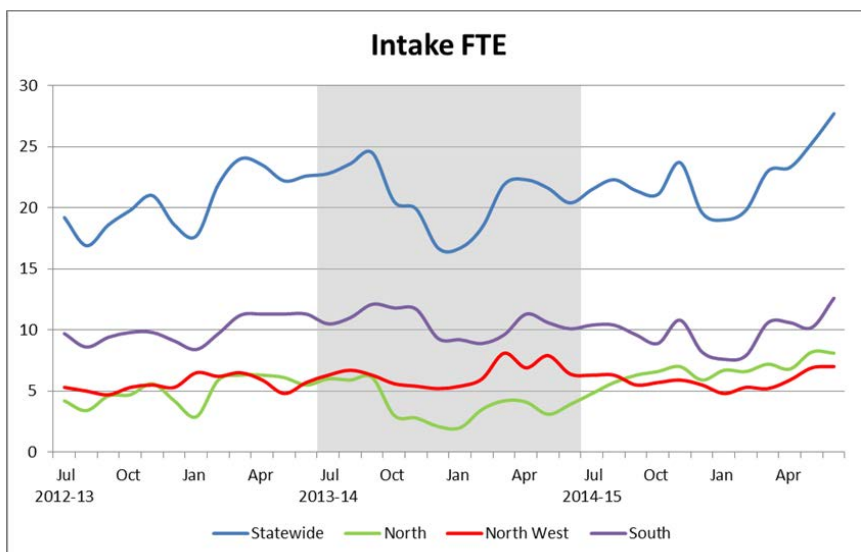
- It was due to this "clean line of sight" of the Deputy Secretary to the operational considerations of CPS that the A/Director NW was able to raise at Executive on the 16 July 2015 that she was concerned about unallocated notifications – at that time it was not defined in terms of depth or quantum, but rather a genuine call for advice and support.

Staffing and Workload in NW Child Protection

- Analysis of business intelligence systems shows that the backlog of intake notifications occurred over a period where there was:
    - o a slight decrease in notifications (0.3 per cent) to child protection in the North West; and



    - o A lower client caseload per worked full time equivalent staff member on the North West (Average notifications received per worked FTE in 2014-15 = 516.4 (NW) compared to 677.9 (Sth) and 606.5 (Nth).
    - o A gradual decrease in vacancies meaning that more staff were in positions, trending towards full occupancy of all available FTE.



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- These indicators would suggest that resourcing was not a factor in the backlog of reports.
- Importantly, it was clear that the identified "backlog" did not represent a complete stoppage to workflow because parallel to this work, activity as usual was clearly being progressed by child protection intake staff.
- In the period August 2014 – July 2015 there have been 3003 notifications received in the North West. Therefore, the 151 notifications in question represented 5% of the total received, meaning that 95% have been dealt with under normal business processes.

Initial observations and findings

Process issues - notifications

Receipt of notifications by Administration staff:

- Within the North West it had become normal practice for notifications to first be received and created by administration staff. This is outside the Intake procedures in the CYS Practice Manual and is contrary to practices undertaken in all other regions across the state.

Created by	North		North West		South		Total	
Admin		0%	921	36%		0%	921	8%
Case Management	102	3%	60	2%	25	0%	187	2%
Intake	2,979	94%	1,282	50%	5,393	99%	9,654	87%
Management	2	0%	5	0%	10	0%	17	0%
OoHC	18	1%	66	3%	3	0%	87	1%
Response	66	2%	208	8%	16	0%	290	3%
Total	**3,167**	**100%**	**2,542**	**100%**	**5,447**	**100%**	**11,156**	**100%**

- An example of this occurring in practice is:
    1. Administration staff member receives an email notification from police.
    2. Notification is created on system by Administration staff member and information from email is transferred/repeated into a notification.
    3. Notification is then submitted to a Team Leader for approval and remains on a Team Leader's console until it is opened, reviewed and triaged.
- Using this process, 31% of notifications in the North West lead to an unallocated incident, compared to only 1% in the South and 5% in the North.

Region	Notifications	Unallocated	%
North	3,167	168	5%
North West	2,542	777	31%
South	5,447	49	1%
Total	**11,156**	**994**	**9%**

- This process poses also significant and inherent risks.
    1. Firstly, the administration worker does not have the practice knowledge to be able to indicate whether this new notification is urgent and therefore requires immediate Team Leader approval and attention.

2. Secondly, the approval could possibly sit upon a Team Leader's Child Protection Information System (CPIS) console for a period of time, without the matter being reviewed or considered by a practitioner. This could lead to possible delays in the matter being triaged and then actioned.

3. Thirdly, there is a risk that by transferring information from the email into the notification that critical risk factors are mis-represented or missed entirely.

- In the North and South, all intake notifications are immediately referred to the rostered Intake Worker by Administration staff. At that time, the Child Protection Worker will take the initial information, seek further clarification and create and approve the new notification on the system.

FINDING:

- Contrary to standard practice in all other regions, the NW practice of administration staff receiving and creating notifications is contrary to the Intake procedures on the CYS Practice Manual and must cease.

Approval of notifications

- All notifications need to be created and then approved on the system so as to allow an incident to be created and allocated to a Child Protection Worker for an initial assessment to be commenced.

- In the Northern and Southern regions, Child Protection Intake staff are responsible for the creation and approval of the notification – thus leading to the notification being managed immediately, allocated directly to the staff member who created the notification, without the need for it to be referred to a Team Leader.

- Within the North West however, the administration staff member or Child Protection Worker can receive and create the notification and then submit the notification to an Intake Team Leader for approval.

FINDING:

- The NW process of requiring the notification to be submitted to a Team Leader for approval creates an unnecessary step in the process and is to cease.

- Child Protection staff will be accountable for creating and approving the notification so that an initial assessment can be created, allocated and initiated immediately.

Triaging and allocation

- Consistent with practice in other regions, it is unnecessary for a Team Leader to always be responsible for the approval of notifications and allocation of incidents (initial assessments) to Child Protection Workers.

- The contrary practice adopted in the NW increases the degree of "double handling" of notifications and prevents Child Protection workers maintaining responsibility for the notifications that they create.

- Until recently, the North West Team Leader was responsible for triaging and allocating all incidents. It would appear that by doing so, the Team Leader was required to first read all newly received notifications and then provide written advice/comment to the Child Protection Worker to whom it is being allocated – before the worker is able to commence any work on the matter. This was an unnecessary delay in what must be a timely process.

- Child Protection staff should be able to undertake initial assessment tasks such as CP history checks, FVCSS and CHaPS checks without direct supervision of a Team Leader. The Team Leader should be overseeing the activities being undertaken by the Child Protection staff and should be engaged if the worker is recommending it is closed without further assessment, or after the Child Protection Worker has initiated the initial steps in the assessment process.

FINDING:

- Child Protection staff in NW Intake would benefit from professional development with regard to decision-making; commensurate with the type or degree of concern being raised.

Lack of workload and workflow oversight

- The Child Protection Information System (CPIS) and the Qlikview data program provide detailed and thorough reports to Managers to support them to manage and monitor work through-put and trends. These systems can provide details of workflow and workload at a state-wide, regional, team and individual level.

- In other regions, these reports are used to focus workload discussions with individual staff and to also brief the Child Protection Manager on critical workflow issues.

- It is unclear as to the extent that the North West office used data and evidence available on CYS systems to raise and discuss notifications and workload issues

FINDINGS:

- Available reports and systems are not being routinely used by the North West to support work load management and supervision.

Lack of practice confidence and expertise

- If staff and Team Leaders were confident in their risk assessment and able to reach a defensible and robust decision without unnecessary information gathering – less time could be spent on notifications where there is low risk, and greater capacity could be created to focus on the more complex and higher risk notifications.

- The presence of anxiety or uncertainty at Intake often results in notifications remaining on caseload for longer than required, which is indicative of what has occurred within Intake NW.

- There is evidence to suggest that some staff are lacking in contemporary risk assessment skills and knowledge. This in part could be due to inconsistent learning and development opportunities in the area of risk assessment in the past (which has and is being resolved).

FINDINGS

- Additional professional supervision and practice support is required for the NW Intake Team.

Vacancy of Community-Based Team Leader position

- The North West region has experienced difficulties in recruiting and filling the critical role of Community Based Team Leader (CBTL). This position has been vacant since January 2015 and has only recently been filled.
- This role is critical to managing the liaison and referral pathway between Child Protection Services (CPS), Gateway Services and Intensive Family Support Service (IFSS).
- It is apparent that a large proportion of notifications have had an initial assessment completed, and the need for referral to Gateway or engagement with IFSS has been identified. As there is a requirement for CPS to keep a case open whilst a referral to Gateway is processed, the absence of a CBTL appears to have stalled the referral to Gateway and has had a significant impact on the workflow of such cases.

FINDINGS

- The difficulties in recruiting a substantive Community Based Team Leader was a factor in the delays experienced at NW Intake.

Bottlenecks at critical case transfer points

- There does not appear to be a clear and structured process in place for the transfer of cases between teams – namely Intake to Response and Response to Case Management.
- Clear processes and expectations must be developed to allow for the efficient and timely transfer of cases along the CPS continuum. There are issues with communication which are often based on history and personalities: with clear and state wide consistent procedures this will be ameliorated.
- Transfer of cases from Response to Case Management appears to have been problematic for some time whereby Case Management have at times refused to accept transfers, therefore leading to cases remaining in Response, thereby having a flow on effect to Response having capacity to pick up new referrals from Intake.

FINDING

- The split location of Intake and Response is viewed as a critical element in this lack of cohesion and communication and will be reviewed to ascertain whether, following consultation, the two teams can be co-located to encourage and require closer and more joined up work.

Issues receiving information from other professionals.

- North West staff have reported that they often experience difficulties and delays in receiving critical and required information from other professionals. These have included external services as well as services that are within CYS – namely FVCSS and CHaPS.

- The numerous matters that have been in the "bottleneck" at Intake NW and on caseload at Intake for significant periods of time have been noted as being delayed due to professional information not being received or not being received in full.

FINDINGS

- Workers have displayed a passive approach to requesting information from other professionals/services which has led to initial assessments being delayed.

Staffing performance issues not managed effectively and consistently.

- There is an inconsistent and ineffective approach to managing and monitoring staff performance within the NW, including those staff who are subject to formal Performance Improvement Plans (PIP).

- The process of a PIP had been initiated with some staff but has not been followed through or monitored. Once again the capacity for being proactive with the management of this issue has not been evident. The PIP process is now being facilitated as part of the additional resourcing provided to the NW.

FINDINGS:

- Proactive, consistent and targeted performance management and risk management strategies have not been adopted within the team.

Lack of appropriate communication and escalation to Deputy Secretary on critical staffing and workload issues.

- The frequency and timing of when issues have been raised with management is still emerging. However, it is apparent that it was only at the end of June 2015, that targeted and specific strategies were being deployed to respond to the growing unallocated list. This is despite the unallocated list steadily and swiftly climbing from February 2015 onwards.

- The manner in which these issues have been raised to operational management remains unknown and it is possible that the way in which the issues have been raised has minimised or affected the type and degree of response by management that in turn prevented the issues being raised with the Deputy Secretary.

FINDINGS:

- Despite awareness of, and attempts to locally resolve, the escalating issues within the NW Intake team at an operational level, the urgency and critical nature of the situation was not adequately communicated and escalated to the CYS Executive Leadership group for resolution until July 2015.

Culture and workplace behaviours

- For many years, the North West office has been observed to display negative cultural issues, exacerbated under the previous regional structure that isolated the North West office and enabled these novel practices to occur.
- This is displayed through behaviours such as:
    - A tangible divide between management and staff which generally permeates both offices.
    - An unwillingness to follow CPS policy and procedure as "the NW is different and does things differently" which is a historical assertion.
    - An inordinate level of tension between teams and team members, which affects communication and work flow, particularly between Intake and Response teams.
    - Avoidance of addressing critical issues due to the fear of being reported for bullying.
    - The use of work practices which could be perceived as deliberate attempts to delay the closure of cases, such as the refusal to undertake required work tasks or limiting the number of closures completed in any given week.

FINDINGS:

- Ongoing work needs to be undertaken to better understand and then manage and drive cultural change in the NW regional office.

Actions Taken in Response

Response Governance

- The CYS Executive Leadership Team (ELT) has overseen the North West response, drawing on professional expertise from across CYS.

- This oversight has included regular decision meetings of the group to ensure that aspects of the response are progressing and on track.

- Short term actions have resulted in a rapid response to address the backlog of reports, however ongoing monitoring is required for further analysis and review, as well as monitoring the implementation progress.

- It is suggested that a broader, longer term governance group is required to oversee the further review and monitor the implementation of performance improvement strategies.

Short Term Actions - Allocation of additional resources

- The decision by CYS ELT to mobilise additional resources in response, resulted in the following:
    - Reassignment of additional resources from within NW CPS to NW Intake (consisting of staff increasing their part-time work hours or other short term support).
    - Establishment of additional decision review mechanisms for children under three (two per week) to monitor case decision-making and ensure appropriate action is taken.
    - Relocation of an additional resource at the Team Leader level (for a period of three weeks) to work alongside NW Team Leaders and provide direct supervision to intake staff and quality assure/support decision making.
    - Addition of two further experienced staff members to the task of initially assessment and allocation of remaining notifications within NW intake
    - Implementation of mechanisms to monitor the through-put of cases from NW Intake to NW Response to ensure that Response are equipped to manage any resulting workflow.

Longer Term - System Improvement Strategies

- The report makes a number of recommendations which are being progressed by CYS. The follow up on those recommendations may be influenced by the following longer term actions.

- While previous reforms within CYS have arisen as a result of reviews and inquiries into adverse events and often been reactive in nature, there is an opportunity to pursue strategic whole of system improvement as a longer term outcome of the NW situation.

- Such service delivery requires a practice structure and practice approach which harnesses that potential for change and inspires workers and families alike. There is now a compelling case that the current ad-hoc service structure and design will not deliver the aspired to

outcomes and that our Child Protection Services (CPS) is simply no longer fit for purpose to achieve such outcomes.

- Whilst there is emerging evidence from a data perspective, as well as evidence from the field, that there are significant challenges in CPS and the need for change, there are a number of strengths within the Tasmanian child protection system that we must harness as we progress any further system change, namely:
  - we demonstrate organisational and service resilience
  - our staff are passionate about children and families, and genuinely want to make a difference.
  - We have strong partnerships across our services, our service partners and community providers
  - We show, through necessity, creativity and nimbleness in resolving chronic issues.
  - We rarely if ever get thanked for the work we do, but each day our services take on the challenge of working with one of the most intractable "wicked problems" of society
  - We have achieved, and continue to achieve, significant structural and organisational reform and / or change, often quietly and with persistence.
  - Our staff are reflective, and recognise the systemic, operational, practice and process changes required.
- Any system improvement should seek to restructure the way we deliver services, and the approach we take to engaging families, in order to increase the opportunities to work with families in the protective intervention space, thus increasing the likelihood of families remaining together.
- While the practices that are the subject of this report were unique to the North West, the culture and systems that enabled them to occur are statewide. The Department will, as a matter of urgency, develop an action plan based on international best practice, aimed at fundamentally changing the way the DHHS engages with families and applies protective intervention.
- While appropriate consultation is critical, the need for change is such that implementation must commence as soon as possible.
- Early in this report, we raised the need for effective governance arrangements to be put in place to consider and comment on the action plan to rebuild child protection services and to monitor progress and ensure its implementation.
- Such governance arrangements are not only critical for effective implementation but also for transparency such that the community can be assured that there is independent oversight of the action plan, the changes it recommends are timely and appropriate and that the DHHS is being held to the task of expediting their implementation.

- It is therefore critical that the Minister consider a governance arrangement, that combines government and independent stakeholders who can drive the completion of the action plan and its implementation.